

INSTITUTIONAL CARE OF THE ELDERLY IN IRELAND

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OF THE
ELDERLY
IN IRELAND**

THE NATIONAL COUNCIL FOR THE AGED

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INTRODUCTION

This report on *Institutional Care of the Elderly in Ireland* is a companion volume to *Housing of the Elderly in Ireland*. The two reports should be read in conjunction with one another. Reports already published by the National Council for the Aged, notably *Day Hospital Care*, *Community Services for the Elderly* and *Home from Home?* are also related to this present volume, as will be forthcoming studies by the Council on Transport, on Voluntary and Private Nursing Homes and on Family Carers.

The assumption that elderly persons are beyond help by virtue of their chronological age has had a negative impact on policy relating to the institutional care of the elderly. Certain cultural expectations relating to the 'dependent elderly' have adversely affected responses to the question of ageing. The dispelling of this 'myth of dependency' offers a useful starting point for discussing future hospital and institutional care provision for the elderly.

There are powerful social arguments against institutionalising elderly persons.¹ The desire to retain independence and/or to remain living in the community is strongly ingrained in our culture and should always be respected. People should be helped and encouraged to live in their own homes and in their own communities for as long as they wish and are able to do so. Elderly people should, at all times, be given the facilities and opportunities to function independently and to retain their identity as individual persons. Institutionalising elderly persons has frequently been seen as the only alternative to a difficult and complex situation at home or to a problem of 'bed blocking' in an acute hospital. The National Council for the Aged takes the view that early thoroughgoing assessment and appropriate practical and psychological support to families and caregivers in the community may well obviate, or at least postpone, the crises and breakdown in family relationships which so often precede application for long-term institutional care. The network of services and skills available in the community is very often inadequate or not harnessed to its full potential. Housing is frequently either inappropriate or inadequate. This leads to a sizeable proportion of elderly persons being admitted to institutional accommodation for 'social reasons' rather than because of physical or mental incapacity.

Comprehensive repairs and adaptation services to the houses of the elderly, together with appropriately designed and serviced special and sheltered housing, supported by day care facilities, day and in-patient hospital facilities, respite and intermittent care in-patient facilities and a range of support services are the prerequisites for effective care of the elderly in the community. Additionally, well organised nursing and home help provision will serve to more effectively support the family doctor and the community caring network—family, voluntary and statutory—and so enable many more elderly people to remain living independently with or near their families and relatives. In the case of those whose physical or mental capacity is such that they cannot be cared for in the community, continuing nursing or terminal care accommodation should be located as near as possible to the person's home and family and should be supported by a wide range of community services. In all instances, service provision for elderly persons should be based on the premise that people's level of dependency changes over time.

This report takes the *community* as its focus and establishes the context in which the general hospital and other hospital and institutional care services can best support the community caring network in achieving its full potential. Acute hospital and continuing nursing care are seen as serving the community caring network, which is also enhanced by improved and more appropriate housing and community services for the elderly.

While ensuring that fewer people end up in institutional care to which they are unsuited, it is also necessary in the short-term to offer the opportunity to those already in such care for purely 'social' reasons to return to live in the community. This requires positive discrimination in favour of such persons in the allocation of special and sheltered housing and in the provision of domiciliary services. In this respect the provision of more appropriately designed, serviced and located sheltered housing would add to the range of options available to elderly people in the community. The Council, while recognising that at Departmental level there has been some shift in emphasis away from the provision of welfare home type accommodation, urges that, in the future, there should be much more concentration on the provision of sheltered housing schemes as part of an infrastructure of community-based services for elderly persons.

The Council believes that the issue of institutional care for the elderly should be addressed in the Irish context as follows:

- (i) There is scope for the adoption of a new and more flexible role by some existing district and geriatric hospitals. This can be achieved by such hospitals taking on the role of *community hospital* which would provide a range of services, including continuing nursing care and intermittent care, ideally for a specific catchment area of approximately 15 miles radius with a population of 20-30,000 persons.

- (b) Existing welfare homes should be re-designated to provide a range of options depending on local demographic and spatial factors. Some such options would be:
 - (a) flats/apartments for those capable of independent living;
 - (b) a home or nursing unit catering for various levels of dependency;
 - (c) a care unit for confused elderly persons;
 - (d) day care facilities for those being cared for at home;
 - (e) intermittent care/floating bed facilities;
- (iii) In the future continuing nursing care facilities, day facilities and sheltered housing facilities for the elderly should be provided, if not on the same site, in close proximity to each other and should be based in the community. The term 'commuinity-based-unit' is used to denote this concept.

Such a policy would fulfil two roles

- (i) It would provide a dynamic and flexible approach aimed at restoring as much independence as possible to the elderly person to allow him/her to live independently at home with dignity and purpose.
- (ii) It would provide sensitive and sympathetic continuing nursing and terminal care in a location close to families and friends.

The Council strongly advocates that admission of elderly persons for long-term institutional care of any type should never be allowed to occur without *full assessment* and without having explored all possible avenues for their rehabilitation and maintenance of function to help them to live in the community.

The key to such assessment is an adequately staffed geriatric department in the general hospital supported by rehabilitation beds and facilities both in the general hospital and at other hospitals or units providing services for the elderly. A day hospital service for the elderly is an integral part of tile assessment and rehabilitation process. Day hospitals should be located in both general hospitals and geriatric and district hospitals as the latter take on the role of community hospital.

The primary aim of hospital care for the elderly should be to provide the required treatment and rehabilitation for the appropriate period in the appropriate hospital setting. The aim should also be to facilitate discharge as soon as the condition of the elderly person, home circumstances and community support services permit. The elderly person should be fully involved in any discussion on his/her future and in any decision reached, particularly if the decision involves admission to any form of continuing nursing care.

The Council takes the view that illness in old age, whether mental or physical, is still all too frequently attended by feelings of pessimism and helplessness Too many elderly patients are still offered treatment in outdated, poorly equipped and inadequate accommodation, granted to them in

the honest belief that such is all they need or can benefit from. Providers of health services sometimes mistakenly envisage legions of sick, disabled and mentally confused elderly people for whom even exhaustive provision would not make any difference. This view has been exacerbated by greater longevity of life and an increase in the numbers aged 75 years and over. 'On average care for the over 85s is at least three times the cost of care for those just over 65'² Some old people themselves regrettably accept and tolerate disease and disability for long periods, declining to seek treatment in the belief that nothing can be done. Such a situation requires an active educational approach supported by a positive dynamic and flexible system of care at all levels so as to ensure that old age and frailty are no longer associated with stigma, dependency or fear of being 'institutionalised'. It also requires a willingness to make financial allowances for demographic growth relating to both the growth in number and change in the profile of the elderly population in the coming decades.

PART I

DEMOGRAPHIC CONSIDERATIONS

1.1 Elderly Population

J.I.1.General

Demographic factors relating to the elderly* in Ireland have been discussed in detail in the report on *Housing of the Elderly in Ireland*, which is a companion volume to this report. Here it is sufficient to draw attention to some of the more salient points and to those specifically relating to hospital and institutional care of the elderly.

In 1981 there were 369,000 persons age 65 years and over¹ in the country as a whole. Between 1971 and 1981 there was an increase of 12% in the elderly population in Ireland, amounting to almost 40,000 persons. During this same period there was an increase of almost 16% in the population in general which means that the proportion of elderly persons in the total population has been declining somewhat; from just over 11% in 1971 to under 11% in 1981 (see Table 1, Appendix 1).

In 1981 there were 131,900 people aged 75 years and over in the country, representing almost 4% of the entire population and 36% of all elderly persons. There were 63,400 people aged 80 years and over, representing less than 2% of the entire population and just over 17% of all elderly persons (see Table 1, Appendix I). These figures show an increase of almost 11% in both age groups, 75 years and over and 80 years and over, in the 1971-1982 period.

In 1981 women accounted for 55% of all elderly persons.² 60% of those aged 75 years and over and 63% of those aged 80 years and over were women. These figures reflect the greater longevity of women's lives.

Improvements in social and economic conditions have led to a significant improvement in expectation of life at various ages over the past thirty years, as can be seen from Table 1.1.

* Throughout this report, the terms 'elderly', 'old' and 'aged' will be used interchangeably to refer to persons aged 65 years and over.

1.1. Life Expectancy: Expectation of Life at Selected Ages from 1950 to 1980

Period

		1950-52	1960-62	1970-72	1978-80
<i>Males:</i>					
Number of additional years a person can expect to live at age	0	64.5	68.1	68.8	69.5
	1	66.9	69.3	69.2	69.5
	5	63.6	65.7	65.5	65.7
	25	44.8	46.4	46.3	46.4
	45	27.0	27.8	27.6	27.7
	65	12.1	12.6	12.4	12.4
	75	6.8	7.1	7.3	7.1

Females:

Number of additional years a person can expect to live at age	0	67.1	71.9	73.5	75.0
	1	68.8	72.7	73.8	74.8
	5	65.4	69.0	70.0	71.0
	25	46.6	49.5	50.5	51.4
	45	28.9	30.7	31.4	32.1
	65	13.3	14.4	15.0	15.4
	75	7.6	8.1	8.5	8.8

Source: *Statistical Information Relevant to the Health Services*, Department of Health, 1984, Table A6.

It should be noted, however, that there has been very little increase in life expectancy for men in older age groups with almost no increase at age 65. Furthermore, the life expectancy at age 65 for all persons in Ireland is lower than in all other EEC countries with the exception of Luxembourg. (Appendix 1, Table 4).

1.2 Marital Status

In 1981 the breakdown of the elderly population according to marital status was as follows: (See also Appendix 1, Table 3)

	Aged 65 & Over	Aged 75 & Over
Single	24%	25%
Married	42%	28%
Widowed	34%	47%

Almost 50% of women aged 65 years and over and 60% of women aged 75 years and over are widows and in each case outnumber widowers by more than three to one. This is due, not only to the greater longevity of women's lives, but also because married women tend to be younger than their husbands.

1.1.3 Regional Distribution

In Ireland, there is a tendency for the elderly to be more heavily represented in the rural than in the urban population, a tendency which is quite marked in some of the poorest counties, as can be seen from Table 1.2.

Table 1.2 *Percentage of Population Aged 65 years and over in Selected Counties, 1981*

Counties with highest % Population aged 65 and over	% Population aged 65 and over	Ranking of County in National Income Per Capita League
Leitrim	17.6	26
Mayo	15.9	24
Roscommon	15.6	21
Sligo	14.2	19
Donegal	14.0	25

Sources: Census of Population, 1981, Volume 2; Gilligan, R., in Kennedy S. (Ed.) One Million Poor? Turoe Press, Dublin 1981, p.112.

Table 1.3 shows significantly higher percentages of elderly in the total area population of the North Western and Western Health Board areas as compared with other health board areas and, in particular, with the Eastern Health Board area. The respective figures for the 65 years and over age group are 14.5% for the North Western Health Board area, 14.1% for the Western Health Board area and 8.5% for the Eastern Health Board area.

Table 1.4 indicates that the proportion of persons aged 65 years and over living alone or in man and wife households has increased significantly, while the proportion living in other types of private households has declined.

Table 1.3 *Population of each Health Board Area by Age and Marital Status, 1981*

		Eastern	Midland	Mid Western	North Eastern	North Western	South Eastern	Southern	Western	Ireland
Total Population		1,194,735	202,146	308,212	288,980	208,195	374,575	525,235	341,327	3,443,405
<i>Age groups:</i>										
Number	0-14 years	357,581	63,554	94,896	91,871	61,968	117,578	156,516	99,765	1,043,729
	15-44 years	544,158	80,208	124,970	117,470	78,158	150,879	213,843	130,634	1,440,320
	45-64 years	191,426	36,478	54,085	49,505	37,822	65,331	93,162	62,593	590,402
	65-74 years	65,437	13,903	22,100	19,538	19,185	25,961	40,081	30,852	237,057
	75 years & over	36,133	8,003	12,161	10,596	11,062	14,826	21,633	17,483	131,897
Percentage	0-14 years	29.9	31.4	30.8	31.8	29.8	31.4	29.8	29.2	30.3
	15-44 years	45.5	39.7	40.5	40.6	37.5	40.3	40.7	38.3	41.8
	45-64 years	16.0	18.0	17.5	17.1	18.2	17.4	17.7	18.3	17.1
	65-74 years	5.5	6.9	7.2	6.8	9.2	6.9	7.6	9.0	6.9
	75 years & over	3.0	4.0	3.9	3.7	5.3	4.0	4.1	5.1	3.8
<i>Marital status (persons aged 15 years and over)</i>										
Number	Single	326,217	54,006	81,511	73,878	58,217	97,176	143,093	97,850	931,948
	Married	455,932	73,901	115,256	108,435	75,462	139,650	196,299	123,165	1,288,100
	Widowed	55,005	10,685	16,549	14,796	12,548	20,171	29,327	20,547	179,628
Percentage	Single	39.0	39.0	38.2	37.5	39.8	37.8	38.8	40.5	38.8
	Married	54.5	53.3	54.0	55.0	51.6	54.3	53.2	51.0	53.7
	Widowed	6.6	7.7	7.8	7.5	8.6	7.8	8.0	8.5	7.5
<i>Dependency ratio</i>		62.4	73.2	72.1	73.1	79.5	73.2	71.1	76.6	69.6

(number of persons aged 0-14 years and aged 65 years or over as a percentage of those aged 15-64 years)

Source: *Statistical Information Relevant to the Health Services*, Department of Health, 1984, Table A2

Table 1.4: *Elderly Persons Classified by Type of Household, 1961, 1966, 1971, 1979, 1981*

Type of Household	1961		1966		1971		1979		1981	
	Number	%	Number	%	Number	%	Number	%	Number	%
One Person	32,210	10.2	35,024	10.8	43,378	13.1	61,327	17.0	68,034	18.4
Man and wife	30,058	95	35,977	11.1	44,754	13.6	62,685	17.3	67,364	18.3
Mult Member Total	228,550	72.6	225,640	69.9	214,820	65.1	208,425	57.7	202,961	55.0
Man and wife and one or more children (of any age)							46,594	12.9	45,131	12.2
Man or wife with Other persons							15,239	4.2	15,507	4.2
Man and wife and one or more children (of any age) with other persons							39,875	11.0	39,530	10.7
Lone parent and one or more children (of any age) with or without other persons							40,186	11.1	39,801	10.8
Other							66,531	18.5	62,922	17.1
Non.Private Households ¹	24,245	7.7	26,366	8.2	27,136	8.2	28,938	8.0	30,595	8.3
All Types	315,063	100.0	323,007	100.0	329,819	100.0	361,375	100.0	368,954	100.0

¹ A non private household is a boarding house, hotel, guesthouse, barrack, hospital, nursing home, boarding school, religious institution, welfare institution, prison or ship.

Source: Census of Population 1961, Census of Population 1966, Census of Population 1971, Census of Population 1979, Census of Population 1981, Central Statistics Office, Dublin 2.

In 1981 there were 68,000 elderly persons living alone (an increase of 54% on the 1971 figure). However, despite these increases, it should be noted that a sizeable proportion of elderly persons continue to live in other types of private households, 55% in 1981.

1.2 Population Trends among the Elderly³

1.2.1 General

In 2006 it is projected that there will be 396,500 persons aged 65 years and over in the country, representing 10A% of the total population, of which 58% will be women.

In the period up to 2006 the elderly population itself is expected to age. From 1981 to 2006 there is expected to be a 20.2% increase in the number of elderly persons aged 75 years and over, by comparison with a 7.4% increase in the number aged 65 years and over and a 10.5% increase in the population as a whole.

Those aged 80 years and over numbered 63,400 in 1981 and constituted 17% of the elderly population. This figure is projected to rise to 81,200 in 2006 or over 20% of the elderly population. (See Appendix 1, Table 6.)

1.2.2 Regional Variations in Population Projections (See Appendix 1, Tables 7 and 8)

It is expected that the projected increases in the elderly population will not be distributed evenly throughout the country. While an overall national increase of 7.4% in the elderly population is expected during the period 1981 -2006, some areas will experience actual decreases in both absolute and relative terms (for example, Donegal, Kerry, Longford and all the counties of Connaught), while others will experience substantial increases (for example, Dublin County). In some instances the percentage of elderly in the total area population will increase even though there will be a decrease in the actual number of elderly persons in the area. For example, in Dublin County Borough the number of elderly persons is expected to decrease by over 9% in the period 1981-2006, but the actual percentage of elderly in the total area population will increase from 11% to 26%.

The number of those aged 75 years and over is expected to increase from 131,900 in 1981 to 158,500 in 2006, an increase of over 20%. The percentage increase in this age group for Counties Carlow, Offaly, Kildare, Louth, Meath and Wicklow and for the County Boroughs of Limerick, Waterford and Cork is expected to be higher than the national average. In the case of Dublin County the number of those aged 75 years and over in the area is expected to more than double in the 25 year period. In the case of Leitrim and Roscommon

there will be a decrease in the number aged 75 years and over.

Full details of these projections are given in Appendix 1, Tables 6,7 and 8.

1.2.3 *Projection of Number of Elderly Persons Living Alone* ⁴

During the period 1971-1981 there was a dramatic increase (57%) in the number of elderly persons living alone, from 43,400 in 1971 to 68,000 in 1981.

In 1981 there were 24,100 elderly male persons living alone. It is projected that in 2006 there will be 21,500 such persons, representing an 11% decrease over the 25 year period.

In 1981 there were 44,000 elderly female persons living alone. It is projected that in 2006 there will be 67,900 such persons, representing a 54% increase over the period.

These figures show a projected overall growth of 31% in the number of elderly persons living alone in the period up to 2006. (See *Housing of the Elderly in Ireland*, National Council for the Aged, 1985 for a fuller discussion of this topic).

1.3 Selected Policy Implications Relating to Demographic Trends

1.3.1 *General*

The projected growth in numbers of those aged 75 years and over in the population has important implications for health, housing and social services. The survival of many more people into old age increases the prevalence of both acute and chronic diseases and the burdens that this places on society and on the health and personal social services. It is likely that the majority of health and social problems, and certainly the most serious of them, occur in the older sectors of the elderly population. Table 1.5 shows that 65% of patients in long-stay geriatric units were aged 75 years and over in 1982, as compared with 22% aged 65-74 years. In this context, the Council wishes to draw attention to the relatively high proportion of persons aged under 65 years in long-stay geriatric units, particularly in health board institutions where some 10% of residents are under 65 years of age.

In 1980, the number of geriatric long-stay residential places per 1,000 persons was 13.2 for the 65-74 age group and 66.5 for the 75 plus age group.⁵ According to NESC projections, the growth in the number of elderly persons would require an increase in places of between 6.4% and 7.4% by 1986 and between 13.3% and 15.7% by 1991 to maintain existing facilities for long stay geriatric accommodation. Table 1.6 gives the projected requirement⁵ for the 65-74 and 75 plus age group for 1986 and 1991, based on the assumption of zero net migration in the period 1981-1991.

Table 1.5 *Age Distribution of Patients in Long-Stay Geriatric Units 31 December 1982*

Category of unit	Health Board		Voluntary & Private	
	Geriatric Hospitals/ Homes	Health Board Welfare Homes	Hospitals/ Homes	Total
Age	%	%	%	%
Under 40 years	0.9	0.1	0	0.7
40-4 years	9.1	8.3	3.8	7.0
65-74 years	24.4	26.4	17.8	22.0
75 years and over	64.9	65.2	64.7	64.9
Not stated	0.7	—	13.3	5.6
Total - Per Cent	100.0	100.0	100.1	100.2
-Number	7,253	1,398	5,583	14,234

Source: *Statistical Information Relevant to the Health Services*, Department of Health, 1984, Table G20

Table 1.6 *Application of Demographic Projections to 1980 Distribution of Geriatric Long-Stay Institutional Places*

Age Group	% Distribution of places in 1980	Projected Requirements	
		1986	1991
75+	67.3	73.8	81.2
65-74	23.5	24.7	24.8

Source: *Health Services: The Implications of Demographic Change*, NESC Report, No.73, Table A2.18.

The policy implications of the NESC projections are two-fold. Firstly, bearing in mind that a significant proportion of the existing institutional care accommodation for the elderly is old and inadequate, any new facilities likely to be provided in the 1980s and onwards will not make it possible to replace old accommodation unless the overall proportion of the elderly population in institutional care can be reduced.

Secondly, the greatest projected requirements for long term care accommodation are in the 75 plus age group. These requirements should be reviewed in the context of improved community support services which can cater for more of the needs of this age group than is currently the case.

1.3.2 Single and Widowed Elderly People

The relatively high numbers of elderly people in the single and widowed category and the growing proportion of these living alone are also likely to make greater demands at all levels of care provision-family, voluntary and statutory. Single or widowed people, particularly if living alone, are more likely to neglect themselves than their married peers, and, to a greater extent require special provision for their care. Binchy and Walsh found that, among admissions of those aged 65 years and over to geriatric and psychiatric facilities in one catchment area, those having a living spouse constituted less than one-third of geriatric admissions and less than one quarter of psychiatric admissions⁶ The Department of Health survey⁷ of persons in long-stay geriatric institutions in 1975 showed that 40% of such persons would otherwise live alone.

Table 1.7 compares the marital status of the elderly population in general with that of elderly persons in geriatric institutions and shows significantly higher proportions of single persons in geriatric institutions than in the population in general.

Table 1.7 *Percentage Distribution of Persons Aged 65 Years and Over by Marital Status in Ireland, 1981 and in Geriatric Institutions, 1975*

	Male				Female			
	Single	Married	Wdwd	Total	Single	Married	Wdwd	Total
1981 Census (Ireland)	26.0	57.4	16.6	100	23.2	29.3	47.5	100
Survey of patients in Geriatric Institutions	67.7	11.0	21.3	100	49.7	8.7	41.6	100

Sources: Survey of Long-Stay Geriatric Patients (1975), Department of Health; Census of Population, 1981, Central Statistics Office, Dublin.

For example while only 26% of the elderly male population are single, 67% of males in Geriatric Institutions are single.

The Council believes that the policy implications relating to increases in the numbers of those aged 75 years and over and to the numbers of elderly people living alone should be addressed in the context of a comprehensive

planning process aimed at achieving the right balance between community and hospital/institutional care services for the elderly.

1.3.3 Local and Regional Variations

The Council recognises that there is a need for varying policy responses to meet the needs of the elderly in various parts of the country. These will be influenced by the following factors:

- (i) the current and projected proportion of elderly persons in the community with particular reference to those aged 75 years and over;
- (ii) the percentage of the population in the 'dependent' age groups (i.e. 0-14 years and 65 years and over);
- (iii) the tenure, location and facilities of households occupied by elderly persons;
- (iv) the potential for family and voluntary care of elderly persons in the community;
- (v) the urban/rural mix in the distribution of population and the related distance from service centres;
- (vi) the traditional and cultural 'styles' of caring, if any, in the particular community;
- (vii) the actual and potential sources of income of the elderly.

In this context it is likely that changes in population in the country as a whole may be less important than local needs and demands which have themselves been determined by local changes in the distribution of population and in the patterns of internal migration.

The growth in population which occurred in the 1971-1981 period was accompanied by a strong trend towards increased urbanisation. While the total population in the country increased by almost 16% the population in aggregate town areas rose by almost 21% as compared with a less than 10% increase in the population of aggregate rural areas (see Table 1.8). In 1981 almost 56% of the total population of the country was living in aggregate town areas with more than half of those living in Dublin and Cork. In the eastern planning region, which includes Dublin, over 85% of the population is living in aggregate town areas, with 71% living in Dublin. By contrast, in the Donegal planning region over 80% of the population lives in aggregate rural areas with 64% living in complete rural areas, i.e. in areas where towns and villages have not more than 50 inhabited houses.

There is a need to adapt and 'fine tune' general and national policies of care provision for the elderly in accordance with local conditions and requirements. For example, it is likely that very rural areas which are distant from service centres will require many more services provided 'on wheels' than urban/town areas. Even within regions (e.g. health board regions) distinctive forms of provision will be required from area to area depending on local demographic, spatial and housing factors.

Table 1.8 *Population in town and rural areas and percentage of population in various size towns, 1981 with % change 1971-1981*
Percentage of Total Population in:

Planning Region	Total Population (% Change 1971-'81)	Aggregate Town Area Population (% Change 1971-'81)	Aggregate Rural Area Population (% Change 1971-'81)	Towns 100,000 and over	Towns 10,00 to 100,000	Towns 1,500 to 10,000	Towns under 1,500 *	County Districts
East	1,290,154 +21.5	1,098,878 +21.6	191,276 +20.8	70.9	5.3	8.9	2.8	12.0
South West	525,235 +12.8	259,660 +17.7	265,575 + 8.4	28.5	3.2	17.7	7.8	42.8
South East	374,575 +14.0	152,253 +17.3	222,322 +11.8	-	26.5	14.1	8.7	50.6
North East	193,561 +11.3	77,770 +18.0	115,791 + 7.2	-	27.1	13.1	9.5	50.3
Mid West	308,211 +14.2	126,715 +22.3	181,497 + 9.2	-	29.3	11.9	11.3	47.6
Donegal	125,112 +15.5	24,626 +26.3	100,486 +13.1	-	-	19.7	16.2	64.1
Midlands	256,689 + IOA	76,784 + 19.9	179,905 + 6.8	-	10.3	19.6	10.8	59.3
West	286,784 +10.8	78,420 +27.0	208,364 + 5.8	-	14.6	12.7	8.5	64.1
North West	83,083 + 5.7	19,679 +22.0	63,404 + 1.4	-	21.7	2.0	13.8	62.5
TOTAL	3,443,405 +15.6	1,914,785 +20.8	1,528,620 + 9.7	30.9	12.0	12.7	7.2	37.2

* But with at least 50 inhabited houses

Source: *The Human Settlements Situation and Related Trends and Policies*, Monograph, Department of the Environment, 1983, Table 8.

The Council takes the view that local planning is an integral part of the development of appropriate local policies and strategies. National guidelines and norms relating to personnel, numbers and types of facilities to be provided need to be continually interpreted and applied in the light of the foregoing considerations. In this context the Council sees co-ordination at local level in the planning and delivery of services for the elderly as essential to the provision of an effective programme of care. Such an approach helps to ensure that statutory financial resources are used in a manner which takes cognisance of area and local priorities. It also serves to ensure that the real need on the ground is identified and an appropriate strategy for meeting this need is identified.

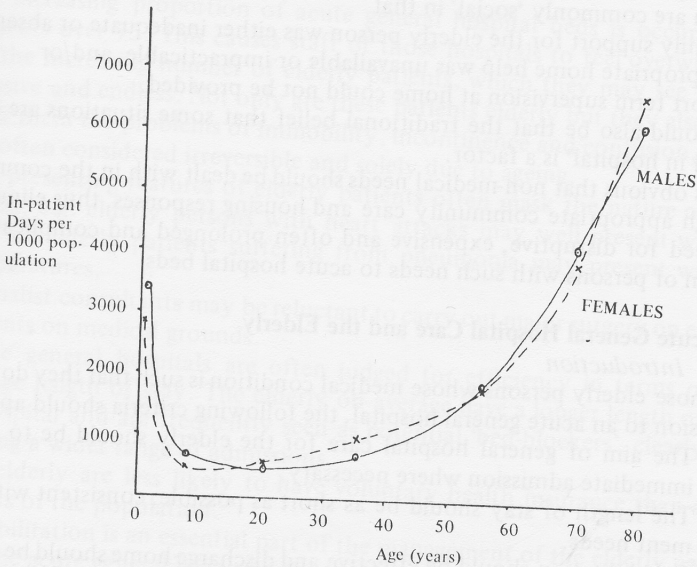
PART II

GENERAL HOSPITAL CARE

2.1 Introduction

There is a higher prevalence of illness among elderly persons than among the population in general. Much of this can be attributed to the gradual biological impairment and failure of certain organs. Most illnesses of elderly persons are adequately managed in their own homes by general practitioners with or without community care services back up. However, an increased usage of acute hospital services does occur with increasing years. This point is illustrated by Figure I.

Figure I *Usage of Acute Hospital Services by Age and Sex*
(In-patient days per 1,000 persons in relevant age group)



Those aged 65 years and over occupy up to 40% of all acute hospital bed days.¹ This is due in part to their longer average duration of stay, as is illustrated in Table 2.1.

Source: *Health Services: The Implications of Demographic Change*, NESC Report No. 73, 1983, Figure 2.1.

Table 2.1 *Average Duration of Stay in Acute Hospitals, 1979 (Days per Age Group)*

Age Group (Years)	Males	Females	Persons
25-44	7.2	6.7	6.9
45-64	11.5	11.9	11.7
65-74	14.9	17.8	16.2
75+	17.6	24.9	21.5

Source: *Health Services: The Implications of Demographic Change*, NESC Report, No.73, 1983, Table A2.2.

It has been suggested² that a significant number of elderly people who are admitted to acute hospital beds may not be there for medical or nursing reasons primarily. The non medical factors which are likely to precipitate admission are commonly 'social' in that (a) family support for the elderly person was either inadequate or absent, (b) appropriate home help was unavailable or impracticable, and/or (c) short term supervision at home could not be provided.

It could also be that the traditional belief that some Situations are 'better treated in hospital' is a factor.

It is obvious that non-medical needs should be dealt with in the community through appropriate community care and housing responses, thus eliminating the need for disruptive, expensive and often prolonged and complicated admission of persons with such needs to acute hospital beds.

2.2 Acute General Hospital Care and the Elderly

2.2.1 Introduction

For those elderly persons whose medical condition is such that they do require admission to an acute general hospital, the following criteria should apply:

- (i) The aim of general hospital care for the elderly should be to provide immediate admission where necessary.
- (ii) The length of stay should be as short as possible, consistent with treatment needs.
- (iii) Rehabilitation should be effective and discharge home should be planned in co-ordination with the community care programme.

In this respect the general hospital is seen as a key element in the overall care provision for the elderly and, as such, must be geared towards helping old people who become ill to return to live independently in their own homes. If the hospital fails to provide immediate or expert care for an elderly person who falls ill or needs rehabilitation, unnecessary suffering and increased disability are inevitable consequences. Moreover, the community services lose

confidence and morale if they are called upon to provide degrees of care and support for which they are not intended and not equipped.

The *Care of the Aged Report*, 1968³ stated that it was frequently difficult to obtain a bed for an elderly person in urgent need of hospital care. Despite a substantial increase in the number of admissions to general hospitals since that time, it is still difficult in 1985 to obtain a bed for an elderly person who requires such care. The very old, disabled, confused, incontinent old people find it difficult to get into acute general hospitals because they are thought of as those who go into long-stay geriatric or welfare homes. The staff of the general hospital may feel that the elderly patient may require a prolonged period of in-patient care and even long-term care. They may also feel that the general hospital is ill-equipped to provide prolonged rehabilitation. The general hospital also often has difficulties in placing patients requiring long-term care.

The main problems in acute general hospital care for the elderly person can be summarised as follows:

1. An increasing proportion of acute general hospital beds is occupied by patients over 75. This causes staff of those hospitals to feel overwhelmed by the increasing number of elderly patients, which they may see as progressive and endless. Not only are these patients elderly but they also bring with them the problems of immobility, incontinence and confusion, which are often considered irreversible and solely due to ageing.
2. The presenting features of elderly patients often mask the nature of their illness, e.g. elderly persons with heart attacks may well present without pain or elderly patients suffering from pneumonia may present without temperatures.
3. Specialist consultants may be reluctant to carry out major surgery on elderly patients on medical grounds.
4. Acute general hospitals are often judged for efficiency in terms of the average length of stay. The elderly on average have a longer length of stay in hospital and are frequently seen as potential 'bed-blockers', clearly preventing a wider range of admissions.
5. The elderly are less likely to have voluntary health insurance than other sectors of the population.
6. Rehabilitation is an essential part of the management of the elderly patient and the acute general hospital often lacks the rehabilitation facilities necessary, particularly for those patients who need more prolonged rehabilitation.
7. The acute general hospital lacks well defined links with rehabilitation, day hospital, continuing care facilities and convalescent beds for the elderly. Hospital staff are, therefore, forced to make inappropriate decisions early in the course of an elderly person's illness. Often in their eyes the choice is simple—either the patient goes home or goes to long-stay accommodation. This leads to the premature placement of the elderly in long-stay or nursing

home accommodation without any real attempt at comprehensive rehabilitation.

8. Acute general hospital staff do not really see themselves as having responsibility for the elaborate and detailed planning of discharge for elderly patients in most instances.
9. The elderly transferred from the acute general hospital to long-stay or nursing home accommodation are unlikely ever to go home again.

2.2.2 Projected Increases in Use of Acute Hospital Services by Elderly Persons

The projected increases in the use of acute hospital services in in-patient days by those aged 65 and over and by those aged 75 years and over can be seen from Table 2.2. which gives the projections for the year 1991.

Table 2.2 *Actual (1979) and Projected (1991) Usage by Elderly Persons of Hospital Services in In-Patient Days. In parenthesis is % increase on 1979 consumption.*

Age	Males		Females		All Persons	
	1979	1991	1979	1991	1979	1991
	(actual)		(actual)		(actual)	
65 plus	781.4	838.6	983.5	1128.7	1764.9	1967.3
		(7.3%)		(14.8%)		(11.5%)
75 plus	322.5	387.9	510.7	617.3	833.2	1005.2
		(20.3%)		(20.9%)		(20.6%)

Assumption: Zero Net Emigration 1981-1991

Source: *Health Services: The Implications of Demographic Change*, NFSC Report No.73. 1983, Tables A2.4, A2.5.

These projections indicate an overall increase of 11.5% in the usage of acute hospital services by all elderly persons with a very significant increase of 20.6% in usage by those aged 75 years and over.

In the Council's view, the projected increases in usage of acute hospital in-patient services by elderly persons should not be regarded as inevitable but should be continuously reviewed in the context of improved assessment, rehabilitation and discharge procedures which are discussed in this report. Such procedures will, of course, be greatly enhanced by improved housing and community care services for the elderly.

2.3 Geriatric Departments in General Hospitals

2.3.1 Introduction

The term 'geriatric department' is used here to refer to an area in a general hospital which can offer total investigative, consultative and therapeutic services for patients aged 65 years and over on either a day or an in-patient basis.

The Care of the Aged Report, 1968,⁴ recommended that in order to improve the care of the elderly in general hospitals, geriatric assessment units should be provided under the direction of a consultant physician in geriatric medicine. Since 1968, there has been a limited development of geriatric departments within general hospitals and there are now seven departments in general hospitals or in groups of general hospitals staffed by ten consultant physicians in geriatric medicine.

In general hospitals which have a geriatric department, many of the problems associated with the acute general hospital care of the elderly referred to above can be circumvented and the elderly patient is more comprehensively assessed, treated and referred. In contrast to other medical departments in a general hospital, the geriatric department is ideally involved in the total care-acute, rehabilitative, day and long-stay-of patients, who are predominantly aged over 75 years.

In practice, the general practitioner decides to admit a patient to a geriatric department rather than to another hospital medical department because of the following factors;

1. advanced age;
2. multiple medical problems;
3. physical dependency;
4. relevant social and environmental factors;
5. serious emotional and psychological factors;
6. one or more of the following common presentations-incontinence, falls, immobility, confusion.

These striking presenting features tend to mask the specific nature of the disease in many instances. Such elderly patients require adequate assessment procedures and an active rehabilitation programme. In order to achieve this the length of stay in the case of some patients may be protracted.

2.3.2 Role of Geriatric Departments

1. Geriatric medicine requires the team approach, the integration of nursing, medical and para-medical staff, to achieve maximum functional recovery of elderly patients. This integration can be most effectively achieved in the geriatric department of the general hospital. The geriatric department requires sufficient beds relative to its catchment population and needs toll access to the diagnostic and rehabilitation facilities of the general hospital.

Some rehabilitation facilities and most long-stay care facilities will be located outside the general hospital.

2. Geriatric departments are geared to deal more effectively than other departments in a general hospital with the increasing number of elderly patients. Planning for more effective use of existing services to deal with problems such as immobility, incontinence and confusion, which are so common in this age group, is more easily attainable in the context of the geriatric department.
3. The average length of stay of the elderly in a geriatric department is much lower than the average length of acute general hospital stay for all elderly patients. For example, figures relating to the Geriatric Medical Department, Cork Regional Hospital shows that the average length of stay in 1983 was 7.67 days.⁵ This compares with a national average of 16.2 days for those aged 65-74 and 21.5 days for those aged 75 years and over (see Table 2.1).
4. A geriatric department cannot function in isolation. It is part of an infrastructure providing a range of services, health and social, for elderly persons. Thus, two-way links with all relevant personnel and agencies is an integral part of the programme of the geriatric department.
5. A geriatric department has assessment, rehabilitation and day hospital facilities and has access to convalescent bed facilities when required. Therefore, premature placement of elderly patients in long-stay accommodation is less likely to take place.
6. Rehabilitation is an integral part of the programme in the geriatric department. This will be discussed in detail below.
7. Training placement of nurses, doctors, physiotherapists or occupational therapists in the geriatric department exposes them to a certain attitude to illness among the elderly which in the long term contributes to attitudinal change in medical and caring professions generally.
8. The geriatric department serves an important function in that innovative and more effective methods and programmes of assessment and rehabilitation can be pioneered and developed and subsequently come to be used in other hospitals, for example in the community hospital, (see 3.2) and in the homes of elderly persons.

2.3.3 Role of Consultative Physician in Geriatric Medicine

The Council recognises the need for expertise in the analysis and treatment of illness among elderly persons and sees geriatric medicine as a speciality in its own right.

The consultant physician in geriatric medicine attached to the geriatric department in a general hospital is trained and skilled in the particular aspect of medicine that relates to the elderly and is a specialist in this area. He/she is expected to have the up-to-date knowledge and expertise in relation to ill-

ness among the elderly, and in this capacity interacts with other consultants in the general hospital and engages in two way referral of elderly patients.

The Council believes that elderly people, like the rest of the population, can benefit enormously from developments in medical technology. Indeed, in some respects it is precisely because of such developments that we are now faced with the 'problem' of the 'very old'. It may be the case, however, that very elderly people are unable to represent themselves in the general hospital milieu where there is 'competition' for very expensive high technology medicine -In this situation the consultant physician in geriatric medicine plays a crucially important role in ensuring that elderly patients who can benefit from such treatment are not excluded. For example, he/she can ensure that someone is not denied a vital service (e.g. renal dialysis) simply on the grounds of age. The presence of the consultant physician in geriatric medicine together with the support services of the geriatric department establishes a clear identity for geriatric medicine in the general hospital and consequently provides for more effective treatment and care of elderly patients.

The consultant physician in geriatric medicine has been described as someone 'who knows the pathways whereby people can re-enter ordinary life'.⁶ He/she plays an important role in the restoration and maintenance of function in frail elderly persons, particularly in the very old who may have multiple problems, by enabling appropriate diagnosis, treatment and/or appropriate referral. In this way the consultant physician gives other specialities confidence to deal with and treat elderly persons. For example, an orthopaedic surgeon may be more likely to carry out a hip replacement on an elderly person if he/she has been assessed as being medically fit for such surgery by the consultant physician in geriatric medicine.

The consultant physician in geriatric medicine is also an important source of referral for the general practitioner or medical supervisor in other hospitals and homes catering for elderly persons in cases where there are complex or multiple problems requiring more expert diagnosis and assessment. Such referral will obviously only be required in a small number of cases and in some instances assessment can be carried out on a day-patient basis.

2.3.4 Assessment

The issue of assessment for elderly persons requiring care and the importance of developing comprehensive and co-ordinated assessment procedures is discussed in detail in Part 4 of this report in the context of Planning Future Services for the Elderly. Effective and purposeful general hospital care of the elderly requires an efficient, comprehensive and appropriate system of assessment, ideally carried out in the geriatric department using a multi-disciplinary team approach.

In the hospital context it is essential to assess for the presence of disease and disability, to determine the prognosis and the potential for functional

recovery and to consider the social background and its relationship to the patient's future. The aim is to identify and meet the service needs of the elderly person and thus enable him/her to continue to live at home at an optimal level of health, comfort and independence.

2.3.5 Rehabilitation

Rehabilitation is one of the key functions of the geriatric department and a key element in the success of geriatric medicine. The targets of rehabilitation can be summarised as follows:

- (a) restoration of lost function and the person's former role;
- (b) maximal use of partial function and attainment of an altered role;
- (c) adaptation to reduced function and a reduced role.

Where realistic individually tailored targets are set, rehabilitation failures are rare and are more likely to be due to professional errors than to lack of patient motivation. The assessment depends on knowing not only what the patient's present state is, but 'who he was, who he is and how he got there.'

Ideally the doctor and other professionals should assess patients in their own environment and talk to them about things that matter to them. In this way rehabilitation can be based both on realism and on sensitivity to the individual patient's personality and wishes. Even if, as often happens, only small improvements are possible and independence is not to be hoped for, a rehabilitation approach may increase morale and self-esteem and lead people to make the most of what is left to them or at least to make their lives a little less barren. Rehabilitation may also mean helping them to keep an attractive and resilient personality despite disability. The vital issue for every elderly person is rehabilitation, even in serious illness.

Geriatric medicine may be said to be ahead of general medicine in putting rehabilitation at the centre. The emphasis is on getting patients up and dressed, and on encouraging them to get going again. New ideas and good practices abound in many centres and for many practitioners geriatric medicine is a developing and exciting area to work in. The multiplicity of disorders and difficulties in old age make it especially important to pinpoint the separate strands of disability, searching for causes that can be remedied or modified. The expectation of patients and family, and even doctors, is often low and social and economic adversity may well, of course, compound health problems at this time in life. In order to overcome these difficulties the team approach, with a truly interdisciplinary cohesive group working together, is particularly crucial to the planning process that must underpin all rehabilitation programmes⁷. This team approach integrates the nursing, medical and para-medical staff who work together to achieve maximum functional recovery of elderly patients.

Patients who have been assessed and treated in a geriatric department, when discharged, will either return to live in the community (sometimes being

referred for further rehabilitation) or they will be referred to continuing nursing care. In the Council's view, the effective and purposeful discharge of elderly patients requires the development of the concept of a wider team approach. This wider team concept envisages the physician in geriatric medicine and the team of the geriatric department working in close co-operation with other health and social services personnel, for example,

- the general practitioner,
- the director of community care,
- the public health nurse,
- the social worker,
- the staff of district and geriatric hospitals.

It will also involve co-operation with housing authorities and voluntary agencies involved in caring for elderly persons in the community.

In order to achieve this co-operation it will be necessary to set up appropriate structures for co-ordination at local level. The concept of local coordination is considered in 4.2.8 of this Report.

2.3.6 Development of Geriatric Departments in Ireland – Current Position

The Council carried out a review of what progress has been made since the publication of the *Care of the Aged* report in relation to the development of specialist geriatric services involving the appointment of consultant physicians in geriatric medicine and the provision of a geriatric assessment, rehabilitation and day hospital facilities. The position regarding development to date or currently planned is shown on table 2.3.

Table 2.3 includes only those general hospitals in respect of which geriatric assessment/rehabilitation or day hospital facilities and services, including the appointment of a physician in geriatric medicine, have either been established since 1968 or where the development of such facilities or the appointment of a physician in geriatric medicine is planned. Of the total of ten physicians in geriatric medicine already appointed, five are located in Dublin, two are in Cork and one each in Galway, Castlebar and Sligo.

2.3.7 Reasons for the Slow Development of Geriatric Medicine in Ireland

Developments in geriatric medicine have been slow in Ireland. The Council sees the following as some of the underlying reasons for this:

1. The existence of a unified National Health Service in the United Kingdom appears to have assisted the growth of geriatric medicine, whereas in Ireland many of the general hospitals, particularly those in the cities, are independently managed, while the district hospitals and geriatric hospitals are under the aegis of the health boards or religious groups.
2. A consultant physician in geriatric medicine has to develop a service which is wider in scope than the general hospital itself. Many rehabilitation and long-stay facilities are located outside the general hospital.

Table 2.3 *Current and Planned Geriatric Services by Health Board Areas, 1985*

Health Board Area and location	Number of Consultant Staffed Facilities						
	Physicians in						
	Geriatric Medicine Appointed or Planned	Assessments Current Planned		Rehabilitation Current Planned		Day Hospital Current Planned	
<i>Eastern Health Board</i>							
St James' Hospital	2	60	60	57	90	50	50
St Vincent's Hospital	1 Appointed	28	45	-	Yet to be planned	-	Yet to be planned
St Columcille's Hospital		-	15	-	15	-	10
St Michael's Hospital	1 Planned	-	-	-	Yet to be planned		Yet to be planned
James Connolly Memorial Hospital		28	30*	28	30*	15	30
St Mary's Hospital	2	45	-	61	-	30	-
St Laurence's Hospital		30		-	†	-	†
Mater Hospital		-	25*	-	25*	-	Yettobe planned
Beaumont Hospital	Under consideration	-	30*	-	30*	-	Yet to be planned
Tallaght Hospital	Does not arise yet	-	15	-	15		20
Naas Hospital	1 Planned	-	15	-	15		10
Midland Health Board							
Tullamore	Post unfilled	Included in	98 bed unit			-	-

*Combined Assessment & Rehabilitation

† See Beaumont Hospital

Mid-Western Health Board

Regional Hospital Umerick	1 Planned	-	20	-	Yet to be planned	-	Yet to be planned
General Hospital Ennis	1 Planned	-	10	-	Yet to be planned	-	Yet to be planned

North-Eastern Health Board

Cavan	Under consideration for area	-	70*	-	70*	-	-
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North-Western Board

Sligo General Hospital	1 Appointed	16	-	so	-	50	-
Letterkenny General Hospital	-	-	-	-	-	-	-

South-Eastern Health Board

Ardkeen General Hospital	1 Sessional now in Community Care	-	12	-	-	-	-
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Southern Health Board

Cork Regional Hospital		30	-	-	-	-	-
St Finbar's Hospital	2 Appointed	80*	-	80*	-	20	-
Tralee General Hospital	1 Planned	-	30*	-	30*	-	-

Western Health Board

Merlin Park Regional Hospital	1 Appointed	28*	-	28*	-	-	-
Castlebar General Hospital	1 Appointed	10/12	15	16/20	-	-	Under discussion

* Combined Assessment & Rehabilitation

3. The availability of beds and other resources in the general hospital itself has been a major difficulty. Other medical staff have had mixed views on the contribution and efficiency of a geriatric department. They may view the establishment of such a department as a threat, especially if that involves any sharing of existing beds and resources.
4. There appears not to have been a strong central policy direction or commitment to the development of geriatric departments. Where additional resources are involved, geriatric medicine has not rated as highly in the order of priorities as some of the other specialities.
5. Too much may have been expected from those geriatric departments that have been established, often with inadequate resources. These departments have, perhaps, had varying degrees of success/effectiveness both within the general hospital context and in their wider involvement with other institutional and community services.
6. There have been a variety of perceptions, both in theory and in practice, not only of the role and function of the geriatric department but also of the role and function of the consultant physician in geriatric medicine. Geriatric medicine as a speciality in its own right has not had universal acceptance by other specialities.
7. In some instances it has been deemed to be more appropriate to allocate scarce resources to the development of smaller scale assessment and rehabilitation units attached to district and geriatric hospitals. This is especially true in the more sparsely populated rural areas where the general hospital is located at a considerable distance from where some of the elderly persons live.

2.3.8 Future Development of Geriatric Departments

The Council advocates the future expansion of geriatric departments in general hospitals and the appointment of the necessary consultant physicians in geriatric medicine. These geriatric departments should provide specialist assessment and rehabilitation services for those elderly persons who cannot be adequately catered for by the general practitioner or in the geriatric and district hospital. In order to achieve this, the hospital based geriatric department, while having sufficient beds relative to its catchment population and full access to the diagnostic and rehabilitative facilities of the general hospital, should have clearly established links with geriatric and district hospitals and with other long-stay facilities. It should also have such links with community services generally. In the Council's view, the physician in geriatric medicine and the geriatric department of a general hospital can make a more positive and effective contribution if working in close co-operation with these other services in meeting the overall needs of the elderly.

2.3.9 Number of Beds/Places Required

Various norms have been published for bed requirements for the elderly. *The Care of the Aged* report, 1968⁸ recommended that 4.5 beds per 1,000 of the population over 65 years should be allocated for assessment including investigation, treatment and rehabilitation of the elderly. This norm of 4.5 beds would, it was considered, provide 1.0 beds for assessment and about 3.5 for rehabilitation.

The Irish Society of Physicians in Geriatric Medicine,⁹ basing its conclusions mainly on the experience gained by geriatricians involved in the development of services in Dublin and Cork, has recommended a planning norm of 5.5 beds, 2.5 for assessment and 3.0 for rehabilitation. The Department of Health, in association with representatives of the medical profession and the health boards, is currently undertaking a study of the use of geriatric assessment units and general medical wards in acute hospitals by the elderly. The study is aimed at obtaining information on medical, social and demographic factors of elderly persons treated in acute hospitals and on the liaison between primary health care and acute hospital care for the elderly. It is hoped that, among other things, the study when completed, will provide relevant information by which the adequacy of current norms can be judged.

The Council acknowledges and wishes to emphasise that national planning guidelines must on all occasions be interpreted to take into account local spatial and demographic factors.

2.3.10 Other Assessment and Rehabilitation Facilities

In addition to the assessment and rehabilitation facilities provided in the geriatric department of the general hospital, the Council recognises that it will also be necessary to provide assessment and rehabilitation facilities in the more local district and geriatric hospitals and associated day hospitals and thus eliminate, as far as possible, unnecessary admission to or detention in the general hospital. Referral to the consultant physician in geriatric medicine should, of course, always be made where deemed necessary.

The Council thus recommends that in addition to the assessment and rehabilitation programmes provided in the geriatric department of the general hospital, active programmes of assessment and rehabilitation should also be provided in other hospitals: geriatric hospitals, district hospitals and associated day hospitals.

2.4 Day Hospitals

2.4.1

Day hospital care has already been referred to in this report and has been the subject of a separate report by the National Council for the Aged.¹⁰ However,

because of the continuing and growing importance of day hospitals in the delivery of health services to the elderly, the topic warrants some further consideration.

The Council sees the day hospital as one of the most valuable arms of the geriatric hospital service. The increasing number of old people in the population, together with the ever increasing cost of hospital in-patient care, suggest that the full application of the principles of day hospital care, as stated by the Council,¹¹ would result in considerable savings in hospital expenses and would improve considerably the delivery of hospital services to the elderly population. The overall objective of day hospitals is to provide all the services available within the hospital on a day4ime only basis. In this way it is possible to extend the hospital services to people in the community for whom inpatient care is either unnecessary, undesirable or unavailable. The day hospital attached to a geriatric department in a general hospital can carry out both assessment and rehabilitation functions. Day hospitals attached to geriatric or district hospitals can provide a rehabilitation service and play an important role in maintaining function in elderly persons. All day hospitals, to a greater or lesser degree, fulfil an important social function, including the provision of a range of non-medical services.

The day hospital serves to retain the person's link with the community. The person attending the day hospital gets the required hospital service while maintaining his/her residence in the community. The existence of the day hospital frequently facilitates the early discharge of a patient from hospital. In addition, the day hospital also provides an important preventive function in that it enables an elderly person to get the full benefit of hospital services while remaining active and mobile in the community.

The Council considers that where geriatric assessment and rehabilitation beds have been provided or planned for a general hospital, a day hospital facility for the elderly should be instituted. Geriatric and district hospitals, particularly those involved in screening admissions and in rehabilitation of the elderly, should also establish day hospital services at their level for the elderly.

2A.2 Transport¹²

One of the key elements in the successful functioning of a day hospital is the provision of transport. This is an area where the cost factor is important. Where it is necessary to provide transport, effort must be made to ensure that all the available local options are explored. Different approaches to the provision of transport will be necessary depending on local circumstances. In son3e instances, for example, health boards may be in a position to provide transport by ambulance or mini-bus from their own fleet or by hiring private mini-buses. In other instances the provision of transport on a voluntary basis may be a more appropriate solution. While the involvement of voluntary

agencies in providing transport should be encouraged, where possible, it must be recognised that there may be limitations to this type of service during the day. Every effort should be made to ensure that patients do not spend a disproportionate amount of time in travelling to and from the day hospital. Special provision should be made for those patients who require frequent visits. Some vehicles will need to be fitted with a wheelchair lift and/or a walking ramp. The Council wishes to emphasise that an efficient and reliable day hospital transport service, using all the options available locally, requires careful planning and regular review -

2.4.3 Mobile Day Hospital

There are practical limitations to extending the coverage of day hospital services for the elderly. These relate in the main to the fact that day hospital services are usually developed in association with an existing in-patient service and consequently the problems of travelling to such clinics have proved to be barriers preventing access to day hospital services for a significant number of elderly persons.

The Council favours the idea, which has already been mooted¹³ of developing a mobile day hospital service in certain instances and suggests that a scheme should be introduced, initially on a pilot basis, in a strategically selected area.

2.4.4 Number of Day Hospital Places

The development of day hospitals in Ireland to date has been rather slow.¹⁴ *The Care of the Aged* report did not make any recommendation regarding a norm for provision of day hospital places associated with geriatric assessment and rehabilitation facilities. The Irish Society of Physicians in Geriatric Medicine recommends a norm of 2.0 places per 1,000 population aged 65 and over. The *Report on the Geriatric Services in South Dublin, Wicklow and Kildare*¹⁵ considered this to be a reasonable basis on which to plan day hospital services initially and referred to a target planning ratio of 2.7 places per 1,000 population aged 65 years and over in England. While urging the expansion of day hospital services, the Council believes that the number of day hospital places and the range of services provided should not be over-determined by planning norms but should reflect local needs at a particular point in time.

2.5 Conclusion

The Council wishes to emphasise that old age should no longer be seen as a disease process. Appropriate and early intervention, coupled with comprehensive assessment and rehabilitation programmes can do much to prevent longer term disability in old age. Early intervention through general practitioner, day hospital and out-patient services can often remove the need for

in-patient treatment. Where in-patient treatment is required the geriatric department in the general hospital, using both the expertise of the consultant physician in geriatric medicine and a multi-disciplinary approach, can significantly reduce the length of stay in hospital and can provide and supervise a rehabilitation programme which, in many instances, leads to full functional recovery. The geriatric department can also make a significant contribution by working in co-operation with other general hospital consultants, with other hospitals and institutions providing care for elderly person and with the community services generally.

Acknowledgement of these factors by the medical profession, the providers of health and social services, by the public and by elderly people themselves will help to establish the climate for reducing the length of time that elderly people spend in hospital or in other institutions.

PART III

OTHER HOSPITAL AND INSTITUTIONAL CARE

3.1 Background to Other Hospital and Institutional Care

3.1.1 - Introduction

In Part II the main emphasis has been on the role of the geriatric department in the general hospital. However, this department cannot function in isolation from other forms of hospital and institutional care for the elderly.

By 'other hospital and institutional care' for the elderly, which is the subject of this section, is meant care at present provided in various settings:

- geriatric long-term care units associated with specific general hospital departments;
- geriatric hospitals, which were often former old county homes;
- long-stay district hospitals;
- welfare homes (an increasing number of welfare home residents are in need of nursing care);
- voluntary and private institutions and nursing homes;
- psychiatric hospitals.

The Council believes that:

- (i) In the past, too often decisions have been taken to place elderly people, and particularly the very old, in institutions on a long-term basis without assessment, without their consent and without consideration of the various alternatives to support them in continuing to live outside institutions, at least on a part-time basis.
- (ii) The general perception regarding many of these institutions is that they are places to commit old people who have, for one reason or another, become a care problem in the family or wider community, places where, once admitted, they remain permanently until the end of their days.
- (iii) It is necessary to re-structure institutional care for the elderly as we know it. This requires that existing institutions and services for elderly people be adapted and developed in a manner which offers flexible systems of care and a real choice to elderly people and to those caring for them.

Research studies have demonstrated that residential institutions for the elderly very often involve a loss of independence and liberty and do not 'adequately meet the physical, psychological and social needs of the elderly living in them'.¹

In the Council's view there is an urgent need to develop a more adequate and flexible philosophy of care for elderly persons than exists at present. This requires us to address a number of fundamental questions as follows:

- (a) Do all elderly persons at present admitted to long-stay hospital or institutional care actually need this form of care?
- (b) Is such care required on a permanent basis?
- (c) What are the processes and pathways by which elderly persons are admitted to long-term institutional care?
- (d) What alternative forms of care should be provided?
- (e) What are the preferences of elderly people themselves in relation to long-term care?

In posing these questions the Council recognises that, despite a very good rehabilitation programme, some elderly persons will fail to make a full functional recovery after illness and will require continuing nursing care, some on a twenty-four hour basis. For some elderly persons this may be for a protracted period of time; for others it will be terminal care and may be for a shorter period.

3.1.2 Statistics on Long-Stay Geriatric Patients

Statistics published by the Department of Health relating to long-stay geriatric units cover the whole spectrum of long-term care for the elderly - hospitals, homes, welfare homes, voluntary and private nursing homes. (see Appendix I, Table 8).

In 1982 there was a total of 15,239 beds in such units. Almost 87% of patients in these units were stated to be aged 65 years and over, which is nearly 3.5% of the total population aged 65 years and over. The total number of patients resident in long-stay geriatric units on 31st December 1983 was 13,556. In addition, there were 1,474 beds in district hospitals which were mainly used for long-stay geriatric patients.²

Figures for 1981 relating to psychiatric hospitals and units indicated that there was a total of 4,936 persons aged 65 years and over resident in such hospitals and units, or 1.3% of the elderly population.³ This gives a total figure of 4.8% of the elderly population in institutional care in Ireland. According to Belton (1983) this figure (approximately 5%) for all elderly people in institutional care is similar to other western countries.⁴

Over 63% of all patients in long-stay geriatric units on 31 December 1982 were female. Almost 65% were aged 75 years and over on the same date. These figures reflect the view that the probability of living in an institution is in all countries strongly influenced by age and to a lesser extent by sex'.⁵

Almost 20% of patients resident in health board geriatric hospitals and homes on 31 December 1982 were designated as being there for 'social reasons'. In the case of private and voluntary nursing homes, the comparable figure was over 31%- (Private and voluntary nursing homes are discussed in detail in 3.4).

In one area of the Eastern Health Board, about half of the beds in all long-stay geriatric units are occupied by welfare patients,⁶ (i.e. frail but ambulant elderly persons not in need of continuing nursing care but in need of social care). The division in the case of private nursing homes in the same area is approximately one-third nursing care and the balance welfare.

The Council wishes to note that while the numbers of patients in long-stay geriatric units is known, there is insufficient information available on their physical and mental condition, their home background and their prospects for discharge. Also, while the number of institutions is known and the number of places in them, there is insufficient knowledge on the facilities provided in the institutions, the criteria for admission of patients and the standards of care provided.

3.1.3 *Is Admission to Institutional Care Necessary?*

The Council believes that early thorough-going assessment and appropriate practical and psychological support to families and care givers may well obviate, or at least postpone, the crisis and breakdown in family relationships which often precede application for long-term institutional care.

Applications which may lead to an important and almost irreversible decision about an old person's life are often dealt with on an *ad hoc* and pragmatic basis. In a study in Newham in Britain⁷, 71% of applicants for places had been assessed by unqualified staff; the ability to perform domestic tasks had not been assessed in one-third of cases; alternative forms of accommodation or relief to caring relatives had been insufficiently examined; and absence of an effective priority system for allocation was noted. Valid and reliable instruments for determining physical and mental disability are rarely, if ever, used in assessments. This may lead to highly subjective and incomplete appraisals of handicap and disability.

A survey in Denmark in 1971⁸ assessed the needs of 4,200 people over 70 years. In judging the need for institutional care, the highest assessment of need for such care was made by the social worker, followed by the doctor, then by the interviewer and finally by the elderly themselves.

These observations reflect the elderly person's desire to remain in his/her own home, which was supported by the interviewer who was not a health professional. A higher assessment of need for institutional care made by the health and social service professionals would appear to reflect their bias towards institutional care.

Throughout this report the Council is suggesting ways by which this 'bias towards institutional care' can be redressed in the Irish context.

3.2 The Community Hospital

Throughout the country each county has at least one geriatric hospital, (which were formerly county homes), and there is also a network of smaller district hospitals. The district hospitals fall into two groups—firstly the ‘short-stay’ district hospitals where the average length of stay is less than thirty days and secondly the ‘long-stay’ district hospitals where the average length of stay exceeds thirty days—in some district hospital over three hundred days. There are twenty-eight ‘long-stay’ district hospitals which generally provide long-term care for the elderly. The geriatric hospitals in the main provide long-term care only.

The Council considers that the long-stay geriatric hospitals and long-stay district hospitals are an under-exploited resource within the community. There is scope for some geriatric and district hospitals to play a more effective role in the provision of care services for elderly people. This can best be achieved, in the Council’s view, by the concept of the *community hospital*. Basically, this hospital should fulfil two roles:

- (i) It should provide a dynamic approach aimed at restoring as much independence as possible to the elderly person to allow them to live independently at home with dignity and purpose.
- (ii) It should provide sensitive and sympathetic continuing nursing and terminal care.

These roles can be fulfilled if an active assessment, rehabilitation and discharge policy is pursued, working closely with the local community services and with families and relatives. This requires an appreciation of the fact that a medical response, while centrally important, will on its own be insufficient to cater for the complex problems with which an elderly person may be faced.

These community hospitals should have an assessment, a rehabilitation, a continuing nursing care role and day hospital facilities. They should be equipped and staffed appropriately, bearing in mind that very often little sophisticated technology may be needed. The importance of motivation and relevant training and experience of all staff – medical, nursing and para-medical – is an important ingredient of success in such hospitals.

The doctor in charge should be skilled in screening elderly patients and be able to supervise the rehabilitation process. Dealing with the problems of elderly persons frequently requires not so much technical skills, or narrow professional expertise but broad clinical knowledge, based on human understanding and common sense. There are, of course, some patients who will require referral to the general hospital geriatric department for consultation with the geriatric physician. Alternatively, there may be scope for the physician in geriatric medicine to be involved in community hospitals on a visiting consultancy basis.

It is in this community context and, where possible, by facilitating a shared

responsibility with relatives, that a patient's continuing to live at home can be more easily arranged and supported.

A feature of a number of long-stay geriatric hospitals and district hospitals is a long waiting list for admission unrelated to assessed needs or community service alternatives. It has been shown in locations such as Carrick-on-Shannon, Cashel, Thomastown, Athy and Rathdrum that the long-stay geriatric hospital can deliver a range of services which support elderly persons in the community. The availability of assessment in these hospitals, combined with rehabilitation and day hospital services at community level, supports the other community care services in maintaining elderly persons in the community. In such a 'community hospital' waiting lists become manageable. It has also been shown that sheltered housing which is linked to or run in conjunction with such a 'community hospital' is effective in those locations where it has been developed and increases the range of choice available as an alternative to long-term institutional care.

The 'community hospital', where it is located in natural centres of each community, close to the patient's own home, provides for an easy visiting pattern by friends and neighbours. This liaison between home and hospital facilitates a shorter stay in hospital. Where long-term care is needed, the support of family and friends remains important and short visits home which can be easily arranged can be very supportive.

The development of a comprehensive programme of care, capable of responding adequately to any situation of need, will require a combination of dedication and team work, ranging from hospital ward, through day hospital to community care, with all disciplines meeting on a regular basis at case conferences, to discuss, in detail, any problems which are presented and to make appropriate joint decisions to deal with the problems.

There is considerable scope for some geriatric hospitals or district hospitals to begin to take on this role. Some, as already stated, are responding, but there is a need for a more co-ordinated national network of such 'community hospitals' to deal with some of the medico-social problems of the elderly which can be ideally responded to at this level.

The Council, therefore, considers that each health board should select a number of appropriately located geriatric or district hospitals to take on the role of community hospital for a specific catchment area of approximately 20,000-30,000 persons. While the size and present catchment area of some of the larger geriatric hospitals may not ideally suit the role of community hospital, the Council considers that the principles outlined above apply to all such hospitals.

3.3 Welfare Homes

The Care of the Aged Report,⁹ 1968, recommended the provision of welfare homes as one element in the overall institutional accommodation of the elderly.

The report envisaged that such welfare homes would cater for:

1. Frail and infirm old persons who are not in need of continuous medical or nursing care, but who may need periodic medical and nursing care of the kind normally given by the public health nurse and family doctor.
2. Elderly persons suffering from minor illnesses who need institutional care for a short period and who require medical and nursing care, but not beyond that normally given by the public health nurse and family doctor.
3. Elderly persons who require terminal care but do not need, or could not benefit from, hospital care.
4. Persons discharged from hospital but who, because of family circumstances need a short period of adjustment before they can resume their place in the community.
5. Elderly persons who need help for a short time because of the illness of relatives or because the relatives need a break from the provision of continuous care, for example to enable them to take a holiday.

The Department of Health, acting on the recommendations of the 1968 Report recommended the provision of 40-bed welfare homes based on a standard plan which included six three bed and twenty single bed rooms plus accommodation for three staff. This standard plan was generally adhered to although a number of health boards introduced modifications to take account of particular circumstances and new ideas. Since the early 1970s a total of 1,243 places have been provided through the provision of welfare homes at various locations throughout the country (see Appendix 2).

The Council recognises that at departmental level there has been some shift in emphasis away from the provision of welfare home type accommodation. In general the type of residents in most welfare homes does not accord with the type of persons envisaged for welfare homes and substantial numbers in such homes require continuing nursing care. In the 1976 Census of the Elderly in long-term care, 15-20% in welfare homes were moderately or severely disabled.¹⁰ Over 28% of patients resident in welfare homes on 31 December 1982 were described as 'chronically' or 'terminally' ill. (See Appendix I, Table 10). This situation has arisen for a number of reasons, but primarily because places in welfare homes had to be used to relieve pressure on existing institutions. In many instances, the original occupants of the welfare homes were transferred from county homes or psychiatric hospitals. In 1982 over 27% of admissions to welfare homes were from other long-stay hospitals and homes (Appendix I, Table 13). In addition, the age of residents in welfare homes inevitably means that they will have an increased level of dependency and require more nursing care (65% were aged 75 and over on 31 December, 1982, see Appendix I, Table 12).

In practice, entry to long-term care by an elderly person almost inevitably leads to an increase in his/her inactivity. Gray¹¹ pointed out that two vital elements of everyday life are lost by those elderly in residential care.

- 1 - They lose the 'physiotherapy' of everyday life, turning on the gas, opening the milk bottles, lifting saucepans.
2. They lose the occupational therapy of everyday life. Decision making (for example, deciding how brown the toast should be, if they can afford a lamb chop or whether they should buy beans or macaroni) uses skills and nerve circuits which function in such personal decisions as deciding to remain continent. Although it may be dreadful that many elderly people spend so much time worrying about fuel bills, the complex calculations of domestic budgeting have many beneficial spin-offs.

Some who have entered residential homes from hospitals may have already lost some of these skills. To those coming from their own homes, residential care may have been presented as an easing of responsibilities. They, and their relatives, may need to be convinced of the value of retaining ordinary functional skills.

The place of the welfare home needs to be questioned further in the Irish context. In this respect it is interesting to review the experiences in Denmark.¹² At first their old age homes were similar to welfare homes in Ireland. The inhabitants of these homes often needed nursing care at some stage and so a new type of home was developed known as a nursing home. The design of these homes has been dominated by the principle that everyone has a right to privacy and that this right should continue to be respected in sickness and old age. A circular from the Ministry of Housing in Denmark in 1952¹³ stated that all inhabitants of old age and nursing homes should have their own rooms; a two-bedded room must be the absolute exception. In the 1960s the need for old age homes in the traditional pattern was queried. It was considered better for people not needing nursing care to live in pensioners' flats or in sheltered housing, with the support of social services in their own homes. The municipalities were, therefore, encouraged to build nursing homes and better state support was made available to approved nursing homes than to old age homes. By 1973, the old age homes had officially disappeared, leaving a widespread and comparatively well equipped system of nursing homes.

The Council takes the view that we in Ireland should strongly consider our policies in relation to welfare homes. We should address ourselves to the following questions:

1. Do we continue to place in welfare homes a mixture of
 - (a) elderly people who could manage in the community with better support services and/or improved sheltered housing, and
 - (ii) disabled elderly people who often lack diagnostic assessment and rehabilitation and who do not receive the nursing care they require in the welfare home?

2. What do we do about existing welfare homes with their present mixed clientele?

The Council is of the view that in the future persons capable of independent living should be accommodated in appropriate community settings, including sheltered housing. In this respect, the Council wishes to note developments in Clonmel and Buncrana where 'welfare' accommodation is provided in independent, self-contained units supported by some communal facilities and services.

The existing welfare homes should be re-designated to provide a range of options in a local comprehensive plan for caring for the elderly in a community based setting.

Some options suggested by the Council are:

- (i) flats/apartments for those capable of independent living;
- (ii) a home or nursing unit catering for various levels of dependency;
- (iii) a care unit for confused elderly persons;
- (iv) day care facilities for persons being cared for at home;
- (v) intermittent care/floating bed facilities.

The choice of option will depend on local requirements and should be linked to appropriate day care facilities.

The Council wishes to draw attention here to a recommendation already made¹⁴ that an Inter-Departmental Working Group should be set up in order to examine and assess the role and contribution of sheltered housing, both statutory and voluntary, in the provision of accommodation and selected services for the elderly within an Irish context and to make recommendations accordingly. The Working Group should be comprised of representatives from both the Department of Health and the Department of the Environment and should consult with local authorities, health boards and voluntary housing associations currently providing sheltered accommodation for the elderly.

3.4 Private and Voluntary Nursing Homes*

3.4.1. Introduction

In addition to the long-term care accommodation for the elderly provided directly by the health boards, there are two other types of nursing home currently providing long-stay bed accommodation for elderly persons-commercially operated private nursing homes and voluntary homes under the control of a religious community or other charitable body. In 1983 there was a total of 5,104 persons resident in voluntary and private nursing homes.¹⁵ The number of persons aged 65 years and over in voluntary and private hospitals and nursing homes in 1982 was 4,603 and represented

* Private and voluntary nursing homes are the subject of two reports to be published by the National Council for the Aged.

just over 35% of all persons in this age group in long-term care and under 1% of the total population aged 65 years and over. (See Appendix I, Table 12).

Table 3.1, which refers to patients in nursing homes being subvented by the Eastern Health Board, gives a breakdown by age of elderly persons in each type of nursing home in the Eastern Health Board area.

Table 3.1 *Health Board Subvented Residents in Private and Voluntary Homes. in Eastern Health Board area, Classified by Age, 1982.*

Age Group	Private Homes		Voluntary Homes	
65-70 years	39	7%	48	7%
71-75years	81	14%	77	13%
75-80years	143	24%	129	21%
81-85 years	164	28%	165	27%
86 plus years	159	27%	196	32%
Total	586	100%	615	100%

Source: Long-Stay Accommodation Provided by Private Nursing Homes and Voluntary Bodies, Eastern Health Board, 1982

In both types of home there is a significant proportion of the patients in the 81 years and over age groups.

Table 3.2 gives a classification of residents in private and voluntary homes in the Eastern Health Board area.

Table 3.2 *Classification of Residents in Private and Voluntary Homes in the Eastern Health Board Area.*

	Private Homes	Voluntary Homes
Ambulant/Mobile	69.6%	87.0%
Bed/Chairfast	30.4%	13.0%
	100.0%	100.0%
Confused	39.7%	14.0%

Source: Long-Stay Accommodation Provided by Private Nursing Homes and Voluntary Bodies, Eastern Health Board, 1982.

The classification 'bed/chairfast' refers to all those who are either bedridden or capable of being moved from bed to chair with assistance. All such persons would be in need of varying degrees of nursing care.

The classification 'ambulant/mobile' includes a proportion of residents requiring light nursing care, whose function may be somewhat impaired as a result of stroke, arthritis or other condition including impairment of mental faculties.

The classification 'confused' refers to those continuously in need of assistance in finding their own way about but not including those who might suffer occasional disorientation.

Almost 70% of patients in private nursing homes were classified as 'ambulant/mobile', while almost 40% were classified as 'confused'. The respective figures for voluntary homes were 87% and 14%.

Table 3.3 gives an indication of the medical/social status of patients resident in all private and voluntary homes and hospitals, as follows.

Table 33 *Medical/Social Status of patients Resident in Voluntary and Private Hospitals/Homes on 31 December 1982.*

	%
Social	29.8
Acute illness	3.2
Chronic Sick	35.6
Terminal	4.2
Mental Handicap	1.5
Chronic Psychiatric	3.8
Other	12.4
Not Stated	9.5
Total - per cent	100.0
number	5,583

Source: Statistical Information Relevant to the Health Services, Department of Health, 1984, Table G 18.

From this table it can be seen that nearly 57% of all patients in these homes were not chronically ill or terminally ill. The medical/social status of almost 30% of patients was described as 'social'.

3 A.2 Private Nursing Homes

These homes are operated primarily on a commercial profit-making basis and are frequently located in houses and buildings which are not purpose built. These homes generally cater for ten to thirty patients. Indications are that a high proportion of patients in such homes do not require full-time or constant nursing care but are ambulant and quite mobile, requiring welfare accommodation only (see Table 3.3).

Some private nursing homes make it a condition that they will take only ambulant persons, while others are quite prepared to take elderly persons who are dependent on nursing care. The usual position is a mixture of both categories with places being used interchangeably. However, most nursing homes operate a policy of retaining a person permanently once admitted and

such persons may require continuing nursing care as their dependency increases with advancing years. However, in some instances nursing homes refuse to take back an elderly person who has been admitted to an acute hospital. The high proportion of persons in the older age group (81 years and over) in private nursing homes is likely to create a significant demand for continuing nursing care in such homes.

3A.3 Voluntary Nursing Homes

The position of voluntary nursing homes regarding admissions is somewhat different from private nursing homes. The voluntary homes tend to be more of the welfare type (see Table 3.2) with a higher percentage of residents ambulant and mobile. The general trend is for such voluntary homes to accommodate thirty to forty persons with some homes catering for up to a hundred persons. Like the private homes, the trend in voluntary homes has been to retain people once admitted. This has created the need for nursing care as dependency increases. In recent years the tendency in many voluntary homes has been to provide a small infirmary unit to cater for those who are in need of nursing care either on a short-term or a long-term basis. The Council welcomes this development and urges that the criteria for nursing care set down in Part IV of this report should be adhered to in all such units.

3.4.4 Legislation Relating to Private and Voluntary Nursing Homes

Health boards have a statutory obligation (under Section 54 of the Health Act, 1953) to provide institutional assistance for persons who are unable to provide for it themselves: 'such institutional assistance as appears to them (health boards) to be necessary and proper in each particular case'.¹⁶

Since the 1970s private and voluntary nursing homes have tended to be used by some health boards as an adjunct to their own institutional services for the elderly and as a method of discharging their obligations under the 1953 Act.

Private nursing homes can also be approved by the Minister for Health for the provision of services under Section 54 of the Health Act 1970.¹⁷ Any person referred by his/her medical practitioner can avail of 'in-patient services' in such homes as an alternative to seeking admission to a health board institution. Patients availing of in-patient services in those nursing homes approved under Section 54 of the 1970 Act can claim, as of right, the Minister's approved subvention (which is currently £6.00 per day). Approval under Section 54 of the 1970 Health Act also enables patients in such approved homes to claim a rebate of income tax against health costs. Since, however, the Department of Health has not approved any new private nursing homes under Section 54 of the 1970 Act for a number of years, persons in homes which have not been approved are availing of tax relief under Section 22 of the 1967 Finance Act.¹⁸

The fact that a particular nursing home has not been approved by the Minister for Health does not necessarily mean that it has failed to reach an acceptable standard. For financial reasons, the Minister has not approved any additional nursing homes since 1980. In fact, there are, at present, some forty nursing homes which have applied for approval and have not been given it, mainly because of financial pressure on health boards. The Minister recently pointed out that it would cost the health boards an additional £1.5m each¹⁹ year to subvent patients in these forty homes, were they to be approved.

Table 3.4 *Number and Status of Private and Voluntary Nursing Homes by Health Board Area, 1984.*

Health Board	Approved	Non-Approved	Total
Eastern	36	48	84
Midland	6	3	9
Mid-Western	14	3	17
North-Eastern	-	8	8
North-Western	3	2	5
South-Eastern	14	8	22
Southern	4	16	20
Western	7	7	14
Totals:	84	95	179

Source: Statistics on Long-Stay Geriatric Patients, Department of Health, 1982.

The distribution of 'approved' homes between the eight health board regions is uneven. As Table 3.4 shows, one health board (the North-Eastern) has no 'approved' home in its region. The Eastern Health Board, on the other hand, has some thirty-six 'approved' homes out of a total of eighty-four homes.

The fact that homes are not being 'approved' at present means that health boards have to make other arrangements with voluntary and private nursing homes for the subvention of elderly persons requiring long-term care. Under Section 26 of the 1970 Health Act 'A Health Board may, in accordance with such conditions ... as may be specified by the Minister, make and carry out an arrangement with a person or body to provide services under the Health Acts 1947 to 1970, for persons eligible for such services'.²⁰ Only the Eastern Health Board has been given permission to provide services in voluntary and private nursing homes under this section of the 1970 Act.

3.4.5 *Health (Homes for Incapacitated Persons) Act 1964*²¹

Persons setting up homes for the care of the elderly are required, in accordance with the provisions of Section 3 of the Health (Homes for Incapacitated Per-

sons) Act, 1964 to notify the appropriate health board if they are maintaining incapacitated persons for private profit. Until 1985 the regulations governing such nursing homes were those made by the Minister for Health in 1966, at which time it was stated in the course of a circular letter to health authorities that it was the aim, in the Act and in the regulations, to achieve a fair degree of elasticity in administration and to ensure that the standards to be prescribed would not be such as to put out of business any home which provides in a reasonable way, the facilities necessary for those being maintained in it. The Minister was then anxious to avoid prescribing standards which might force those homes with reasonable standards either to close down or to make their charges prohibitively high.

For some time it has been generally accepted that the 1964 Act and the 1966 regulations are outmoded and require to be updated to meet present circumstances. A report prepared by one health board stated that 'It is the view of the Officers of our Board concerned, that a new set of Regulations containing a number of more specific provisions regarding standards, is now required to enable inspections of Private Nursing Homes to be carried out to more effect'.²²

There has been a considerable increase in the number of new private nursing homes coming into the market since the early 1970s. The growing numbers of elderly persons accommodated in such homes are less and less financially independent and, therefore, more vulnerable. The greatest difficulty and the greatest need to protect standards occurs at the lower end of the market which caters predominantly for persons in the lower income groups.

Private and voluntary nursing homes are now being used as an adjunct to health boards' own long-stay geriatric institutions, particularly in the Eastern Health Board area. In 1982, the Eastern Health Board was subsidising the maintenance of some 50% of residents in private nursing homes in its area. In the case of voluntary nursing homes, the Eastern Health Board subsidised the maintenance of almost 40% of residents.²³

While the private and voluntary nursing homes have been providing a valuable and necessary support service, there are, however, a number of shortcomings:

- 1 Much of the existing accommodation, particularly in private nursing homes, does not come up to modern standards. 'Many of the buildings are old, of poor quality and were originally built for other purposes. There is often a lack of privacy and personal environment for the residents.'²⁴
2. The adequacy of nursing staff in terms of numbers, qualifications and training is open to question in respect of a number of private nursing homes. It would seem that most homes tend to employ minimum numbers for both day and night cover, the latter being particularly light in a number of instances. Where nursing aides are employed these can often be untrained and inexperienced.

3. The provision of special equipment and facilities, such as assisted baths, specially equipped showers and toilets, wheelchair toilets and other aids, e.g. ramps, grab rails and handrails, is lacking in a number of homes.
4. Most private nursing homes lack any programme of activity aimed at rehabilitation or even the maintenance of basic function in the elderly residents. Most forms of recreation, entertainment or diversion therapy programmes are lacking.
5. The unsuitable location of private nursing homes frequently results in elderly residents being cut off from their former environment, friends or even relatives. This 'tends to militate against the development within each community care area of a balanced range of services for the elderly. This is especially relevant in the context of the implementation of the policy which aims to keep elderly persons in their own homes or within a sheltered environment in the community for as long as possible, with the aid of various back-up services'²⁵
'It was concluded that institutions which are inconveniently placed relative to the populations which they serve discourage admissions and cannot be fully credited in a count of available beds.'²⁶
6. The health boards have no direct control of admissions. The choice of nursing home is made by or on behalf of the applicant, generally by a relative or the family doctor, but referrals to private nursing homes are also made through the general hospitals, mostly through the hospital social workers. The first contact with the health board frequently occurs when an application for a financial subvention is made. This usually happens after admission has already taken place.
7. Complaints which are made concerning unsatisfactory conditions in private nursing homes generally 'refer to under staffing, over-crowding, inadequate heating, insufficient or poor food and unhygienic conditions or practices.'²⁷

The Minister for Health has issued new regulations (Homes for Incapacitated Persons Regulations, 1985) relating to the operation of Private Nursing Homes. (See Appendix VII). These regulations have been drawn up by the Department of Health following consultation with the health boards and the Irish Private Hospitals and Nursing Homes Association and in the light of recommendations made in the Eastern Health Board's report on *Long-Stay Accommodation Provided by Private Nursing Homes and Voluntary Bodies* (See Appendix V).

The Council considers that the new regulations, while being a major improvement on the 1966 regulations in some respects, are too vague and general in their requirements and too open to subjective interpretation. The Council notes and welcomes the intention of the Minister to carry out a further review of these regulations and to proceed with the introduction of new legislation, including the updating of the Health (Homes for Incapacitated Persons) Act, 1964. The Council recommends that any new legislation relating to nursing

homes should include provisions for a system of registration for all private and voluntary nursing homes. Refusal or cancellation of registration should be possible for stated reasons relating to standards in the home or to the person operating the home. Health boards should have power to specify the staff requirements in a particular home at any given time.

3 A.6 Other Matters Relating to the Role of the Private and Voluntary Nursing Homes

As already stated, health boards have a statutory responsibility to provide long-stay care for elderly persons who are unable to provide it for themselves. This, of course, applies to those who are unable to pay the full cost of such care in private nursing homes or who require some financial contribution towards the cost of their maintenance in such homes.

The charge for maintenance in private nursing homes can range between £60 and £150 per week, the average charge being in the region of £90 per week. In the case of homes approved under Section 54 of the Health Act 1970 the health board is required to contribute £6.00 per day (£42.00 per week) towards maintenance. The period for which such a contribution can be obtained from the health board may vary-there is no statutory limitation as such. However, financial contribution under this provision was intended to cover 'In-patient services', that is services for a person who is sick. Difficulties have arisen in the cases of 'extended nursing care' and at least one health board imposes a limit of six weeks on financial contributions in cases where extended nursing care of an elderly person is involved.²⁸ Such financial contributions are made without a means test as such.

The Eastern Health Board has been authorised to contribute on a long-term basis towards the cost of maintenance of elderly persons in private and voluntary nursing homes. The Board can contribute at varying rates up to a maximum of £42.00 per week, depending on financial means and the weekly rate of charge made by the nursing home. The maximum rate of contribution is the same regardless of whether or not the elderly person in the nursing home requires continuing nursing care. There appears to be merit in applying a higher rate of financial contribution in the case of those requiring nursing care as distinct from those who are ambulant and in the welfare category. The Council considers that the possibility of a two tier system of financial contribution should be further explored.

The introduction of a higher rate of contribution for those requiring continuing nursing care would be expected to assist in improving standards generally. It would, of course, have to be allied to a comprehensive system of assessment prior to admission and ongoing review following admission.

The private nursing home can undoubtedly continue to provide a valuable service if a system of registration, monitoring of standards and appropriate financial contribution is introduced. However, it is, of course, important that health boards should not become over-dependent on the private nursing homes

for the discharge of their statutory obligations, especially towards the elderly who are financially vulnerable and in need of continuing nursing care, and those requiring the most expensive nursing care.

It would appear that many private nursing homes are set up for reasons other than that there is a clearly identified need. In order to avoid this, private and voluntary nursing homes should, in the Council's view, be placed in the context of the health board's obligation to ensure that a comprehensive range of services for the elderly is provided both at community and institutional levels. Part of this obligation is to ensure that long-term care accommodation for the elderly should be provided at an appropriate level throughout their areas.

It is recommended elsewhere in this report that the ideal to be aimed at would be for the provision of small scale units dispersed throughout the various community areas, linked to both community and hospital services. If the private and voluntary nursing homes are to have a meaningful role within such a system, this requires that the level of service to be provided by them (for those elderly persons financed in whole or in part from public funds, including state pensions and financial subvention from health boards) should be defined and agreed with the relevant health board from the outset. In each case this provision should start with pre-admission assessment of elderly persons and should ensure their continuing assessment in the context of a comprehensive institutional and community care service to meet all the needs of the elderly in the area.

3.5 Mental Health Disorders of the Elderly

3.5.1 Introduction

A particular need which the Council considers requires to be tackled with energy and urgency is the organisation and development of a comprehensive service geared to deal with the range of mental health disorders which occur in old age.

‘There have never been so many people surviving into old age and the greater the age the higher the incidence of dementia and age related psychiatric disorders.

As will already have been seen in Part I there has been a significant improvement in expectation of life over the past three decades in Ireland. The total population aged 65 years and over increased by 40,000 between 1971 and 1981 and projections indicate a further increase of the order of 27,000 by 2006. However, the most significant feature of this projected increase is that almost all of it is in the category 75 years and over and two-thirds of the increase, i.e. 18,000, is in the category 80 years and over. (See Appendix I, Table 6).

The likelihood of disability of one form or another occurring increases with age. ‘Very old people need a lot of care in their final years, much of it because

of the greatly increased incidence of mental illness and intellectual failure in old age.’³⁰

The aged with mental disorders do not form a homogeneous group. The following categories are based on a classification used by the Department of Health and Social Security in Britain,³¹

1. Patients who had entered a mental hospital before modern methods of treatment were available and who have grown old in them.
2. Elderly patients with functional mental disorders, e.g. depression and various neuroses. These disorders are as treatable in old age as in younger age groups and are usually reversible.
3. Elderly patients suffering from dementia. Dementia is generally referred to as ‘senility’ and is a slowly progressive impairment of memory and personality which limits the individual’s capacity to cope with the needs of everyday life. An elderly person is sometimes prematurely regarded as suffering from dementia before the possible reversible causes of such symptoms have been ruled out. This group may be further sub-divided into:
 - (a) the mild to moderately demented not suffering from a significant physical illness or disability;
 - (b) dementia with behavioural problems who are not suffering from significant physical disability or illness;
 - (c) those with dementia, whether mild or severe, who suffer from concomitant physical illness and disability.

Elderly persons in Category 1 are obviously under the care of psychiatrists and staff of psychiatric hospitals. It is likely that most of them will spend their remaining years there.

Those in Category 2 may present for medical treatment to general practitioners and a proportion of them will be referred to psychiatrists. This is numerically the largest group and where referred, may be treated as outpatients or admitted for varying periods of in-patient treatment.

Those in Category 3, elderly persons suffering from progressive intellectual failure, may be found in the community, in psychiatric hospitals, private nursing homes, and especially where there is a multiple disability, physical as well as mental, in units of the geriatric service. Elderly persons in this category tend to be disproportionately significant in terms of the problems that arise in relation to their care. Such problems highlight the lack of a comprehensive and co-ordinated range of services, medical and social, aimed at supporting such elderly persons in the community for as long as possible and backed by adequate and appropriate facilities for in-patient care, operating under a clear and widely accepted assessment and placement policy. These growing problems probably highlight most of all the lack of a specialist resource within the psychiatric service, which

- (a) works with and supports the family and other carers, in the community;

- (b) supports and works with general practitioners and directors of community care by harnessing the network of community supports necessary;
- (c) works in close co-operation and partnership with the geriatric services especially the geriatricians.

A specialist psychiatric service for the elderly will also be able to address functional mental disorders of old age more effectively. 'These disorders respond well to treatment but are sometimes overlooked by those without specialist knowledge of psychiatric illness in the elderly. The presence of a psychiatrist with such special skills may, therefore, greatly aid general practitioners and the welfare services in their management of the elderly.'³²

3.5.2 Incidence

Although epidemiologists have tended to focus mainly on dementia, the consensus of community studies has been that between a fifth and a quarter of the over 65 population suffers from an identifiable psychiatric disability.³³

Symptoms of functional mental disorders in older people tend to be regarded as part of the ageing process or as an understandable reaction to increasing social and physical restriction and thus are seen as irremediable. Some indication of the size of this unmet need is given by the rise in referral rates for elderly people with functional illness which usually follows the introduction of specialist psychiatric services for the elderly.³⁴

At a conservative estimate, about 7% of elderly persons suffer from dementia and in half of them the condition is severe. The prevalence increases from 2% in those aged 65-75 to about 20% in those over 80. This is true for most of the nations of the western world.³⁶

There is not a 'bottomless pit' of dementia to be unearthed. Epidemiological surveys consistently show a finite number of cases. An average population of 200,000 will have 2,500 old people with dementia, most of whom will have a relatively mild condition.³⁷ The average general practice of 2,500 will care for about twenty-five patients suffering from dementia of whom half will be severely demented.

There is no statistical information on the extent to which the elderly with mental disorders are reached by various community services. Of its nature mental disorder, particularly mild mental disorder in the elderly, may not easily come to notice and it is reasonable to assume that a proportion of the elderly needing treatment is undetected. Evidence suggests that mental disorders among the elderly are less likely to be recognised as such and referred to specialist psychiatric services than mental disorders of equivalent severity at any other age. A survey in North Dublin City found that of 105 elderly persons studied, twenty-five had mental disorders, seven of them severe. Yet only three out of the twenty-five were known to their family doctors and presumably also to the community care service.³⁸

The majority of the elderly, suffering from mental disorders, live in their own homes and many are cared for by general practitioners in collaboration with the community care services. It is likely that a significant number of such elderly persons are widowed and living alone. The informal care provided by families, neighbours and friends is extremely important and should, where possible, be encouraged, mobilised and supported by statutory services. This can be achieved through the provision of a range of support services, such as day care services, home helps, planned respite/intermittent care facilities and crisis intervention services.

In addition, the provision of more sheltered housing schemes for the elderly which are appropriately located and serviced will, in the Council's view, enhance the possibility of caring for more elderly people with mental disorders in a non-institutionalised environment.

3.5.3 Present Situation

There has been an increasing recognition of the problem created by the numbers of elderly mentally disabled people for whom in-patient admission of one form or another is sought. Questions which arise include criteria for admission to care, placement of those deemed in need of institutional care and who should take what initiatives in relation to those who need not be admitted to such care.

The type of in-patient facility the elderly person is admitted to is often determined simply by the availability of a vacant bed. This may be in a general hospital, a geriatric unit, a psychiatric hospital or a private nursing home. Assessment, treatment and/or long-term care services in such institutions may or may not be appropriate to the needs of the person admitted to them. If not appropriate it may be difficult to secure a transfer to a more appropriate situation.

Trends in the mental health field generally, improved social attitudes and advances in treatment, are gradually leading us away from traditional patterns of custodial care. This progress has been least marked, however, in the case of the elderly where the emphasis has tended to remain very much on institutional care, with inadequate attention given to the scope that exists for the recognition, treatment and community support for those with mental disorders.⁴⁰

In 1981 there were almost 5,000 persons aged 65 years and over resident in psychiatric hospitals and units, representing 1.3% of the elderly population.⁴¹ In the same year, 4,518 persons aged 65 and over were admitted to such hospitals and units and constituted almost 16% of all admissions.⁴² The Council urges that no elderly person should in the future be admitted to a psychiatric hospital simply on the grounds that there appears no alternative way of responding to his or her needs.

There is no accurate information on the number of persons who are mentally disabled in other long-stay institutions for the elderly. Binchy and Walsh

(1977) estimated that approximately 40% of patients resident in geriatric facilities suffered from a recognisable psychiatric illness.⁴³ Thus the number of such patients being treated by the geriatric service is double that of the psychiatric service. The Council is aware that many geriatric long-stay units and nursing homes, are inadequately geared either in terms of staffing or accommodation (many being buildings converted from other uses) to deal adequately with elderly persons suffering from mental disorders.

The first consultant geriatrician in Ireland was appointed in the late 1960s and there are currently ten such consultant posts filled. To date, however, no consultant psychiatrist with specific responsibility for the elderly has been appointed. It is increasingly recognised that such appointments would be desirable and beneficial in the delivery of psychiatric care to the elderly, especially if incorporated into an organised structure with close co-operation with geriatricians and general practitioners and backed up with reasonable facilities.

3.5.4 Suggestions for the Future

The Council is aware that various aspects of future policy in relation to requirements for the elderly with mental health disorders are at present under review by Department of Health, Comhairle na nOspideal and Eastern Health Board study groups or committees.

The Council is aware of and supports the idea of there being one psychiatrist in each service catchment area who would have a special responsibility for the elderly with mental disorders. In large urban centres of population, particularly Dublin and Cork, the Council supports the idea of wholetime appointments.

The consultant psychiatrist should ideally have a unit in a general hospital which is linked with both the geriatric and psychiatric departments and staffed by nurses trained in both general and psychiatric nursing. Such units should be short-stay assessment and treatment units.

The Council sees the specialist hospital unit as providing a back up to the community services when these are no longer able to meet the demands of the elderly people with mental disorders. This unit will concentrate on the more seriously ill or disabled old people who require specialist treatment. Although this is its main function, its role in providing support, advice and relief at times of special difficulty to families and community care services is an essential ingredient of a successful comprehensive service. The consultant psychiatrist should have beds available under his direct control for long stay (for the more severely behaviourally disturbed patients) and should also have access to other long-stay beds for appropriate referrals. The consultant psychiatrist should also have beds available for intermittent care admissions and for holiday/respite care. The community hospital discussed earlier in this

Report should not be ruled out for such referrals. The use of holiday respite care beds enables some patients to be managed permanently in their own homes or delays the time when continuous hospital care becomes inevitable. Experience in the United Kingdom suggests that an effective service has a clear identity as part of the psychiatric department and is a partner of the geriatric department.⁴⁴ It serves other specialised hospital departments and also the general practitioners. It is a close partner of the community and welfare services and works with voluntary organisations and other community bodies. It is an identifiable comprehensive service to which anyone seeking information, advice and service for the elderly with mental disorders can go.

Given the unsuitability of existing psychiatric hospital and geriatric long-stay facilities, the Council strongly supports the establishment of specialist homes for the elderly mentally disabled particularly in urban areas where the numbers of patients requiring this type of care would justify such homes. In these cases, it may be appropriate to re-designate existing welfare homes for this purpose. Such homes should cater for the particular needs of mentally impaired residents. They should not be seen as separatist or as simply a means of preventing confused residents from offending susceptibilities of other patients or indeed the expectations of inadequately trained or selected staff. If this is to be achieved, the homes must be architecturally suitable and close to a defined community or catchment area. Staff ratio should be adequate and include psychiatric nurses. Appropriate training for all grades of staff would be essential. There should be defined inputs from both the psychiatrist with special responsibility for the elderly and the geriatrician and there should be full integration with hospital and community services for the elderly.

3.5.5 Conclusion

The Council is convinced that there is an urgency about providing an adequate range of services and facilities for the elderly suffering from mental disorders. It shares the view that 'it is no longer good enough to try to muddle through with leftover buildings and disorganised unplanned services.'⁴⁶

Mental disorder among the elderly is a problem which should be addressed by the whole of society. The Council suggests that there has been an ostrich-like approach by both health workers and government, the former because of the intractable nature of dementia, the latter because remedies seem expensive. However, it should be remembered that 'the incurable is not untreatable'.⁴⁷

PART IV

PLANNING SERVICES FOR THE ELDERLY

4.1 Context for Planning

4.1.1 *Introduction*

The elderly population is not a homogeneous group either medically or socially or mentally. It has been stressed throughout this report and throughout its companion report, *Housing of the Elderly in Ireland* that the correct application of specialist medical knowledge, coupled with detailed attention to the social and housing needs of the individual elderly person, can do much to prevent longer term disability in old age. In order to achieve this, it has been emphasised that a multi-disciplinary and a multi-agency approach involving a wide range of services is essential.

The Council recognises that most illness in the elderly is adequately managed at home by the general practitioner with or without community care service back-up. The general practitioner plays a crucial role in the early recognition of disease and the consequent prevention of deterioration. An old person's failure to cope in their own home may be progressive. This process may be slowed down or even halted by early intervention and by the availability of adequate assessment and rehabilitation facilities and programmes.

The 'need' for institutional care is relative and multi-faceted, determined to a great extent by the network of services and skills available in different areas as well as by express demands arising from potential applicants and their informal and formal carers.

Administrative pressures exercised by staff of acute general hospitals for urgent transfer of elderly persons to long-term institutional care reflects the general hospitals' anxiety to achieve their discharge. However, it may not necessarily mean that an individual needs such care. More appropriate housing and more support services in the community may serve the elderly person's health and other interests better.

The development of specialist and flexible hospital and institutional care

services for the elderly; as suggested throughout this report, is seen by the Council as crucially important in supporting and enhancing the caring potential of the community. The Council, however, believes that such developments will be fully effective only in the context of ongoing development and expansion of community care services in their own right. This requires an understanding and an acknowledgement of the importance of various elements of community care by policy makers at both national and local level and a further analysis of the inter-relationship between these elements.

4.1.2 *Community Care*

Care in the community may be provided 'informally' through kinship networks, by friends, neighbours and volunteers or 'formally' by statutory social services. Thus it is possible to distinguish between:

- (a) Informal care provided by neighbours, friends and more particularly by families and relatives,
- (b) Formal and quasi-normal care-provided by voluntary organisations.
- (iii) Formally organised care-provided by health boards and local authorities.

The notion of 'community care' in the Irish context usually embodies a combination of all three. Informal care is not necessarily more desirable than formal care. 'Both may be narrowly or expansively conceived and operated, they may enhance or reduce dependency, deny or facilitate rights and restrict or enhance freedom,'¹ In each instance, however, the aim is to maintain the elderly person living in the community and in so doing to lessen the need for institutional care.

It is likely that a substantial minority of elderly persons currently in institutions would be able to care for themselves in the community with adequate support.² In this context it should be noted that 28% of all persons in long-stay geriatric units in this country are there for 'social' reasons.³ In addressing this issue it should be recognised that care in the community, while ideologically desirable, is only better for a particular elderly person if it is in fact better care. In many instances when elderly people become ill and dependent their needs can only be adequately met through some form of institutional care.

4.1.3 *Community Care in Practice*

In practice, community care can be said to be about very practical and personal matters. It is about loneliness and isolation; illness and incontinence; help with climbing stairs and distress; aid with preparing meals and housework. It is also about the provision of appropriately designed houses with suitable aids and adaptations, and all of this in the context of maintaining and ensuring the elderly person's independence and enhancing their potential for self-care.

Elderly people living at home, and particularly if living alone, may need special support to enable them to cope with their infirmities and to prevent

their isolation from society. As their capabilities diminish, they will more often need home help, laundry services, meals-on-wheels and chiropody. Loss of mobility brings the need for social visits, transport to social clubs, day centres, day hospitals and arrangements for holidays if social isolation is to be avoided. When illness is added to other infirmities, they may need more nursing, night care and help generally in the home. In terminal illness, an elderly person may for a limited period need considerable help from many of the community care services.

The Council has already considered the question of community services for the elderly and has made various recommendations in this regard in an earlier Report.* Here, a brief reference is made to a number of factors which are likely to have a bearing on the care of the elderly in the community.

1. The position of houses occupied by elderly persons in terms of structure, facilities and amenities appears to be less favourable than that of the population as a whole.⁴ The elderly living alone are even less well equipped with basic facilities such as water and sanitation than other elderly households. Because of the age of many of the houses occupied by elderly persons it is not surprising that many have problems of draughts and dampness. While the Task Force on Special Housing Aid for the Elderly has dealt with many such problems in the past three years, indications from various parts of the country are that a sizeable number of houses occupied by the elderly, particularly those living alone, continue to be lacking in one or more basic amenities.
2. Many houses occupied by elderly persons are not appropriate for elderly persons because of their design, location and size.
3. The lack of social contact, fear and loneliness experienced by many elderly persons living alone has been well documented in recent years. Power makes the point that if one basic reason for loneliness among the old and alone can be identified 'it is quite simply lack of company'.
4. Attention has been drawn to the particular problems of the elderly living in rural areas the general pattern which emerges is a concentration of services in urban areas with a diminishing level of service provision according to the degree of remoteness from an urban area'.⁶ In addition, the high level of out migration of young adults from such areas means that the potential for voluntary effort is likely to be greatly reduced.
5. Transport services for the elderly, particularly those in rural areas, are frequently inadequate.
6. While there is, as yet, inadequate information available on the position of family carers⁷ in Ireland, the indications are that people caring for elderly

* See *Community Services for the Elderly*, National Council for the Aged, 1983.

or infirm relatives do. not frequently get the support services they require from either the statutory, or the voluntary sector. The lack of such support services is likely:

- (i) to give rise to a breakdown in the family caring system which results in an unnecessary admission to an acute hospital, geriatric hospital, nursing home or welfare home;
- (ii) to have serious physical, emotional and financial consequences on the person carrying out the caring function

7. In view of the importance of home helps in the provision of care for elderly persons, in the community, the Council wishes to reiterate with urgency a recommendation already made,¹² that the Department of Health carry out a review of the home help service.

In particular the Council wishes to point to the need for more training for personnel involved in the home help service in order to

- (i) enable them to take on some of the work currently being carried out by nurses, for example, getting people up and dressed and putting them to bed;
- (ii) ensure that the form of assistance they give to elderly persons is not creating further dependency, for example getting the person to peel their own potatoes rather than peeling them for them.

8. The Council is concerned about the problems that elderly persons may be faced with, due to fear of burglary and/or being attacked. It is particularly concerned that, because of such fears, elderly persons may be forced to seek admission to some form of institutional care. Indications are that such a trend is indeed developing.

While urging that every effort be made to lessen such fear through the promotion of neighbourhood surveillance and the development of effective communication and alarm systems, the Council believes that it is also necessary to ensure that an appropriate counselling and advice service is provided for elderly people who have either been the subject of attacks and/or break-ins, or who live in daily fear of such an occurrence. In cases where elderly people are seeking admission to some form of institutional care because of such fear, the counselling service should be provided by the health board community care team who should marshal assistance and support for the elderly person from all available sources.

4.1.4 Role of Families in 'Community Care'

A number of factors have contributed to reducing the pool of potential family carers in the community. Changes have occurred which have affected the structure of the standard nuclear family within which care has traditionally taken place. Among these changes are a decline in the birth rate (resulting in smaller families), later parenthood, greater geographical mobility, an increase

in single parent families and, most importantly, greater participation by women in labour markets.

In addition to and related to these factors is the trend for increasing numbers of elderly persons to live alone. Yet, summarising the evidence about community care of the elderly in Britain, Parker concluded that the family still plays a major role in meeting the needs of the elderly.⁸

It is likely that there are many more dependent elderly people living and being cared for in their own homes or in their relatives' homes than in all institutions put together. In Britain, it has been estimated⁹ that there are twice or three times as many bedfast and severely disabled elderly people living with their families as there are in institutions.

However, because of the above demographic factors, the family as a caring agency is likely to be more fragile and, consequently, more likely to break down at times of stress. Thus, the family will in the future need more support from statutory services if it is to continue to fulfil its caring role successfully.

4.1.5 Cost of Community Care

The shift in emphasis away from institutional care to community-based care has at times been based on the widely held belief that such community care not only represents a better but also a cheaper alternative, which may be a crucial factor when governments are looking to cut public expenditure.

The relative costs for community and insututional care are very difficult to establish. While urging that greater efforts be made to establish the costs of providing effective community care for elderly persons and of planning accordingly, the Council wishes to emphasise that it may well be that the full costs of adequate and appropriate housing for elderly persons coupled with the necessary levels of domiciliary and community support services are not far removed from those of institutional care.

4.2 Future Policy Considerations

4.2.1 Future Needs

The increase in the elderly population in Ireland is especially marked among the group most likely to require care, i.e. those aged 75 years and over. The high usage of acute general hospital services by persons aged over 75 has been referred to earlier. In 1982 almost 65% of residents in long-stay geriatric units were aged 75 years and over. National Economic and Social Council projections¹⁰ indicate significant increases in requirements for both acute hospital services and for long-stay geriatric accommodation by persons aged 75 years and over in the period up to 1991. It is the view of the Council that such requirements will be largely influenced by the type and level of housing and community care services for the elderly that will be provided.

4.2.2 *Care in the Community*

If care in the community for a growing number of dependent elderly persons is to be provided and maintained at an adequate level it would appear that greater effort needs to be put into supporting the family, particularly in the light of the demographic factors referred to earlier. This requires a more defined and organised role both for statutory services and for neighbourhood and community voluntary organisations. It also requires a much greater level of flexibility and co-ordination in the provision of services –housing, social and medical– than is currently the case. The emphasis on maintaining more old people in the community and in their own homes rather than in institutions requires that different people and agencies

- families, voluntary groups and statutory services,
 - hospitals and community care services,
 - housing and health authorities,
- work together to achieve this end.

Care of the elderly in the community necessitates support of the family as the basic caring unit insofar as possible. Formal and quasiformal voluntary and statutory bodies should work towards this end by providing day care, night sitting and intermittent care services. Where the above mentioned bodies do not exist or fail to provide these family support services, neighbourhood and voluntary caring networks should be established to do so. In such instances, the health boards must explore, encourage and facilitate more innovative approaches to community involvement in supporting families or in finding other community based solutions to the care of vulnerable elderly people.

In this respect, the Council considers that the boarding out of dependent elderly persons with families, on either a short-term or on a long-term basis would provide a satisfactory alternative to institutional care in certain instances. (Boarding out of elderly persons in Ireland is discussed in detail in a Report already published by the Council¹¹).

A common presumption about community care is that the government will have to do less if it simply urges families and communities to do more. However, very much more is required than simple urging. There is a need to facilitate, support and encourage families and neighbourhood and voluntary groups and to encourage new and innovative responses to the needs of elderly persons. This requires planning and co-ordination at national and local level. It requires the development of effective and flexible systems of assessment, rehabilitation, admissions and discharges. It also involves a recognition of the central importance of housing in the provision of care in the community for elderly persons. ‘The right mix of housing measures (from government, housing associations and building societies), together with adequate pensions, would enable a more hopeful approach to the question of personal care of old

people. It would enable many more families to care for those old people who stay in their own homes and it would prevent some elderly people from having to enter residential care.’¹²

4.2.3 *Assessment* (see also 3.1.3)

The concept of assessment has been referred to earlier in the Report in the context of geriatric departments in general hospitals and its importance has been emphasised. The Council considers that the lack of appropriate and well-defined criteria of assessment for elderly people requiring care is a major problem in our current services.

Different criteria for assessment of need can obtain from area to area and from hospital to hospital, even within the same health board area. This is particularly true in the case of elderly persons being admitted to long-term care where in many instances no assessment of need is carried out.

Given that patients, once admitted to long-term care, are extremely unlikely ever to go home again, full assessment and every effort at rehabilitation should be made before such admissions occur.

The geriatric department in the general hospital, where one exists, plays an important role in the assessment of elderly patients and in the initiation and development of an appropriate programme of rehabilitation. (See 2.3.4 and 2.3.5). A small number of geriatric and district hospitals have also established assessment units and procedures. (See 3.2). Pre-admission screening through multi-disciplinary admission committees also takes place in the case of a number of welfare homes. Often, however, there is virtually no medical assessment and, even where there is such a practice, it is rarely at specialist level.

In the case of private nursing homes it is likely that a significant proportion of admissions and discharges are not subject to any form of objective assessment. As has been stated in 4.1.2, some 28% of elderly persons resident in long-stay units are there for ‘social’ rather than medical reasons.

At present decisions regarding services to be provided for elderly people in either community or institutional settings can be made by one or a combination of the following.

- (i) the general practitioner
- (ii) the public health nurse
- (iii) the social worker
- (iv) the committee of a voluntary organisation
- (v) the home help service
- (vi) the family or friends of the elderly person
- (vii) the consultant in the general hospital
- (viii) the consultant physician in geriatric medicine
- (ix) the psychiatrist

(x) the matron of the geriatric hospital or welfare home

(xi) the elderly person him/herself.

This results in a situation where very different criteria and standards operate and where consequently inadequate or inappropriate services may be provided.

The Council considers that the early identification of 'social' need among elderly persons (e.g. poor or inappropriate housing circumstances or fear of violent attack or lack of family or neighbourhood support) coupled with an appropriate intervention can do much to prevent serious medical and social problems later on. The community care team and the housing welfare officers play an important role in this respect.

Accurate assessment and early intervention when elderly persons become acutely ill is also crucial if such illness is not to result in chronic illness and consequent dependency and possible 'institutionalisation. Similarly, in the case of confused elderly persons, the appropriate assessment and correct diagnosis can lead to the successful treatment of a functional mental disorder or a contributory physical disorder.

The Council considers that as far as is practicable (i.e. in non-emergency cases) the initial assessment should be carried out at primary care level. In this context the general practitioner plays an important role. In the more complex cases, particularly in cases of mental confusion, the patient will obviously need to be referred to the consultant physician in geriatric medicine who should be available to visit the elderly person's home when required but who, in some instances may need to use the diagnostic facilities of the general hospital. Referral to a consultant psychiatrist for assessment will also be appropriate in the case of some patients.

The Council considers that there is a need to develop a system of assessment of elderly people requiring care whether in the community, in the acute hospital or in a long term unit. Such a system should be multidisciplinary and should provide not only for initial assessment but also for ongoing reviews of progress. Assessment procedures need to be built into all treatment programme, not only of acute general hospitals, but also of all hospitals and homes catering for the elderly. Such procedures should also be an integral part of the community care programme for the elderly. The Council agrees with a recommendation¹³ that has been made that each area should have drawn up a standard multi-disciplinary assessment procedure which can be applied at home, in a district or geriatric hospital or in the general hospital. The schedule for such an assessment procedure should contain both medical and social components and be adequate to deal with a situation where social need may mask medical need. Again, in the more complex cases, referral will need to be made to the consultant physician in geriatric medicine.

The level and type of treatment and care to be provided at any time for the elderly person should be decided on the basis of this assessment. The

assessment should always actively involve the elderly person him/herself except in cases of obvious and diagnosed mental confusion.(See3.5.3 and also 4.2.4). The relatives of the elderly person should also be involved where appropriate, thus ensuring that their caring potential is fully explored and adequately supported.

The Council considers that in order to improve and develop assessment procedures at all levels there should be some provision for training in geriatric medicine for all general practitioners and for all nursing and para-medical staff working with the elderly.

4.2A Continuing Nursing Care

Parts II and III of this Report outlined the Council's view on how the geriatric departments of the general hospital and the other forms of hospital and institutional care for the elderly, such as community hospitals, might serve to support the retention of the maximum number of elderly persons in the community for the longest period possible.

Despite a comprehensive rehabilitation programme, some elderly persons will fail to achieve a full functional recovery and will require continuing nursing care, some on a 24 hour basis. For some elderly persons this may be for a protracted period of time. For others it will be terminal care and will be for a shorter period. In some instances it will be possible to provide this continuing nursing care in the elderly person's own home through the concerted efforts of family, relatives and voluntary and statutory domiciliary services. In many instances this may not be possible and the continuing nursing care will need to be provided in other residential settings, for example, in the community hospital or in another nursing unit or home.

The Council believes that in all instances where continuing nursing care is provided outside the person's own home, consideration should be given to various criteria relating to:

- (i) Admission.
- (ii) Alternatives to permanent admission.
- (iii) Staffing and facilities.
- (iv) location and scale of continuing nursing care units.

(i) Admission

Thorough and multi-disciplinary assessment is an essential pre-requisite for the admission of an elderly person to continuing nursing care. Furthermore, no person should ever be admitted to continuing nursing care without having participated in efficient rehabilitation programmes. The question as to why a person needs admission to continuing nursing care rather than be supported in a community setting must be asked continuously. The Council urges that there should be mandatory provision for multi-disciplinary assessment before an elderly person is admitted to any form of continuing nursing care.

(ii) Alternatives to Permanent Admission

There are two main alternatives to permanent admission to continuing nursing care, viz.

- (a) Day Hospital Care. This has already been discussed in 2.4. Obviously, the availability and accessibility of day hospital care to an individual elderly person is important whether that person lives in his/her own home, with family or relatives, in sheltered housing or is boarded out with a family.
- (b) Intermittent Admission. Those caring full-time for dependent elderly persons would be greatly facilitated by the availability of relief or floating beds for planned intermittent admissions, and for other short-stay admissions, including crisis admissions, or admissions to allow respite to those caring full-time at home for dependent elderly persons. (See Appendix 9).

The availability of such relief beds would take some of the pressures off families and particularly off individual family carers, who may feel trapped by the never-ending cycle of continuous caring for a dependent relative.

In addition to the relief and floating beds provided in hospital and nursing home settings, the possibility of developing short-term family placement schemes to provide respite and relief accommodation for dependent elderly persons being cared for at home by relatives should, in the Council's view, be explored further in the Irish context. A number of such schemes appear to operate successfully in Britain and provide a useful support system in the maintenance of elderly people in the community. (See Appendix 10).

(iii) Staffing and Facilities

- (a) The Council supports the further development of geriatric departments at general hospitals and the parallel appointment of physicians in geriatric medicine.
- (b) In other hospitals and institutional settings, such as the proposed community hospitals, the medical supervision could ideally be carried out by the patient's own family doctor but the doctor with overall responsibility for the supervision of any nursing unit should have the necessary motivation and an interest in the care of the elderly, allied to the appropriate degree of training in geriatric medicine.
- (c) A sufficient number of trained para-medical staff, i.e. physiotherapists and occupational therapists with the necessary facilities and equipment is, of course, essential. Careful attention needs to be given to the organisation and development of the limited resources available under this heading.
- (d) The mix of professional nursing staff and other 'care staff' needs to be adequate to meet the dependency level of chronically ill or incapacitated elderly patients at any given time. A flexible approach to staffing levels

should be maintained, reflecting changing dependency levels within any given nursing unit .

- (e) Nursing units for the elderly require to have equipment and facilities which will help to maintain the patient in optimum comfort. The medical and nursing personnel in charge of the unit play a vital role in this respect. Maximum privacy for residents should be aimed at in all instances.

(iv) Location and Scale of Continuing Nursing Care Units

The location of continuing nursing care beds in a local community setting not only helps to keep the elderly patient in close contact with relatives and friends but also facilitates the intermittent discharge of such patients to be cared for by their families and friends. The nursing, medical and social support available to families through the provision of continuing nursing care at local level is likely to greatly enhance the role of the family in caring for elderly infirm relatives.

The local community setting also facilitates local people who are willing to take an interest in the unit and its patients and to arrange visitors, diversionary activities and entertainment. In this respect, the Council suggests that each continuing nursing care unit should have a committee of local people who would take an interest in the running and the programmes of the unit. Such a committee should meet regularly with health board representatives to ensure that the best possible standards prevail.

There is difficulty in regard to the scale (300 beds approximately) of a number of existing geriatric hospitals providing continuing nursing care, in that they are quite remote from some of the communities they serve. This inhibits their full development as part of an overall support network for the elderly in individual communities.

4.2.5 Discharge Procedures

Discharge procedures for elderly persons from the acute general hospital or from other forms of hospital and institutional care should be in keeping with the particular problems faced by elderly persons, especially those who are living alone or with relatives who are themselves frail or infirm. The Council considers that there is a need to pay much greater attention to planning for discharge requirements of the elderly. This planning should involve appropriate community care services.

The need for housing accommodation and housing repairs or adaptations is also an important consideration in this respect as is the need for co-ordination between hospital and community care services.

With this in mind the Council wholly endorses the recommendation made by the Working Party on General Nursing,¹⁴ that liaison nurses be designated in all areas to achieve more co-operation and more effective working relationships between hospital and community nursing services and to improve dis-

charge procedures from hospitals for the elderly. It is also suggested by the Council that hospitals should adopt a uniform system of pre-discharge checklists and ensure that no patient is discharged until the details of this checklist have been complied with in individual cases.

4.2.6 Co-ordinating Hospital and Community Care Services

The Council considers that each Director of Community Care should designate a medical officer who has a special interest in the elderly to take responsibility for coordinating hospital and community care services for the elderly in the area. This would serve to provide an opportunity for the development of close working relations between the hospital based consultants (responsible for providing specialist services and advice in relation to the elderly), general practitioners, the community based services for the elderly and voluntary groups involved in the care of the elderly in the community. The person designated should liaise with the nurses, physiotherapists, occupational therapists, chiropodists and social workers as appropriate to the needs of the elderly in the area.

4.2.7 Planning Future Units for the Elderly

Given the increasing longevity of the elderly population, an adequate level of provision must be made in relation to the facilities for long-term continuing nursing care of those physically and mentally disabled elderly people for whom admission to such care is the final option.

The Council is concerned to note that, probably in part due to a policy vacuum concerning the future provision of welfare homes, there has been no capital investment of any significance in recent years in the provision of long-term care facilities for the elderly.

The Council notes that existing long-term care accommodation standards are reflected in descriptions such as the following: 'Many of the buildings used are old, of poor quality and were originally built for other uses. There is often a lack of privacy and personal environment for the residents.'¹⁵ '... the standard of much of the accommodation for the elderly in Dublin in both the Health Board and other sections, voluntary and private, falls far short of the ideal. Many of the buildings are old and generally unsuitable having been originally provided for other purposes.'¹⁶

The Council is, of course, aware that long-term accommodation of a high standard has been provided in a number of locations throughout the country. However, there remains the need to either upgrade or replace the remaining accommodation, as well as making provision for extra needs projected for the future. It is encouraging to note the beginnings of such a policy commitment by the Government in the National Plan *Building on Reality 1985-1987*. The Council trusts that in future years, an equitable share of available capital

resources will be devoted to either upgrading, replacing or providing extra long-term care accommodation for the elderly.

The Council believes that in all future planning of services and facilities, continuing nursing care of the elderly should be provided in small units serving specific communities and should be part of a dynamic and flexible system of care for the community served. Continuing nursing care facilities, day facilities and sheltered housing facilities should be provided, if not on the same site, in close proximity to each other.

The idea of a *Community Nursing Unit* has been developed by the North Western Health Board and such a unit is currently in operation in Buncrana, Co. Donegal. A similar type concept is proposed by the Eastern Health Board, called a *Multi-Purpose Unit* (see Appendix 3). In each case the term used denotes a comprehensive range of services for the elderly provided on the same site and related to other community services.

In this context the Council envisages that elderly persons requiring social care rather than continuing nursing care should be accommodated in sheltered housing.

These services, provided in small community based units, should be closely related to the general community care services, on the one hand, and to the general hospital based geriatric service on the other. This would result in the majority of elderly persons continuing to be cared for in their own homes, which would be maintained in a structurally adequate condition and contain all the necessary amenities, facilities and adaptations. In addition to rehabilitation and day care facilities aimed at enabling the elderly to retain the capacity for the activities of daily living, either in their own homes or in sheltered housing, the community based unit would also contain a number of beds for intermittent care or other short-stay admissions including crisis admissions or admissions to allow respite to those caring fulltime for elderly infirm relatives.

The Council considers that this approach would result in a responsive local service and that small community based units would have the best chance of achieving close integration with the various community services, while, at the same time, operating in a co-ordinated way with the general hospital based services.

The Council, while taking the view that, in the future, the aim should be to concentrate much more on sheltered housing schemes as part of an infrastructure of community services for the elderly, wishes to insert a note of warning against exaggerated expectation of, or 'unreal idealism' about such a policy, as Coleman¹⁷ called it. Thus it is necessary in the Irish context to achieve the right balance between sheltered housing and continuing nursing care requirements and to provide for easy access from one to the other. Evans¹⁸ states that the British experience has not yet established the parameters of a successful system', but he warns that 'a failed community system

can cause more hardship than does over-institutionalisation'. The task facing policy-makers in Ireland is to ensure that the community system is *planned* in a sufficiently adequate manner to reduce the risk of failure.

4.2.8 *Co-ordination of Services for the Elderly*

The increasing numbers of elderly people in the community and particularly the growing numbers of those aged 75 years and over with increased levels of dependency represents a major social challenge and presents a major test to the health and social services. If this challenge is to be met there is a need for a much greater level of flexibility and co-ordination in the provision of services -housing, social and medical- than is currently the case. The emphasis on maintaining old people in the community and in their own homes rather than in hospital or institutions requires that different agencies co-operate at local level towards this end. The starting point for such working together is an acceptance of the idea that the needs and conditions of each local area should determine the way services are organised in that area. The next stage is the availability of a forum where all the people who provide services or dispose of resources can meet together to ensure that:

- (i) the right mix of services is provided;
- (ii) different services by different agencies are not duplicating each other;
- (iii) agencies and their personnel are offering each other the kind of expertise they have got.

In the foregoing context, it is the view of the Council that the appropriate mix of services for elderly people at local level can best be achieved if health and social care policy for the elderly is governed by the following considerations:

1. That it be seen as comprehensive, that is to say, based on informed and up-to-date demographic information, which would be the basis for adequate provisions at every level and which would ensure that all elderly persons in need are reached, rather than just those who are referred for care.
2. That it be seen as an integrated range of services from the provision of simple supports for mainly comfort or preventative reasons to acute hospital care and continuing nursing care for those who require specialist medical or nursing attention.
3. That it be seen as the responsibility of a number of parties including the family, the public, the housing and health authorities as well as the medical, para-medical and nursing professions.

This requires an integrated and co-ordinated approach both at the level of provision and the level of planning between:

- (i) families, voluntary groups and statutory services;
- (ii) hospitals and community care services;
- (iii) housing and health authorities.

The needs of elderly persons rarely fall into watertight compartments to be met by one authority or one service only. An elderly person may be enabled to remain living in the community not only through the support of his/her family and friends, but also through

- (a) the efforts of the housing authority (in facilitating house adaptations, improvements, extensions);
- (b) the efforts of the voluntary and neighbourhood caring network;
- (c) the provision of domiciliary help and nursing care by the community care services
- (d) the availability of effective assessment, rehabilitation and other hospital services on a day and in-patient basis;
- (e) the availability of intermittent in-patient care facilities for both planned and crisis admissions.

The purposeful and smooth functioning of all these elements requires Coordination of services at local level. This co-ordination can only effectively occur if it is based on four considerations, as follows:

- (i) The commitment of each health board to promote and facilitate the development of a co-ordinated range of services for elderly persons involving the hospital and community care programmes is essential. In order to achieve this, resources may have to be redistributed; the hospital programme may have to become less insular and more community conscious and both programmes will need to ensure that a mechanism is established for coordinating their information and activities.
- (ii) Appropriate and adequate housing accommodation is fundamental to the care of the elderly in the community. The local authority must, therefore, be involved in any coordinating mechanism established in a local community to promote improved community care provision for the elderly.
- (iii) Though it may not always be adverted to, community care, by definition, implies that the people being cared for continue to live at home or in a surrogate 'home'. Care in the community is, therefore, founded on in-formal care, whether that be the care provided by families, by friends and neighbours or by members of voluntary organisations. These sectors must necessarily be included in any mechanism designed to improve the coordination of services for the elderly.
- (iv) Elderly persons themselves, who, incidentally, are often in a position of providing care for a more dependent relative or friend, have much to offer in identifying needs and should be involved in any mechanism for coordination of services at any level.

4.2.9 *Co-operation between Health and Housing Authorities*

The inter-relatedness of the elderly person's needs necessitates close co-ordination between health and housing authorities. This in turn calls for a willing.

ness to share knowledge and engage in consultation. This process will be founded on an understanding of the roles of personnel working in other agencies and an appreciation of the constraints governing them. Taking such factors into account it is then possible to engage effectively in the 'nittygritty of co-ordination'¹⁹ in the best interests of elderly people.

In many instances such sharing of information occurs on an informal and *ad hoc* basis and thus influences the actions of some of the personnel involved. Some local authorities in Britain have gone beyond such *ad hoc* arrangements between individuals and have set up joint care co-ordination teams or their equivalent to discuss policy and plans relating to the elderly and pool relevant information.

In 1976 Stockport local authority produced a jointly agreed overall strategy between housing and social services departments for the longer-term development of services to meet the needs of its elderly population. In essence this implied a considerable shift away from 'residential' solutions to support for the elderly in their own homes and a consequent shift of resources.

The need for co-ordination between health and housing authorities in the Irish context is obvious. With a view to facilitating such co-ordination the Council recommends that each local authority and each health board should designate an officer or officers to be responsible for liaison in matters concerning the elderly. (Where staffing numbers do not allow, this might initially need to be part of a wider brief). Such officers should be of senior rank and should have a clearly designated responsibility for such matters as joint planning, information sharing, joint financial allocations where appropriate (for example sheltered housing) and joint in-service training for selected staff of both agencies. These officers would be in a position to identify individuals at local level who would form committees of key personnel to review local services for the elderly and to plan for local requirements in housing, community services and institutional care.

4.2.10 *Developing an Appropriate Structure for Local Co-ordination*

The Council considers that the role of the statutory body, whether local authority or health board, should be more than that of provider of services for the elderly. Its role as planner, initiator, enabler and co-ordinator is all important if families are to get the type of support they require and if the voluntary caring potential in a community is to be tapped and realised. Currently, voluntary organisations in Ireland operate in a policy vacuum. Yet their involvement, particularly in times of economic stringency, is a key element in the provision of an adequate level of 'community care' for elderly persons. The greater involvement of neighbours and of voluntary groups requires a planned approach on the part of the statutory bodies. This requires

co-ordination between community care services and hospital based services; between these services and housing provision; between the informal family and kinship caring system and formal statutory and voluntary services.

The Council envisages that future services for the elderly should

1. reflect a policy of providing a range of care options;
2. build on the natural caring network of the family on the one hand and on the spirit of goodwill and neighbourliness in the community on the other;
3. take account of the needs and conditions of each local area;
4. ensure that, as far as possible, decisions concerning the transformation of cash into services are made by those with the most detailed and up to date knowledge of the area and its needs;
5. facilitate and encourage innovative developments at local level.

In order to ensure this, it is necessary to facilitate more effective liaison and co-ordination at all levels of the caring system than is currently the case.

The Council considers that this can only be achieved in the context of a revised structure which

- (a) provides a greater flow of information on both needs and resources in the community,
- (b) develops a partnership between hospital/community; health/housing; voluntary/statutory; formal/informal,
- (c) overcomes some of the barriers created by current administrative structures.

While co-ordination is not a substitute for adequate resources, it may, nevertheless, help to ensure that what resources are available are used to the best effect and so limit possible duplication and waste.

The Council recognises that there are substantial blocks to be overcome if successful partnerships are to emerge. The issues of independence and tradition which apply to both the voluntary and statutory sector are likely to be strong and deep rooted and need to be approached with sensitivity and diplomacy.

The Council considers that there is a need to explore further at a practical level the issue of co-ordination of services and suggests that this could be done under Section 25 of the Health Act 1970, which refers to arrangements between health boards and local authorities and Section 26 of the same Act which refers to arrangements by health boards for provision of services. (See Appendix 11).

With this in mind the Council recommends that the Department of Health should make funds available for the setting up of two pilot projects which would develop and evaluate the concept of co- services for the elderly in terms of both planning and provision at local level. Such projects would be located in selected community care areas which are generally coterminous with local authority functional areas and would ideally have a rural and urban dimension. The projects would seek to involve all levels of the caring system in the development of an appropriate coordinated community oriented range of services to meet the varying levels of need of the elderly population.

Such projects might establish broadly based local joint services for the aged committees, representative of voluntary and statutory agencies, whose principal functions would be to

- 1 assess the special accommodation and welfare needs of the aged in the community having regard to local social and demographic factors;
2. propose programmes of action to the parent statutory authorities for meeting these needs;
- 3' make recommendations to the parent statutory authorities on the priorities which should be adopted;
4. co-ordinate the implementation of agreed programmes and regularly evaluate the effectiveness, efficiency and degree of satisfaction with the accommodation and supportive services for the aged provided by statutory authorities;
5. maintain contact with regional and national developments in providing for the special needs of the aged and, in particular, identify 'good practices' in other areas that might be followed.

It is the view of the Council that the development and refinement of the concept of co-ordination at local level will do much to ensure that more elderly people can remain living in their own environment, adequately cared for and close to relatives and friends, for a longer period of time.

4.3 Innovation and Information

Throughout this report the Council has drawn attention to a number of interesting and innovative responses which have been developed at various locations throughout the country. The point has also been emphasised that services and facilities need to be developed and adapted in accordance with local needs and local resources. The Council considers that it is most desirable to have a system whereby information on 'good practices' both here and abroad can be quickly disseminated around the country – 'even the very best of us can do better and innovation spreads quite rapidly once people understand and know where to look'.²¹

The Council considers that the establishment of a national central information service which would identify and compile and circulate basic information on all relevant innovative developments relating to the care of elderly persons would be very desirable. The Council, however, also wishes to note that this or any other information system will only be worthwhile insofar as the various agencies involved in the provision of such services are open to innovation and development in this field.

PART V

SUMMARY OF MAIN RECOMMENDATIONS

Introduction

In this report the Council has considered various issues relating to the institutional care of elderly people. The report expresses views on these issues and makes a number of suggestions and recommendations relating to the future planning of services for the elderly. This section contains a summary of the main conclusions and findings, including some of the recommendations contained in the report. The full context of these recommendations can be found in the relevant sections of the report.

Local Demographic and Geographical Factors (1.3.3)

The Council recognises that there is a need for varying responses to meet the needs of the elderly in various parts of the country depending on both local demographic factors and on factors relating to the urban/rural mix of the population and the related distance from service centres.

National guidelines and norms relating to personnel, numbers and types of facilities to be provided need to be continually assessed and applied in the light of these factors. Such an approach helps to ensure that statutory financial resources are used in a manner which takes cognisance of area and local priorities.

Recommendation 1

The Council recommends that health boards should give greater consideration to local demographic and geographical factors relating to community care areas and to parts of community care areas in the planning and provision of services for the elderly.

Geriatric Departments in General Hospitals (2.3)

The Council recognises the need for expertise in the analysis and treatment of illness among elderly persons and sees geriatric medicine as a speciality in its

own right. Geriatric medicine requires the team approach integrating nursing, medical and para-medical staff in order to adequately assess and achieve maximum functional recovery of elderly patients. This integration can be most effectively achieved in the geriatric department of the general hospital.

The geriatric department in the general hospital is an important source of referral for the general practitioner and medical supervisors in other hospitals and homes catering for elderly persons in cases where there are complex or multiple problems requiring more expert diagnosis.

Recommendation 2

The Council advocates the further expansion of geriatric departments in general hospitals and the appointment of the necessary consultant physicians in geriatric medicine. These geriatric departments should provide specialist assessment and rehabilitation services for those elderly persons who cannot be adequately catered for by the general practitioner or in the geriatric and district hospital. In order to achieve this, the hospital based geriatric department should have clearly established links with geriatric and district hospitals and other long-stay facilities; also with community services generally.

Assessment and Rehabilitation Facilities (2.3.4 and 2.3.5)

The geriatric department in the general hospital requires sufficient beds relative to its catchment population and full access to the diagnostic and rehabilitation facilities of the general hospitals. The Council recognises that it will also be necessary to provide assessment and rehabilitation facilities in the more local district and geriatric hospitals and thus eliminate, as far as possible, the need for unnecessary long distance travelling by elderly patients. However, in some instances it will be necessary to refer patients to the consultant physician in geriatric medicine.

Recommendation 3

The Council recommends that, in addition to the assessment and rehabilitation programmes provided in the geriatric department of the general hospital, assessment and rehabilitation facilities should also be provided in other hospitals: geriatric hospitals, district hospitals and associated day hospitals.

Day Hospitals (2.4)

The Council sees the day hospital as one of the most valuable aspects of the geriatric hospital service. The increasing number of old people in the population, together with the ever increasing cost of hospital in-patient care, suggest that the full application of the principles of day hospital care would result in considerable improvements in hospitals' services to the elderly population.

Recommendation 4

The Council recommends that where geriatric assessment and rehabilitation beds have been provided or planned for in a general hospital, a day hospital facility for the elderly should also be provided. Geriatric and district hospitals, particularly those involved in screening admissions and in rehabilitation of the elderly, should also establish day hospital services for the elderly.

The Council also supports the idea of developing on a pilot basis the concept of a mobile day hospital.

Fear of Violence and Admission to Institutional Care (4.1.3)

The Council is concerned about the problems that elderly persons may be faced with due to fear of burglary and/or being attacked. It is particularly concerned that, because of such fears, elderly persons may be forced to seek admission to some form of institutional care. Indications are that there is a trend towards the latter in recent months.

Recommendation 5

While urging that every effort is made to lessen such fear through the promotion of neighbourhood surveillance and the development of effective communication and alarm systems, the Council believes that it is also necessary to ensure that an appropriate counselling and advice service is provided for elderly people who have either been the subject of such attacks and/or break-ins or who live in daily fear of their occurrence. In cases where elderly people are seeking admission to some form of institutional care because of such fear, the counselling service should be organised by the health board community care team who should marshal assistance and support for the elderly person from all available sources.

The Community Hospital (3.2)

The Council considers that the long-stay geriatric hospitals and long-stay district hospitals are an under-exploited resource within the community. There is scope for some geriatric and district hospitals to play a more effective role in the provision of care services for elderly people. This can be achieved, in the Council's view, by adopting the *community hospital* model. This would place an emphasis on

- (i) an active assessment, rehabilitation and discharge policy which enables the elderly person return home with dignity and purpose, and
- (ii) the provision of sensitive and sympathetic continuing nursing and terminal care.

Recommendation 6

The Council, therefore, recommends that each health board should select a number of appropriately located geriatric or district hospitals to take on the

role of community hospital for a specific catchment area of approximately 20,000-30,000 persons. While the size and present catchment area of some of the larger geriatric hospitals may not ideally suit the role of community hospital, the Council considers that the principles outlined above apply to all such hospitals.

Welfare Homes (3.3)

The Council considers that it is necessary to address the following two questions in relation to welfare homes:

1. Do we continue to place in welfare homes a mixture of
 - (a) elderly people who could manage in the community with better support services and/or improved sheltered housing, and
 - (b) disabled elderly people who often lack diagnostic assessment and rehabilitation and who do not receive the nursing care they require in the welfare home?
2. What do we do about existing welfare homes with their present mixed clientele?

Recommendation 7

The Council recommends that the long-term plan should be to redesignate the welfare homes to provide a range of options in a local comprehensive plan for caring for the elderly in a community based setting.

Some options suggested by the Council are:

- (i) *flats/apartments for those capable of independent living,*
- (ii) *a home or nursing unit catering for various levels of dependency,*
- (iii) *a care unit for confused elderly persons.*
- (iv) *a day care unit for those being cared for at home by families,*
- (v) *intermittent care/floating bed facilities.*

The choice of option will depend on local requirements and should be linked to appropriate day care facilities.

Private and Voluntary Nursing Homes (3.4)

- (i) The Council notes that the Minister for Health has revised the regulations relating to private and voluntary nursing homes. This revision does not include provision for a system of registration for private and voluntary nursing homes. The Council believes that a system should operate whereby refusal or cancellation of registration should be possible for stated reasons relating to standards in the home or to the person operating them.

Recommendation 8

The Council recommends that the Minister for Health should prepare legislation which will provide for an effective system of registration for all private and voluntary nursing homes.

- (ii) The maximum rate of contribution from health boards to persons resident in private and voluntary nursing homes is the same regardless of whether or not the elderly person in the nursing home requires continuing nursing care. The Council believes that there would be merit in applying a higher rate of financial contribution in the case of those requiring nursing care as distinct from those who are ambulant and in the welfare category. The introduction of a higher rate of contribution for those requiring continuing nursing care would be expected to assist in improving standards generally. It would, of course, have to be allied to a comprehensive system of assessment prior to admission and ongoing review following admission.

Recommendation 9

The Council recommends that the possibility of a two-tier system of financial contribution from health boards to persons in voluntary and private nursing homes should be further explored by the Department of Health with the possibility of amending Section 54 of the Health Act 1970 accordingly.

- (iii) Private and voluntary nursing homes should, in the Council's view, be placed in the context of the health boards' obligation to ensure that a comprehensive range of services for the elderly is provided at both community and institutional level.

Recommendation 10

The Council recommends that the level and type of services to be provided by voluntary and private nursing homes (for those elderly persons financed in whole or in part from public funds, including state pensions and financial subvention from health boards) should be defined and agreed with the relevant health board from the outset. In each case this provision should start with pre-admission assessment of the elderly by health board personnel and should ensure their continuing assessment in the context of a comprehensive institutional and community care service to meet all the needs of the elderly in the area.

Mental Health Disorders of the Elderly (3.5)

The Council is convinced that there is an urgent need to provide an adequate range of services and facilities for the elderly suffering from mental disorders. In this respect the Council wishes to acknowledge that most old people suffering

from mental disorders remain in their own home, under the care of the general practitioner in collaboration with community care services, and supported by in-patient and out-patient hospital services when in need of specialist treatment.

The Council is aware of and supports the idea of there being one psychiatrist in each service catchment area who would have a special responsibility for the elderly with mental disorders. In larger urban centres of population, particularly in Dublin and Cork, the Council supports the idea of wholetime appointments.

Recommendation 11

The Council recommends that the consultant psychiatrist with responsibility for the elderly with mental disorders should have a unit in a general hospital which is linked with both geriatric and psychiatric departments and staffed by nurses trained in general and psychiatric nursing. Such units should be short-stay assessment and treatment units and should also play a central role in providing support, advice and relief at times of special difficulty to families and community care services.

Recommendation 12

Given the unsuitability of existing psychiatric hospital and geriatric long-stay facilities, the Council recommends the establishment of specialist homes for the elderly with mental disorders, particularly in urban areas where numbers of patients assessed as requiring this type of care would justify such homes.

Home Helps (4.1.3)

The Council wishes to point to the need for more training for personnel involved in the home help service in order to:

- (i) enable them to take on some of the work currently being carried out by nurses, for example, getting people up and dressed and putting them to bed;
- (ii) ensure that the form of assistance they give to elderly persons is not creating further dependency, for example, by getting the person to peel their own potatoes, rather than peeling them for them.

Recommendation 13

In view of the importance of home helps in the provision of care for elderly persons in the community, the Council wishes to reiterate with urgency a recommendation already made, that the Department of Health organises a review of the home help service.

Assessment (4.2.3)

The Council considers that there is a need to develop a system of assessment of elderly people requiring care whether in the community, in the acute hospital or in a long term unit. Such a system should be multi-disciplinary and should provide not only for initial assessment but also for ongoing reviews

of progress. Assessment procedures need to be built into all treatment programmes, not only of acute general hospitals, but also of all hospitals and homes catering for the elderly. Such procedures should also be an integral part of community care programmes for the elderly.

The level and type of treatment and care to be provided at any time for the elderly person should be decided on the basis of this assessment. The assessment should always actively involve the elderly person him/herself except in cases of obvious and diagnosed mental confusion. The relatives of the elderly person should also be involved where appropriate, thus ensuring that their caring potential is fully explored and adequately supported.

Recommendation 14

The Council agrees with a recommendation that has been made, that each health board should draw up a standard multi-disciplinary assessment procedure which can be applied domiciliary, in a district or geriatric hospital or in a general hospital. The schedule for such an assessment procedure should contain both medical and social components and be adequate to deal with a situation where social need may mask medical need.

Sheltered Housing (3.3 and 4.2.7)

The Council takes the view that, as far as is practicable, frail elderly people requiring 'welfare' or 'social' care as distinct from continuing nursing care should be accommodated in independent, self-contained units of the sheltered variety. In addition to the normal community care support services these units should have other facilities, such as resident wardens, community meals, sick bay facilities, alarm/communications systems, recreational and occupational therapy facilities. Such 'sheltered' accommodation should be located as near as possible to the elderly person's original environment and should be so organised to ensure that the ordinary values of everyday life are protected.

Recommendation 15

The Council recommends that an Inter-Departmental Working Group should be set up in order to examine and assess the role and contribution of sheltered housing-both statutory and voluntary-in the provision of accommodation and selected services for the elderly within an Irish context and to make recommendations accordingly. This Working Group should be comprised of representatives from both the Department of Health and the Department of the Environment and should consult with local authorities, health boards and voluntary housing associations currently providing sheltered accommodation for the elderly.

Intermittent Admission (4.2.5)

Those caring full-time for dependent elderly persons would, in the Council's view, be greatly facilitated by the greater availability of relief beds for planned intermittent admissions, or admissions to allow respite to those caring full-time at home for dependent elderly persons. The availability of such relief beds takes some of the pressure off families, and particularly off individual family carers, who may feel trapped by the never-ending cycle of continuous caring for a dependent relative.

Recommendation 16

In addition to the relief and floating beds provided in hospital and nursing home settings, the Council recommends that health boards should explore the possibility of developing short-term family placement schemes to provide respite and relief accommodation for dependent elderly persons being cared for at home by relatives.

Discharge Procedures (4.2.5)

Discharge procedures for elderly persons from the acute general hospital or from other forms of hospital and institutional care should be in keeping with the particular problems faced by elderly persons, especially those who are living alone or with relatives who are themselves frail or infirm. The Council considers that there is a need to pay much greater attention to planning appropriate discharge procedures and arrangements for the elderly. This planning should involve the community care personnel and the housing authority, when necessary.

Recommendation 17

With this in mind, the Council wholly endorses the recommendation made by the Working Party on General Nursing, that liaison nurses be designated in all areas to achieve more co-operation and more effective working relationships between hospital and community nursing services and to improve discharge procedures from hospitals for the elderly. It is also suggested that hospitals should adopt a uniform system of pre-discharge check lists and ensure that no patient is discharged until the details of this check list have been completed in each individual case.

Co-ordination between Hospital and Community Care Services (4.2.6)

The Council considers that it is necessary to develop closer working relations between the hospital based consultants responsible for providing specialist services and advice in relation to the elderly, general practitioners, the community based services for the elderly and voluntary groups involved in the care of the elderly in the community.

Recommendation 18

The Council recommends that each Director of Community Care should designate a medical officer who has a special interest in the elderly to take responsibility for co-ordinating hospital and community care services for the elderly in the area. The person designated should liaise with nurses, physiotherapists, occupational therapists, chiropodists and social workers as appropriate to the needs of the elderly in each individual instance.

Community Based Units (4.2.7)

The Council believes that health boards should provide continuing nursing care units as part of a comprehensive range of services for elderly people at local level.

These services, provided in small community based units, should be closely related to the general community care services, on the one hand, and to a general hospital based geriatric service on the other. In addition to rehabilitation and day care facilities aimed at enabling the elderly to retain the capacity for the activities of daily living, either in their own homes or in sheltered housing, the community based unit would also contain a number of beds for intermittent care or other short-stay admissions, including crisis admissions or admissions to allow respite to those caring fulltime for elderly infirm relatives.

Recommendation 19

The Council recommends that in all fixture planning of services for the elderly continuing nursing care should be provided in small units serving specific communities and should be part of a dynamic and flexible system of care for the community served. Continuing nursing care facilities, day facilities and sheltered housing facilities should be provided, if not on the same site, in close proximity to each other.

Local Involvement in Continuing Nursing Care Units (4.2.4)

The availability of continuing nursing care beds in a community based setting helps to keep the elderly patient in close contact with relatives and friends and also facilitates the intermittent discharge of such patients to be cared for by their families and friends. The nursing, medical and social support available to families through the provision of continuing nursing care at local level is likely to greatly enhance the role of the family in caring for elderly infirm relatives.

The local setting also facilitates local people who are willing to take an interest in the unit and its patients and arrange visitors, diversionary activities and entertainment.

Recommendation 20

In this respect, the Council recommends that each continuing nursing care unit should have a committee of local people who would take an interest in

the running and programme of the unit. Such a committee would meet regularly with health board representatives to ensure that the best possible standards prevail.

Co-operation between Health and Housing Authorities (4.2.9)

The needs of elderly persons rarely fall into watertight compartments to be met by one authority or one service only. Therefore, the Council considers that there is a need for more effective co-ordination between health and housing authorities in the Irish context. This requires, first of all, an identification and clear recognition of the common interest, i.e. the maintenance of function and the support of elderly persons in the community, between health and housing authorities and their respective personnel.

Recommendation 21

With a view to facilitating such coordination, the Council recommends that each local authority and each health board should designate an officer or officers to be responsible for liaison in matters concerning the elderly. (Where staffing numbers do not allow, this would initially be part of a wider brief). Such officers would be of senior rank and would have responsibility for matters such as joint planning, information sharing, joint financial allocations where appropriate (e.g. sheltered housing) and joint in-service training for selected staff of both agencies.

Developing an Appropriate Structure for Local Co-ordination (4.2.10)

The Council considers that the role of the statutory body whether local authority or health board should be more than that of provider of services to the elderly. Its role as planner, initiator, enabler and coordinator is all important if families are to get the type of support they require and if the voluntary caring potential in a community is to be tapped and realised⁴. Currently, voluntary organisation in Ireland operate in a policy vacuum.

The Council recognises that there are substantial blocks to be overcome if successful partnerships are to emerge. The issues of independence and tradition which apply to both the voluntary and statutory sectors are likely to be strong and deep-rooted and need to be approached with sensitivity and diplomacy.

The Council considers that there is a need to explore further at a practical level the issue of coordination of services and suggests that this could be done under Section 25 of the Health Act 1970 which refers to arrangements⁵ between health boards and local authorities and Section 26 of the same Act which refers to arrangements by health boards for provision of services.

Recommendation 22

With this in mind the Council recommends that the Department of Health should make funds available for the setting up of two pilot projects which would develop and evaluate the co-ordination of services for the elderly in terms of both planning and provision at local level. Such projects would be located in selected community care areas which are generally coterminous with local authority functional areas and would ideally have a rural and urban dimension. The projects would seek to involve all levels of the caring system:

- family, voluntary, statutory;*
- health and housing authorities;*
- hospital and community care programmes;*
- and elderly persons living in the community*

in the development of an appropriate co-ordinated community range of services to meet the varying levels of need of the elderly population.

Innovation and Information (4.3)

The Council considers that the establishment of a national central information service which would identify, compile and circulate basic information on all relevant innovative developments relating to the care of elderly persons would be very desirable. The Council, however, also wishes to note that this or any other information or advisory system will only be effective to the extent that the various agencies involved in the provision of such services are open to innovation and development in the provision of such services for the elderly.

Recommendation 23

The Council recommends that the Department of Health should designate an appropriate body to provide an information service which would identify, compile and circulate basic information on relevant innovative developments relating to the care of elderly persons.

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APPENDIX 1

TABLES

TABLE 1

Population Aged 65 Years and Over by Age Group (in Parenthesis is Proportion of Total Population)

AgeGroup	1966	1971	1981	% change	
				1966-71	1971-81
65 - 69	114,226 (4.0)	111,751(3.8)	133,919 (3.9)	-2.2	19.8
70-74	90,099(3.1)	98,986(3.3)	103,138(3.0)	9.9	4.2
75 - 79	62,801(2.2)	61,775 (2.1)	68,451(2.1)	-1.6	10.8
80 and over	55,881(1.9)	57,307 (1.9)	63,446 (1.8)	2.6	10.7
65 and over	323,007 (11.2)	329,819(11.1)	368,954(10.7)	2.1	11.9
75 and over	18,682 (4.1)	119,082 (4.0)	131,897 (3.8)	0.3	10.8
80 and over	55,881(1.9)	57,307(1.9)	63,446(1.8)	2.6	10.7

Sources: Census of population 1979, Vol II: Census of Populatton 1981, Vol 2 Central Statistics Office, Dublin.

TABLE 2
Population Aged 65 and Over by Sex, 1966 - 1981 (in Parenthesis is proportion of total population)

Age Group						% Change	
	1966	1971	1979	1981	1966-71	1971-81	
Men							
65 and over	149,949 (10.3)	150,637 (10.1)	162,968 (9.6)	165,183 (9.6)	4.6	9.7	
75 and over	52,660 (3.6)	51,551 (3.4)	52,172 (3.1)	52,497(3.1)	-2.1	1.8	
80 and over	23,916 (1.7)	23,777 (1.6)	23,032 (1.4)	23,325 (1.3)	-0.6	1.9	
Women							
65 and over	173,058 (12.1)	179,182 (12.1)	198,407(11.8)	203,771 (11.9)	3.5	13.7	
75 and over	66,022 (4.6)	67,531 (4.6)	77,132 (4.6)	79,400 (4.9)	2.3	17.6	
80 and over	31,965 (2.2)	33,530 (2.3)	37,416 (2.2)	40,121 (2.3)	4.9	19.7	
All Persons							
65 and over	323,007 (11.2)	329,819 (11.1)	361,375(10.7)	368,954 (10.7)	2.1	11.9	
75 and over	118,682 (4.1)	119,082 (4.0)	129,304 (3.8)	131,897 (3.8)	0.3	10.8	
80 and over	55,881 (1.9)	57,307 (1.9)	60,448 (1.8)	63,446 (1.8)	2.6	10.7	

Source: Incomes of the Elderly in Ireland: And An Analysis of the State's Contribution, National Council for the Aged, Dublin, 1984.

TABLE 3
Population Aged 65 and Over by Sex and Marital Status, 1966 -1981 (in Parenthesis is proportion of
total population aged 65 and over or aged 75 and over).

	Aged 65 and over			Aged 75 and over		
	1966	1971	1981	1966	1971	1981
Men						
Single	40193 (26.8)	40315 (26.8)	42995 (26.0)	13466 (25.6)	12956 (25.1)	13185 (25.1)
Married	80550 (53.7)	82467 (54.7)	94845 (57.4)	23286 (44.2)	23467 (45.5)	24897 (47.4)
Widowed	29206 (19.5)	27855 (18.5)	27343 (16.6)	15908 (30.2)	15128 (29.3)	14415 (27.5)
Women						
Single	42945 (24.8)	44891 (25.1)	47247 (23.2)	15804 (23.9)	16695 (24.7)	19641 (24.7)
Married	48953, (28.2)	50264 (28.1)	59647 (29.3)	10905 (16.5)	10917 (16.2)	11842 (14.9)
Widowed	81160 (46.9)	84027 (46.9)	96877 (47.5)	39313 (59.5)	39919 (59.1)	47917 (60.3)

*Source:*Incomes of the Elderly in Ireland: And An Analysis of the State's Contribution, National Council for the Aged, Dublin, 1984.

TABLE 4

Life Expectancy: Life Expectancy at Selected Ages for EEC Countries

Country	Period	Sex	Life expectancy in years				Excess of Female life Expectancy over Male expectancy At age 0
			0	1	40	65	
Belgium	1972-76	M	68.60	68.94	32.03	12.27	6 46
		F	75.06	75.21	37.45	15 74	
Denmark	1981-82	M	71.4	710	338	138	60
		F	77.4	770	390	177	
France	1982	M	70.7	705	33 7	143	8 1
		F	78.8	785	407	185	
German Federal Republic	1979-81	M	69.90	6991	3294	1300	669
		F	76.59	7644	3860	1663	
Greece	1970	M	70.13	7216	35.14	1387	351
		F	73.64	7532	3777	1529	
Ireland*	1978-80	M	69.47	6948	3223	1238	548
		F	74.95	7482	3681	1540	
Italy	1974-77	M	69.69	70.30	33.05	13.17	622
		F	75.91	76.31	38.35	16.28	
Luxembourg	1976-78	M	68.0	67.9	31.3	12.0	7 1
		F	75.1	75.0	37.1	15.5	
Netherlands	1981	M	72.7	72.4	34.8	14.0	6.6
		F	79.3	78.9	40.8	18.5	
United Kingdom	1977-79	M	70.0	70.0	32.6	126	62
		F	76.2	76.1	38.1	1636	

Source: Statistical Information Relevant to the Health Services, Department of Health, 1984.

TABLE 5

Life Expectancy: Expectation of Life at Selected Ages from 1950 to 1980.

		Period			
		1950-52	1960-62	1970-72	1978-80
<i>Males:</i>					
Number of additional years a person can expect to live at age					
	0	64.5	68.1	68.8	69.5
	1	66.9	69.3	69.2	69.5
	5	63.6	65.7	65.5	65.7
	25	44.8	46.4	46.3	46.4
	45	27.0	27.8	27.6	27.7
	65	12.1	12.6	12.4	12.4
	75	6.8	7.1	7.3	7.1
<i>Females:</i>					
Number of additional years a person can expect to live at age					
	0	67.1	71.9	73.5	75.0
	1	68.8	72.7	73.8	74.8
	5	65.4	69.0	70.0	71.0
	25	46.6	49.5	50.5	51.4
	45	28.9	30.7	31.4	32.1
	65	13.3	14.4	15.0	15.4
	75	7.6	8.1	8.5	8.8

Source: Statistical Information Relevant to the Health Services, Department of Health, 1984.

TABLE 6
Population Projections for those aged 65 years and over,
1981 - 2006

	1981	1986	1991	1996	2001	2006	% Change 1981-2006
Males							
Over 65	165.2	167.5	167.3	164.7	163.2	167.4	(1.3)
Over 75	52.5	55.8	58.9	58.7	57.8	56.7	(8.0)
Over 80	23.3	23.3	25.1	26.4	26.0	25.6	(9.9)
All Ages	1729.5	1797.9	1832.4	1851.4	1859.5	1903.2	(10.1)
Females							
Over 65	203.8	213.3	220.6	222.2	222.6	2291	(12.4)
Over 75	79.4	84.3	91.5	95.7	99.9	101.9	(283)
Over 80	40.1	41.8	44.5	49.2	52.0	55.6	(38.6)
All Ages	1714.0	1786.3	1823.6	1845.0	1855.0	1907.7	(10.9)
Persons							
Over 65	369.0	381.0	387.9	387.0	385.9	396.5	(7.4)
Over 75	131.9	140.1	150.4	154.5	157.8	158.6	(20.2)
Over 80	63.4	65.1	69.6	75.6	78.1	81.2	(28.1)
All Ages	3443.4	3584.2	3656.0	3696.4	3714.5	3804.9	(10.5)

Source: Blackwell J. Population Projections by County in Housing of the Elderly in Ireland, National Council for the Aged, 1985, Appendix 2

TABLE 7
Population Projections for those Aged 65 years and over, by
County and County Borough 1986, 1991, 1996, 2001, 2006

	In parenthesis in percentage or total area Population 000's						% Change 1981-2006
	1911 (actual)	1986	1991	1996	2001	2006	
State	369.0(10.7)	381.0(10.6)	387.0(10.6)	387.0(10.5)	385.8(10.4)	396.4 (10.4)	7.4
Donegal	17.5(14.0)	17.6(13.5)	17.2(12.8)	16.5(12.1)	15.8(11.5)	16.0(11.3)	-8.6
Leitrim	4.9(17.6)	4.8 (18.0)	4.3 (17.9)	4.1 (17.6)	3.7(17.3)	3.4(17.2)	-51.0
Sligo	7.9(14.2)	7.9(14.0)	7.8(13.7)	7.6(13.3)	7.1 (12.7)	7.1 (12.4)	-10.1
Galway	21.5(12.5)	22.0(12.4)	21.8(12.1)	21.3(11.7)	20.8(11.5)	21.3(11.5)	-0.9
Mayo	18.2(10.9)	18.5 (16.1)	17.8(15.9)	16.6 (15.5)	13.) (15.1)	14.9(14.8)	-18.1
Clare	10.9(12.4)	11.0(11.9)	10.9(11.4)	10.6(10.9)	10.3(10.5)	10.6(10.4)	-2.7
Limerick Co. Borough	5.5 (9.1)	5.6 (9.4)	5.9(10.1)	6.0(10.7)	6.0(11.4)	6.1(12.0)	10.9
Limerick County	10.8(10.7)	11.2(10.5)	11.3(10.3)	11.1 (9.9)	11.0 (9.6)	11.) (9.7)	6.5
Tipperary N.R.	7.0(11.9)	7.0(12.1)	7.3(12.9)	7.1(13.0)	7.8(13.3)	6.7(13.1)	-4.2
Cork Co. Borough	13.6(10.0)	13.9(10.4)	14.3(11.0)	14.5(11.6)	14.9(12.5)	15.2(13.3)	11.8
Cork	38.9(11.6)	31.8(11.)	31.8(11.0)	31.0(10.)	38.4(10.1)	30.9(10.0)	0.0
Kerry	17.2(14.0)	17.6(14.2)	17.1(13.9)	16.2(13.5)	15.3(15.1)	15.0(12.9)	-12.8
Carlow	3.9 (9.8)	4.0 (9.7)	4.1 (9.9)	4.1(10.0)	4.1(10.1)	4.2(10.2)	7.7
Kilkenny	7.7(10.9)	8.1(10.8)	8.2(10.7)	8.1(10.4)	8.0(10.1)	8.0 (9.95)	3.9
Tipperary S.R.	8.6(11.3)	8.8(11.3)	8.9(11.5)	8.7(11.4)	8.4(11.1)	8.2(10.9)	-4.8
Waterford Co. Borough	3.5 (9.3)	3.6 (8.7)	3.8 (8.9)	4.0 (9.0)	4.4 (9.5)	4.8(10.1)	37.1
Waterford County	5.8(11.5)	3.8(11.5)	5.8(11.5)	5.6(11.2)	3.5(11.2)	5.4(11.1)	-6.9
Wexford	11.2(11.3)	11.3(11.1)	11.4(11.2)	11.4(11.1)	11.3(11.2)	11.7(11.5)	4.5
Dublin Co. Borough	38.5(11.1)	59.1(12.6)	60.0(14.7)	39.5(17.3)	37.1(20.7)	53.0(126.0)	-9.4
Dun Laogharre	7.5 (13.8)	7.3 (14.2)	7.4(14.6)	7.4(15.2)	7.3(15.9)	7.2(16.6)	-4.0
Dublin County	19.9 (4.7)	24.8 (4.6)	28.4 (4.6)	33.6 (4.7)	48.6 (5.1)	31.4 (5.6)	158.3
Kildare	7.2 (6.9)	7.9 (6.6)	8.4 (6.4)	8.7 (6.1)	9.2 (6.0)	10.5 (6.2)	45.8
Wicklow	8.4 (9.6)	8.8 (9.2)	9.2 (8.9)	9.5 (8.7)	10.0 (8.7)	10.9 (8.9)	29.8
Meath	8.) (8.7)	8.8 (8.2)	9.3 (8.0)	9.5 (7.7)	9.7 (7.3)	10.6 (7.5)	27.7
Cavan	7.4(13.8)	7.3 (14.2)	7.4(14.7)	7.0(14.8)	6.3 (14.8)	6.0(14.4)	-18.9
Louth	8.1 (9.2)	8.8 (9.5)	9.5(10.0)	9.) (9.9)	9.6 (9.9)	10.0(10.1)	23.3
Monaghan	6.3(12.3)	6.3(11.9)	6.2(11.7)	6.0(11.2)	3.7(10.8)	5.5(18.2)	-12.7
Laois	3.6(11.0)	5.8(10.9)	3.9(11.0)	5.9(10.8)	0.7(10.4)	5.6(18.1)	0.0
Longford	3.9(12.7)	4.1(12.9)	4.1(13.0)	4.0(12.8)	3.8(12.5)	3.6(11.9)	-7.7
Offaly	5.9(10.2)	6.3(10.)	6.6(11.0)	6.6(11.1)	6.5(11.1)	6.5(11.1)	10.2
Roscommon	8.5 (15.6)	8.4(15.3)	8.1(15.4)	7.8(15.3)	7.3(14.9)	6.9(14.3)	-18.8
Westmeath	6.4 (10.4)	6.5 (10.2)	6.8(10.6)	6.9(10.7)	6.8(10.7)	6.9(18.7)	7.8

Source: Blackwell J., Population Projections by County in Housing of the Elderly in Ireland,
National Council for the Aged, 1985, Appendix 2

TABLE 8
Population Projections for those aged 75 years and over 1986, 1991, 1996,2001, 2006 by
County and County Borough.

	In parenthesis in percentage or total area Population 000's						
	1981	1986	1991	1996	2001	2006	1981-2006
State	131.9 (3.8)	140.1 (3.9)	150.1 (4.1)	154.4 (4.2)	157.8 (4.2)	158.5 (4.2)	20.2
Donegal	6.5 (5.2)	6.9 (5.3)	3.3(5.5)	7.3(5.4)	7.0 (5.1)	6.8(4.8)	4.6
Leitrim	1.7 (6.2)	1.7 (6.4)	1.8 (7.4)	1.8 (7.8)	1.6 (7.7)	1.5 (7.6)	11.8
Sligo	2.9 (5.2)	3.0 (5.2)	3.2(5.6)	3.3 (5.6)	3.1 (5.6)	3.1(5.4)	6.9
Galway	7.9(4.6)	8.3 (4.7)	9.1 (5.0)	9.2 (5.1)	9.0 (5.0)	8.8 (4.8)	11.4
Mayo	6.3 (5.7)	6.9 (6.0)	7.6(6.8)	7.6 (7.0)	7.1 (6.9)	6.7(6.6)	3.1
Clare	4.0(4.6)	4.1(4.4)	4.4 (4.6)	4.4(4.1)	4.3(4.4)	4.3(4.3)	5.0
Limerick Co. Borough	1.9(3.1)	2.0(3.4)	3.2(3.7)	2.2(3.9)	2.3(4.3)	2.4(4.7)	26.3
Limerick Co.	3.6 (3.6)	3.9(3.7)	4.3(3.9)	4.4(3.9)	4.4(3.9)	4.3(3.6)	19.4
Tipperary N.R.	2.6(4.4)	2.7(4.6)	2.8(4.9)	2.8 (5.1)	3.0(3.6)	2.9(3.7)	11.5
Cork Co. Borough	4.9(3.6)	3.3(3.9)	3.3 (4.3)	3.6(4.5)	3.9 (4.9)	6.0(3.3)	22.4
Cork	11.1(4.1)	11.6(4.1)	12.3(4.3)	12.9(4.3)	12.7(4.2)	12.4(4.0)	12.7
Kerry	3.9 (4.7)	6.3 (5.1)	7.0(5.7)	7.0(3.0)	6.7(3.7)	6.3(3.4)	0.6
Carlow	1.4(3.3)	1.3(3.6)	1.5(3.6)	1.6 (3.0)	1.6(4.0)	1.7(4.0)	21.4
Kilkenny	3.7(3.0)	2.0 (3.9)	3.0(3.9)	3.1(4.0)	3.2(4.1)	3.2(4.0)	10.3
Tipperary S.R.	3.2(4.2)	3.2(4.1)	3.3(4.3)	3.4(4.4)	3.3(4.7)	3.4(4.6)	6.2
Waterford Co. Borough	1.3(3.4)	1.4(3.4)	1.3(3.4)	1.5(3.4)	1.6(3.6)	1.7(13.6)	30.8
Waterford Co.	2.1(4.3)	2.1(4.0)	2.1(4.2)	3.2 (4.4)	2.2(4.3)	3.1(4.3)	0.0
Wexford	4.2(4.2)	4.5 (4.4)	4.5 (4.4)	4.3 (4.3)	4.7(4.6)	4.7(4.6)	11.9
Dublin Co. Borough	21.0(4.0)	22.2(4.7)	23.1(3.6)	23.0(6.7)	23.7(0.6)	23.7 (1.6)	12.9
Dun Laoghaire	3.9(5.3)	3.2(6.0)	3.2 (6.3)	3.1(6.3)	3.1(6.9)	3.3(7.3)	10.3
Dublin Co.	6.7(1.6)	8.0(1.3)	9.6(1.3)	11.4(1.6)	13.3(1.7)	11.0(1.0)	138.8
Kildare	2.3(2.2)	2.7(2.2)	3.11(2.2)	3.2(2.3)	3.3 (2.3)	3.6 (17.3)	36.3
Wicklow	3.1(3.3)	3.4(3.6)	3.7(3.3)	3.0(3.3)	4.0(3.3)	4.2(3.4)	33.5
Meath	2.9(3.0)	3.0(2.0)	3.4(2.9)	3.6 (2.9)	3.0 (2.9)	3.9(2.0)	54.3
Cavan	2.6(4.0)	2.6 (4.9)	2.0(3.6)	2.0(6.0)	2.0(6.3)	2.6(6.2)	5.0
Louth	2.0(3.2)	3.0(3.3)	3.4(3.3)	3.7(3.0)	4.0(4.2)	4.1 (4.0)	42.9
Monaghan	2.3(4.5)	2.3(4.4)	2.4(4.5)	2.4(4.3)	2.4(4.3)	2.3(4.3)	0.0
Laois	2.9(3.9)	2.1(3.9)	2.2(4.1)	2.3(4.2)	3.4(4.4)	2.4(4.2)	20.0
Longford	1.3(4.2)	1.3(4.2)	1.3(4.0)	1.6(3.1)	1.6(3.2)	1.5 (3.11)	13.4
Offaly	2.2(3.0)	2.3(3.7)	2.4(3.9)	2.3 (4.3)	2.7(4.6)	2.7(4.6)	22.7
Roscommon	3.1(3.7)	3.1(3.7)	3.3(6.3)	3.3 16.4)	3.1(6.4)	3.0(6.3)	3.2
Westmeath	2.4(3.9)	2.4(3.0)	2.3 (3.9)	2.6(4.0)	3.0(4.3)	2.0(4.3)	16.7

Source: Blackwell, J., Population Projections by County in Housing of the Elderly in Ireland,
National Council for the Aged, 1985, Appendix 2.

TABLE 9
Long-Stay Geriatric Units 1982.

Beds/ Patients	Category of unit	Health Board	Health Board	Voluntary and	Total
		Geriatric Hospitals/ Homes	Welfare Homes	Private Hospitals/ Homes	
Number of Beds		7,798	1,452	5,989	15,239
Number of patients in residence on 31/12/82		7,253	1,398	5,583	14,234
Percentage of beds occupied on 31/12/82		93.0%	96.3%	93.2%	93.4%

Source: Statistical Information relevant to the Health Services,
Department of Health, 1984.

TABLE 10

Medical/Social Status of Patients Resident in Long-Stay Geriatric
Units on 31st December 1982

	Health Board			
	Patient	%	%	%
Social	19.5	62.9	29.8	27.8
Acute Illness	3.3	—	3.2	2.9
Chronic Sick	60.1	18.1	35.6	46.3
Terminal	5.1	0.8	4.2	4.3
Mental Handicap	3.5	1.9	1.5	2.6
Chronic Psychiatric	5.8	9.4	3.8	5.4
Other	2.4	6.7	12.4	6.8
Not Stated	0.3	0.1	9.5	3.9
Total – Per Cent	100.0	99.9	100.0	100.0
–Number	7,253	1,398	5,583	14,234

Source: Statistical Information Relevant to the Health Services, Department of Health, 1984.

TABLE 11
Sex of Patients in Long-Stay Geriatric Units on 31st December, 1982

Sex	Category of Unit	Health Board	Health Board	Voluntary and	Total
		Geriatric Hospitals/ Homes	Welfare Homes	Private Hospitals/ Homes	
Male		43.5	41.3	26.0	36.4
		56.5	58.7	74.0	63.6
Not Stated		-	-	-	-
Total	-Per Cent	100.0	100.0	100.0	100.0
	- Number	7,253	1,398	2,482	14,234

Source: Statistical Information relevant to the Health Services,
Department of Health, 1984.

TABLE 12

Age Distribution of Patients in Long-Stay Geriatric Units on 31st December, 1982

Age	Category of Unit	Health Board	Health Board	Voluntary and	Total
		Geriatric Hospitals/ Homes	Welfare Homes	Private Hospitals/ Homes	
Under 40 years		0.9	0.1	0.5	0.7
40-64 years		9.1	8.3	3.8	7.0
65-74 years		24.4	26.4	17.8	22.0
75 years and over		64.9	65.2	64.7	64.9
Not Stated		0.7	-	13.3	5.6
Total	-PerCent	100.0	100.0	100.1	100.2
	-Number	7,253	1,398	5,583	14,234

Source: Statistical Information relevant to the Health Services,
Department of Health, 1984.

TABLE 13
Source of Admissions to Long-Stay Geriatric Units in 1982

Sources of Admission \ Category of Unit	Health Board Geriatric Hospitals/ Homes	Health Board Welfare Homes	Voluntary Private Hospitals/ Homes	Total
	%	%	%	%
Community	47.2	52.1	58.2	52.2
Acute Hospital	36.2	17.4	34.4	34.8
Long-Stay Hospital/Home	8.5	27.1	5.0	7.6
Other	3.2	3.4	0.8	2.1
Not Stated	5.0	—	1.6	3.3
Total -Per Cent	100.1	100.1	100.0	100.1
-Number	6,988	443	5,948	13,379

Source: Statistical Information relevant to the Health Services,
Department of Health, 1984.

TABLE 14
Destination of Discharges from Long-Stay Geriatric Units in 1982

Destination on Discharge \ Category of Unit	Health Board Geriatric Hospitals/ Homes	Health Board Welfare Homes	Voluntary and Private Hospitals/ Homes	Total
Community	36.4	17.8	53.4	43.1
Acute Hospital	10.3	18.2	4.4	8.0
Long-Stay Hospital/Home	7.3	35.3	5.7	7.5
Death	44.5	26.1	33.3	39.1
Other	1.3	1.8	2.6	1.9
Not Stated	0.1	0.7	0.6	0.4
Total - Per Cent	99.9	99.9	100.0	100.0
-Number	6998	433	5,598	13,029

Source: Statistical Information relevant to the Health Services,
Department of Health, 1984.

TABLE 15
Length of Stay of Patients Discharged from Long-Stay
Geriatric Units in 1982

Length of stay	Category of Units	Health Board Geriatric Hospitals/Homes %	Health Board Welfare Homes %	Voluntary approved Nursing %	Other Private Nursing %	Total %
Less than 6 months		56.6	29.6	30.6	61.1	47.8
6 months to 1 year		13.0	10.9	5.3	8.5	9.9
1 year to 2 years		10.0	10.9	4.2	7.2	7.9
2 years to 4 years		8.2	16.4	6.3	7.5	7.8
4 years to 6 years		5.0	11.1	2.4	5.4	4.4
6 years to 10 years		3.5	9.2	1.1	6.5	3.2
More than 10 years		2.3	1.2	0.5	1.8	1.7
Not Stated		1.4	10.9	49.5	2.0	17.2
Total per cent		100.0	100.2	99.9	100.0	99.9
Total-Number		6998	433	4190	1480	13029

Source: Statistics on Long-Stay Geriatric Units, Department of Health, 1982

TABLE 16
Long-Stay Geriatric Units, 1982

Health Board Beds/ Patients	Mid- North- North- South E/ternM/land w/tern E/tern W/tern E/tern S/tern W/tern Total								
	E/tern	M/land	w/tern	E/tern	W/tern	E/tern	S/tern	W/tern	Total
Number of beds	4347	1031	2125	1382	1124	1766	1751	1713	15239
Number of patients resident 31/12/82	4012	986	1897	1286	1105	1697	1676	1575	14234
Percentage of beds occupied 31/12/82	92.3	95.6	89.3	93.1	98.3	96.1	95.7	91.9	93.4

Source: Statistics on Long-Stay Geriatric Units, Department of Health, 198

TABLE 17
Medical/Social Status of Patients Resident in Long Stay
Geriatric Units on the 31/12/82

Beds/ Status	Health Board	Mid- North- North- South								Total
		E/tern	M/land	w/tern	E/tern	W/tern	E/tern	S/tern	W/tern	
		%	%	%	%	%	%	%	%	%
Social		35.3	33.0	23A	15.3	28.6	19.0	30.1	27.5	27.8
Acute Illness		2.1	6.7	1.3	2.0	4.7	7.0	1.4	1.5	2.9
Chronic Sick		35.9	41.3	58.6	57.4	36.7	55.7	49.0	46.2	46.3
Terminal		2.9	2.9	2A	1.5	3.5	8.6	2.8	10.9	4.3
Mental Handicap		0.8	1.9	3.1	4.7	4.3	2.0	4.7	2.4	2.6
Chronic Psychiatric		2.7	11.8	2.7	5.4	12.9	3.8	5.2	7.9	5.4
Other		8.7	2.4	7.7	13.7	9.0	2.5	6.8	0.5	6.8
Not Stated		11.6		0.9	-	0.2	1.4	-	3.0	3.9
Total- per cent		100.0	100.0	100.1	100.0	99.9	100.0	100.0	99.9	100.0
Total-number		4012	986	1897	1286	1105	1697	1676	1575	14234

Source: Statistics on Long-Stay Geriatric Units, Department of Health, 1982

TABLE 18
Sex of Patients Resident in Long-Stay Geriatric Units
on 31/12/82

Sex	Health Board									
		E/tern	M/land	Mid- w/tern	North- E/tern	North- W/tern	South E/tern	S/tern	W/tern	Total
		%	%	%	%	%	%	%	%	%
Male		24.4	42.4	39.8	41.8	39.8	40.4	40.2	44.1	36.4
Female		75.6	57.6	60.2	58.2	60.2	59.6	59.8	55.9	63.6
Not Stated		-	-	-	-	-	-	-	-	-
Total - per cent		100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Total-number		4012	986	1879	1286	1105	1697	1676	1575	14234

Source: Statistics on Long-Stay Geriatric Units, Department of Health 1982.

TABLE 19
Age Distribution of Patients in Long-Stay Geriatric Units
on 31/12/82

Age	Health Board									
		E/tern	M/land	Mid- w/tern	North- E/tern	North- W/tern	South E/tern	S/tern	W/tern	Total
		%	%	%	%	%	%	%	%	%
Under 40 years		0.4	0.6	1.5	0.8	0.3	0.5	0.7	0.7	0.7
40 - 64 years		3.3	7.9	6.2	11.3	9.2	10.2	8.2	6.7	7.0
65 - 74 years		17.8	28.3	26.3	22.9	23.4	20.4	22.9	22.2	22.0
75 years and over		61.2	63.2	66.1	65.0	67.1	67.5	68.1	65.7	64.9
Not Stated		17.3	-	-	-	-	1.4	-	4.8	5.6
Total - per cent		100.0	100.0	100.0	100.0	100.0	100.0	99.9	100.1	100.2

Source: Statistics on Long-Stay Geriatric Units, Department of Health, 1982

TABLE 20
Actual 1979 and projected 1986 and 1991 consumption by age and sex of acute hospital services in inpatient days, and % changes on 1979 consumption

MALES					
Age	1986				
	1979	I	II	I	II
< 1	120763.20	124432.80	123765.60	119095.20	118761.60
1-14	301314.42	317764.26	315922.86	321753.96	318132.54
15-24	176355.96	189252.84	188187.96	195642.12	193512.36
25-44	281940.48	338411.52	335923.20	376842.24	371865.60
45 - 64	564126.75	562039.50	555208.50	596763.75	583481.25
65-74	458955.76	45399.34	450257.14	450671.36	441972.74
75+	322470.72	358918.56	353358.72	387953.28	377451.36
Total	2225927.20	2345218.70	2322623.90	2448721.70	2405177.30
% Change over 1979 figures	-	5.36	4.34	10.01	8.05

FEMALES					
Age	1986				
	1979	I	II	I	II
<1	100788.16	101074.49	100501.83	96779.54	96206.88
1-14	228424.68	241513.80	240048.60	243711.60	241074.24
15-24	186411.12	199856.74	198681.88	206514.28	204164.56
25-44	388837.85	468502.19	464908.31	522110.90	514823.31
45-64	547214.36	514350.04	~34752.68	567922.74	554911.28
65-74	472851.66	502088.16	498579.78	511443.84	502867.80
75+	510664.14	554378.58	548417.52	617300.88	606041.10
Total	2435191.80	2608763.80	2585890.40	2765783.60	2720089.00
%Change over 1979 figures	-	7.13	6.19	13.58	11.70

ASSUMPTION 1: Zero Net Emigration, 1981 - 1991

ASSUMPTION II: 5,000 Per Annum Net Emigration 1981 - 1991

Source: Health Services: The Implications of Demographic Change. NESC Report, No.73, 1983, Tables A 2.4 and A 2.5

APPENDIX 2

HEALTH BOARD WELFARE HOMES

Eastern Health Board

Welfare Home	No. of Places
Clarehaven, St. Camce's Road, Ballygall	40
The Orchard, Bray	40
St. Brocs, Clonskeagh	40
Ashcrone House, Navan Road	40
Donnybrook (Srs. of Charity)	40

The Eastern Health Board plans to provide further units in each community care area.

Midland Health Board

Welfare Home	No. of Places
Athlone	40
Birr	40
Edenderry	40
Tullamore	40

Mid-Western Health Board

Welfare Home	No. of Places
Kilrush	42
Nenagh	40
Newcastle West	40
Roscrea	40

North Eastern Health Board

Welfare Home	No. of Places
Cavan	40
Drogheda	40

Further home planned for Dundalk (40 places).

North Western Health Board

Welfare Home	No. of Places
Ballyshannon	35
Manorhamilton	40
Mohill	45
Falcarragh	35
Ramelton	38
Buncrana	45
Carndonagh (brief under examination)	48
Ballymote (brief under examination)	35

The North Western Health Board have plans for nursing and welfare units in Donegal.

Southern Health Board

Welfare Home	No. of Places
Fermoy	40
Midleton	40
Youghal	40

Further home planned for Dingle (20 places).

South Eastern Health Board

Welfare Home	No. of Places
Carlow	40
Dungarvan	40
Tipperary Town	40
Waterford (Holy Ghost Hospital)	43
Clonmel	40

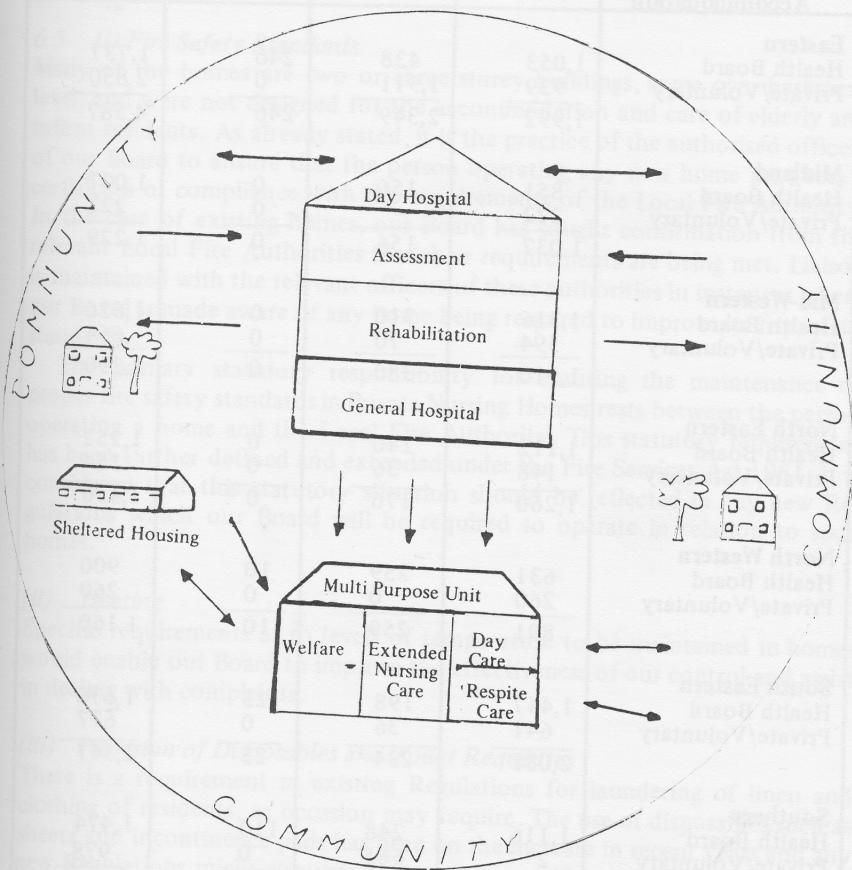
Western Health Board

Welfare Home	No. of Places
Belmullet	40
Boyle	60
Carraroe	40
Claremorris	40
Clifden	42
Newcastle, Galway City	40
Westport	40
Ballina	40
Castlerea	40

Source: Hospital Planning Unit, Department of Health

APPENDIX 3

Diagrammatic Representation of Housing, Community Care and Nursing Services for the Elderly.



Source: Institutional Geriatric Care in Eastern Health Board Area, Medium Term Programme for Capital Development, Appendix 3.

APPENDIX 4
BED ACCOMMODATION FOR THE ELDERLY 1984

Health Board	Category			Total
Type of Accommodation	Long-Stay	Welfare	Assessment	
Eastern				
Health Board	1,053	438	246	1,737
Private/Voluntary	939	1,911	0	2,850
	1,992	2,349	246	4,587
Midland				
Health Board	851	156	0	1,007
Private/Voluntary	222	-	0	222
	1,037	156	0	1,229
Mid-Western				
Health Board	1,316	310	0	1,626
Private/Voluntary	594	70	0	664
	1,910	380	0	2,290
North Eastern				
Health Board	1,112	140	0	1,252
Private/Voluntary	148	36	0	184
	1,260	176	0	1,436
North Western				
Health Board	631	259	10	900
Private/Voluntary	260	0	0	260
	891	259	10	1,160
South Eastern				
Health Board	1,447	198	25	1,670
Private/Voluntary	641	36	0	677
	2,088	234	25	2,347
Southern				
Health Board	1,116	248	110	1,474
Private/Voluntary	2	685	0	978
	1,409	933	110	2,452
Western				
Health Board	1,106	418	0	1,524
Private/Voluntary	352	10	0	
	1,458	428	0	1,886
Totals				
Health Board	8,632	2,167	391	11,190
Private/Voluntary	3,449	2,748	0	6,197

Source: Department of Health

APPENDIX 5

Draft Revised Standards for Private and Voluntary Nursing Homes as Out-lined in the Eastern Health Board Report (1982)

6.5 (i) Fire Safety Standards

Many of the homes are two or three storey buildings, some over basement level, and were not designed for the accommodation and care of elderly and infirm residents. As already stated, it is the practice of the authorised officers of our Board to ensure that the person operating any new home produces a certificate of compliance with the requirements of the Local Fire Authority. In the case of existing homes, our Board has sought confirmation from the relevant Local Fire Authorities that their requirements are being met. Liaison is maintained with the relevant officers of these authorities in instances where our Board is made aware of any home being required to improve its fire safety standards.

The primary statutory responsibility for ensuring the maintenance of proper fire safety standards in Private Nursing Homes rests between the person operating a home and the Local Fire Authority. This statutory requirement has been further defined and extended under the Fire Services Act 1981. It is considered that this statutory situation should be reflected in any new Regulations which our Board will be required to operate in relation to such homes.

(ii) Heating

Specific requirements as to levels of temperature to be maintained in homes would enable our Board to improve the effectiveness of our control and assist in dealing with complaints.

(iii) Provision of Disposables and Toilet Requisites

There is a requirement in existing Regulations for laundering of linen and clothing of residents, as occasion may require. The use of disposables such as sheets and incontinence pads has been on the increase in recent years and any new Regulations might stipulate that such items, if used, must be supplied in sufficient quantity by the person operating the home and changed as frequently as occasion may require. All toilet requisites should also be supplied by the home.

(iv) Care of the Dying and Mortuary Arrangements

It may be difficult to make a specific provision in any revised Regulations which would satisfactorily cover the very sensitive and personal requirements involved in the care of the dying. Indeed there is no reason to doubt but that

most homes treat this situation with the required degree of sensitivity. However, problems may arise from time to time. Dying has its own dignity which should be preserved and the needs of the individuals and of relatives should be fully taken into account. The special training and experience of qualified nursing staff should be available. The required degree of discretion should be exercised in relation to other residents and it should be arranged to transfer the dying person to a single room if this is considered appropriate.

Following death, the remains should be laid out in a single room. Alternatively, removal by a local undertaker to a funeral home may be arranged, and a number of homes follow this practice. Only 1 out of the 59 homes surveyed has a mortuary as such.

Any revised Regulations should make appropriate provision for the above requirements.

6.6 Draft Revised Standards

During 1981, our Board participated in discussions with the Department of Health regarding draft revisions in the existing standards for Private Nursing Homes circulated to health boards by the Department. These are as follows:

1. Medical Staffing

A general practitioner shall be available to attend patients and arrangements shall be made for a medical practitioner to be on-call for emergencies.

2. Nurse Staffing

There shall be an adequate number of trained nurses on duty at all times, having regard to the number of patients in the homes and their degree of dependency.

3. Planning Approval

Planning permission must be obtained for new buildings, structural alterations and extensions to existing premises, and for the change of use of existing premises into nursing homes.

4. Fire Safety

Compliance with fire safety standards to the satisfaction of the appropriate local authority is essential.

5. Accommodation Standards

(i) Single room minimum of 100 sq. ft (9.3m) with minimum ceiling height of 8 ft is acceptable.

(ii) Shared room minimum of 80 sq. ft per bed (7.4m²) is acceptable. Portable screens or screening curtains should be available.

(iii) Reception Area - A visitors' reception area should be provided.

6. Sanitary Facilities

(i) W.C.s There should be 1 W.C. per 8 patients. At least 1 W.C. should provide access by wheelchair patients.

A wheelchair toilet with wash hand basin requires 30 sq. ft (3m²). All W.C.s should be fitted with grab rails.

(ii) Baths/Showers There should be not less than one bath for every fifteen patients. If showers are provided, they should be additional. Recommended area for an assisted bathroom is 100 sq. ft. (9m²) and a non-assisted one 70 sq. ft (7m²).

(iii) Sluice/Dirty Linen Storage - There should be a sluice room of 100 sq. ft (9m²).

7. *Circulation*

Doorways and corridors must allow for easy use of wheelchairs and walking aids.

Adequate handrails should be provided in circulation areas to facilitate patients' movements. There should be no loose mats or slippery floor surfaces.

8. *Heating*

Patient areas should be adequately heated and maintained at 65°F (18°C).

Day spaces/sitting areas should be at 70°F (21°C).

9. *Lighting*

There should be adequate general lighting, supplemented by bed-head lamps. Night lighting and emergency lighting should be provided.

10. *Office Accommodation*

Each home should have an office for staff use, for filing of records and for the safe custody of drugs.

11. *Cooking Facilities*

There must be a separate kitchen with adequate and suitable cooking facilities.

12. *Storage of Food*

Food shall be stored in hygienic conditions. Particular attention should be paid at all times to maintaining a high standard of hygiene in relation to the storage and preparation of food and to the disposal of kitchen refuse.

The amendment of the existing Regulations by the incorporation of the above draft revisions, would go quite a way towards making them sufficiently specific for effective control of standards. The limitations of any inspection system, however well devised, must, of course, be borne in mind.

6.7

It is recommended that the revisions in standards proposed by the Department of Health should be brought into effect with the following additions:

(i) Our Board should be empowered to specify the number of nurses (part-time nurses being converted to wholtime equivalents) to be on duty at any given time, if such action is considered necessary in respect of any home.

Our Board should also be empowered to verify the number of staff (in terms of wholetime equivalents), including nursing aides, employed by any home at any given time and for this purpose to inspect all relevant records.

The person in charge in a home at any given time should be a fully qualified Registered General Nurse. This is considered particularly necessary where the owner of the home is not so qualified.

(ii) Separate dining and sitting areas, preferably in separate rooms, should be provided for mobile residents.

(iii) Consideration should be given to the introduction of a formal system of registration of Private Nursing Homes. Registration would be personal to the person operating the home. The number and type of incapacitated persons accommodated in the home and the maximum number of residents to be accommodated in either single, double or larger rooms would be specified in a certificate of registration to be displayed in the home. Refusal or cancellation of registration would be possible for stated reasons referring either to the person operating the home or the standards in the home. Registration might be withheld or suspended until certain specified matters were put right.

The exercise of such powers by our Board would give rise to a right of appeal by the person operating a home.

(iv) Provision of disposables and toilet requisites by the home (see paragraph 6.5).

(iv) Adequate provision should be made by the home for the care of the dying and for mortuary arrangements (see paragraph 6.5).

(v)

Source: Long-Stay Accommodation Provided by Private Nursing Homes and Voluntary Bodies, Eastern Health Board, 1982.

APPENDIX 6

Health (Homes for Incapacitated Persons) Act, 1964.

An Act to Make Provision in Relation to the Standards of Homes in which Incapacitated Persons Are Maintained for Private Profit. (20th May 1964)

BE IT ENACTED BY THE OIREACHTAS AS FOLLOWS:

(Interpretation)

1. (1) In this Act - 'incapacitated', in relation to a person, means incapable of looking after himself by reason of

- (a) old age,
- (b) physical infirmity or a physical injury, defect or disease, or
- (c) mental infirmity or a mental handicap;

'home' means any premises in which incapacitated persons are maintained, excluding

- (a) premises in which no incapacitated person is maintained for private profit,
- (b) premises in which not more than one incapacitated person is maintained,
- (c) premises in which a majority of the persons being maintained are being treated for acute ailments by or under the control of medical or surgical specialists,
- (d) a maternity home in respect of which a person is registered in the register of maternity homes under the Registration of Maternity Homes Act, 1934, (1934, No.14) and in which incapacitated persons who are not maternity patients are not maintained, and
- (e) a mental institution, within the meaning of the Mental Treatment Acts, 1945 to 1961.

but where

- (1) a person who is the spouse of the occupier of any premises or a parent, grandparent, child, grandchild, brother, sister, uncle, aunt, nephew or niece of the occupier or of the spouse (if any) of the occupier is maintained in those premises, or
- (11) an incapacitated person who has become incapacitated while a resident in premises consisting of a bona fide hotel, guest house or boarding house is maintained in those premises for a period not exceeding one month,

such maintenance shall, for the purpose of this definition, be disregarded.

(2) The Health Acts, 1947 to 1960 and this Act shall be construed as one.

(3) Without prejudice to the generality of subsection (2) of this section, a reference in the Health Act, 1947, (1947, No.48) to that Act shall, save where the context otherwise requires, be construed as including a reference to this Act.

2. (1) The Minister may, for the purpose of ensuring adequate and suitable accommodation, food and care for incapacitated persons while being maintained in homes and the proper conduct of homes, make such regulations as he thinks appropriate in relation to homes.

(2) Without prejudice to the generality of subsection (1) of this section, regulations under this section may

- (a) prescribe requirements as to the care of incapacitated persons while being maintained in homes,
- (b) prescribe requirements as to the number and qualifications of the staffs of homes,
- (c) prescribe requirements as to the design, maintenance, repair, ventilation, heating and lighting of homes and the amount of space in bedrooms and wards in homes,
- (d) prescribe requirements as to the accommodation (including washing facilities and sanitary conveniences) provided in homes,
- (e) prescribe requirements as to the food provided for incapacitated persons while being maintained in homes,
- (f) prescribe requirements as to the cleanliness of homes,

- (g) prescribe requirements as to the description of homes in written communications and the display in homes of notices specified in the regulations,
- (h) provide for the conduct of interviews (including interviews in private) of persons (including staff) in a home where the health authority have reasonable cause to believe that a person in the home is not receiving proper care,
- (i) provide for the enforcement and execution of the regulations by health authorities and their officers.

(3) Regulations under this section prescribing requirements of the kind referred to in paragraph (a) or (b) of subsection (2) of this section shall provide that a requirement shall not apply in relation to a home carried on by or on behalf of a religious body or organisation if compliance with that requirement by the home would be contrary to the religious beliefs or principles of the body or organisation.

(4) Regulations under this section prescribing requirements of the kind referred to in paragraph (a) of subsection (2) of this section shall provide that a requirement shall not apply in relation to a person if submission by the person to the carrying out of that requirement in relation to him would be contrary to his religious beliefs or principles.

(5) Where, in relation to a home, there is a contravention of a provision of regulations under this section, the person carrying on the home and any person

concerned with the management thereof shall be guilty of an offence and shall be liable, on summary conviction, to a fine not exceeding fifty pounds, and, in the case of a continuing offence, to a further fine (not exceeding fifty pounds in all) not exceeding five pounds for each day on which the offence is continued or, at the discretion of the Court, to imprisonment for a term not exceeding three months or to both the fine or fines and the imprisonment.

- (6) (a) Where a person is convicted of an offence under this section, the Court may, either in addition to or in substitution for the penalties referred to in subsection (5) of this section, by order declare that the person shall be disqualified during such period as may be specified in the order for carrying on, or taking part in the management of, the home to which the conviction related or, at the discretion of the Court, of any home.
- (b) A person in respect of whom an order is made under this subsection shall not during the period specified in the order carry on, or take part in the management of, the home specified in the order, or of any home, as the case may be.
- (c) A person who contravenes paragraph (b) of this subsection shall be guilty of an offence and shall be liable to a fine not exceeding fifty pounds and, in the case of a continuing offence, to a further fine (not exceeding fifty pounds in all) not exceeding five pounds for each day on which the offence is continued or, at the discretion of the Court, to imprisonment for a term not exceeding three months or to both the fine or fines and the imprisonment.

(7) A person who wilfully obstructs the execution of a regulation under this section shall be guilty of an offence and shall be liable on summary conviction to a fine not exceeding fifty pounds and, in the case of a continuing offence, to a further fine (not exceeding fifty pounds in all) not exceeding five pounds for each day on which the offence is continued or, at the discretion of the Court, to imprisonment for a term not exceeding three months or to both the fine or fines and the imprisonment.

(Duty of persons in charge of homes to notify health authority)

3. (1) The person in charge of a home shall, within one month after the commencement of this Act, notify in writing the health authority in whose functional area the home is situated of the name and address of the home and the name of the person in charge of the home.

(2) Where a person proposes to establish a home, he shall, not less than one month before the date on which it is proposed to commence business, notify in writing the health authority in whose functional area the home will be situated of the name and address of the home and the name and address the person in charge of the home.

(3) A person who contravenes subsection (1) or (2) of this section shall be guilty of an offence and shall be liable on summary conviction to a fine not exceeding twenty-five pounds.

(Exemption from Act of certain homes)

4. (1) The Minister may, if he so thinks fit, grant exemption from the provision of this Act to any home approved of by him pursuant to a provision of the Health Acts, 1947 to 1960, for any of the purposes of those Acts.

(2) The Minister may, if he so thinks fit, on the application of any home, grant exemption from the provisions of this Act to that home.

(3) This Act shall not apply in relation to a home in respect of which an exemption under this section has been granted and has not been withdrawn.

(4) An exemption under this section may be withdrawn at any time by the Minister.

(Prosecution of offences)

5. An offence under this Act may be prosecuted by the health authority in whose functional area it was committed.

(Amendment of section 64 of Health Act, 1947)

6. Section 64 of the Health Act, 1947, is hereby amended by the insertion in paragraph (b) of subsection (3) after 'convalescent home' of ' , home within the meaning of the Health (Homes for Incapacitated Persons) Act, 1964'.

(Saving)

7. Nothing in this Act shall be construed as authorising the reception and care of a person where such reception and care would contravene any provision of the Mental Treatment Acts, 1945 to 1961.

(Laying of regulations before Houses of Oireachtas)

8. Every regulation made by the Minister under this Act shall be laid before each House of the Oireachtas as soon as may be after it is made and, if a resolution annulling the regulation is passed by either such House within the next subsequent twenty-one days on which that House has sat after the regulation is laid before it, the regulation shall be annulled accordingly but without prejudice to the validity of anything previously done thereunder.

(Short title, collective citation and commencement)

9. (1) This Act may be cited as the Health (Homes for Incapacitated Persons) Act, 1964.

(2) The Health Acts, 1947 to 1960, and this Act may be cited together as the Health Acts, 1947 to 1964.

(3) This Act shall come into operation on such day as the Minister may appoint by order.

APPENDIX 7

Homes for Incapacitated Persons Regulations 1985

The Minister for Health, in exercise of the powers conferred on him by section 2 of the Health (Homes for Incapacitated Persons) Act, 1964 (No.8 of 1964) hereby makes the following Regulations:-

1. These Regulations shall come into force on the 1st day of _____ 1985.
Regulations, 1985.
2. These Regulations shall come into force on the 1st day of 1985.
3. The Homes for Incapacitated Persons Regulations, 1966 (S.I. No.44 of 1966) are hereby revoked.
4. In these Regulations
'the Act' means the Health (Homes for Incapacitated Persons) Act, 1964 (No. 8 of 1964),
'home' has the meaning given to it in subsection (1) of section 1 of the Act, 'health board' in relation to a home, means a health board within the meaning of the Health Act, 1970 in whose functional area the home is situated, 'medical practitioner' means a person registered in the register established under the Medical Practitioners Acts, 1927 to 1961 or the Medical Practitioners Act, 1978, nurse- means a person registered in the general division of the register of nurses established under the Nurses Act, 1950, 'patient' means a person who is incapacitated within the meaning of section (1) of the Act, 'record' means any record kept or retained in pursuance of article 5 of these Regulations including any book, card, form, tape, computerised record, film or notes.
- 5.(1) The person carrying on a home shall keep a register of all patients, which shall include the following particulars in respect of each patient-
 - (a) The name, address, date of birth, marital status and religious denomination of the patient,
 - (b) The name, address and telephone number, if any, of the patient's relative, or other person nominated by the patient to act on the patient's behalf as a person to be notified in the event of a change in the patient's health or circumstances,
 - (c) The name, address and telephone number of the patient's medical practitioner,

- (d) The latest date on which the patient was admitted to the home,
 - (e) Where the patient has left the home, the date on which he left it,
 - (f) Where the patient is admitted to hospital, the date of and reasons for the admission and the name of the hospital,
 - (g) Where the patient dies in the home, the date, time and the certified cause of death,
- (2) A register kept under sub-article (1) shall be retained for a period of not less than two years beginning with the date on which the last entry was made in the register.
- (3) The person carrying on a home shall keep a case record in respect of each patient which shall include the following particulars-
- (a) a medical report on the patient at the time of admission;
 - (b) an adequate daily statement of the patient's health and condition;
 - (c) details of any medical investigations made and treatment given including drugs and medicines prescribed and administered;
 - (d) details of nursing observations and treatment given.
- (4) The case records kept under sub-article (3) shall be retained for a period of not less than two years after the patient to whom they relate ceases to be a patient in the home.
- (5) Nothing in this article authorises any person other than a medical practitioner in the service of a health board, or the patient's general practitioner to inspect any clinical record relating to a patient in a home.
- (6) The person carrying on a home shall keep a record of-
- (a) the name, date of birth and details of position and dates of employment at the home of each member of the nursing and ancillary staff,
 - (b) details of the qualifications and registration numbers of each member of the nursing staff employed,
 - (c) appropriate duty rosters.
- (7) The person carrying on a home shall keep a record of-
- (a) the procedure to be followed in the event of fire;
 - (b) all fire practices which take place at the home;
 - (c) all fire alarm tests carried out at the home together with the result of any such test and the action taken to remedy defects;
 - (d) the number, type and maintenance of fire fighting equipment.
- (8) The person carrying on a home shall keep a record of all medical, nursing and ancillary equipment in the home together with a record of all maintenance carried out on such equipment.
6. (1) Adequate arrangements shall be made in, or by, every home for the care of the dying and for mortuary arrangements.

(2) If a patient dies in a home, the person carrying on the home shall send a notice in writing of the death to the health board not later than seven days after it occurs.

7. (1) The person carrying on a home and any person concerned in the management thereof shall-
 - (a) permit designated officers of the health board who are authorised in that behalf by the said health board, to enter and inspect the home and shall afford the said officers such facilities and information as they require for that purpose,
 - (b) subject to sub-article (2), permit designated officers of the health board who are authorised in that behalf by the said health board to inspect records kept by the home,
 - (c) provide facilities for designated officers of the health board who are authorised in that behalf by the said health board to conduct interviews (including interviews in private) with persons (including staff) in the home where the health board has reasonable cause to believe that a patient in the home is not or has not been receiving proper care and attention.
- (2) Nothing in this article authorises any person other than a medical practitioner in the service of a health board, or the patient's general practitioner, to inspect any clinical record relating to a patient in a home.
8. Inspection of a home pursuant to article 7 shall be made by designated officers of the health board not less than once in every period of six months.
9. In every home there shall be provided for patients maintained in the home-
 - (a) suitable and sufficient care having regard to the nature and extent of the incapacity of the patients,
 - (b) facilities for the occupation and recreation of patients,
 - (c) suitable and sufficient accommodation which shall meet the minimum standards provided for in article 10 of these Regulations,
 - (d) suitable, sufficient and nutritious food, properly prepared, cooked and served.
10. In every home there shall be provided-
 - (a) suitable and sufficient equipment and facilities having regard to the nature and extent of the incapacity of the patients maintained in the home,
 - (b) suitable and sufficient lighting, heating and ventilation, with natural lighting and ventilation in rooms which are permanently occupied,

- (c) over bed lamps at each bed and permanent night lighting with dimming facilities,
- (d) minimum heating of 65 degrees F (18 degrees C) in bedroom areas and 70 degrees F (21 degrees C) in day areas,
- (e) bed and bedding appropriate to the incapacity of each patient and suitable and sufficient furniture and other necessary fittings and equipment,
- (f) a separate kitchen with suitable and sufficient cooking facilities, kitchen equipment and tableware (2) In every home there shall be provided-
 - (a) adequate accommodation and space in single and shared sleeping areas and portable screens or screening curtains to ensure privacy for individual patients.
 - (b) adequate day space for each patient in an area separate from the circulation sleeping area and dining and sitting rooms for mobile patients separate from each other,
- (c) doorways and corridors which allow for easy use of wheelchairs and walking aids and access ramps where appropriate,
- (d) a visitors reception area and adequate facilities for patients to receive visitors in private,
- (e) an office for staff and general use.
- (3) The person carrying on a home shall ensure that the maximum number of patients to be accommodated in the home and the maximum number of patients to be accommodated in shared rooms in the home shall not exceed the number approved of by the health board in respect of that home.
- (4) The person carrying on a home shall ensure that-
 - (a) there is sufficient supply of piped hot and cold water and that wash hand basins are provided in each room,
 - (b) there is a sufficient number of W.C.s having regard to the number of patients in the home and that a sufficient number of W.C.s are designed to provide access for patients in wheelchairs having regard to the number of wheelchair patients in the home,
 - (c) a sufficient number of commodes is provided,
 - (d) there is a sufficient number of baths and showers having regard to the number of patients in the home and that a sufficient number of assisted baths are provided having regard to the type of patients in the home,
 - (e) there are adequate arrangements for the laundering at regular intervals, and as occasion may require, of linen, clothing and other belongings to or used by patients maintained in the home,

- (f) a well ventilated room is provided for sluicing, for the provision of laundry facilities and for the storage of dirty linen,
 - (g) where items such as disposable sheets and incontinence pads are necessary, they are supplied in sufficient quantity by the person carrying on the home,
 - (h) bed linen, disposable sheets and incontinence pads are changed as frequently as may be required for the comfort and well-being of the patient.
- 11 (1) The person carrying on a home shall-
- (a) maintain the home in a proper state of repair and a clean and hygienic condition,
 - (b) take adequate precautions against the risk of fire, including the provision of adequate means of escape in the event of fire and make adequate arrangements for detecting, containing and extinguishing fires, for the giving of warnings and for the evacuation of all persons in the home in the event of fire and for the maintenance of fire fighting equipment,
 - (c) make adequate arrangements to secure by means of fire drills and practices that the staff, and so far as is practicable the patients, in the home, know the procedure to be followed in the case of fire,
 - (d) ensure that materials contained in bedding and the internal furnishings of the home have adequate fire retardancy properties and where possible have low levels of toxicity when on fire,
 - (e) supply on demand to a designated officer of the health board, written confirmation that all the requirements of the statutory Fire Authority have been complied with,
 - (f) provide emergency lighting in the home and emergency call facilities at each bed,
 - (g) provide handrails in circulation areas and grab-rails in W.C.
 - (h) provide adequate and safe floor covering,
 - (i) provide for the storage of food in hygienic conditions and maintain a high standard of hygiene in relation to the storage and preparation of food and to the disposal of kitchen refuse,
 - (j) make adequate arrangements for the disposal of swabs, soiled dressings, instruments and disposable sheets, incontinence pads and other similar substances and materials,
 - (k) made adequate arrangements for the recording, safe-keeping administering and disposal of drugs,
 - (l) provide adequate arrangements for the prevention of infection, toxic conditions, or spread of infection at the home,
 - (m) take precautions against the risk of accidents to any patient ill the home,
 - (n) provide for the safekeeping of personal belongings which a patient has with him in the home.

12. In every home the person carrying on the home shall ensure that
- (a) a medical practitioner is available to attend patients maintained in the home and for a medical practitioner to be on call for emergencies,
 - (b) the person in charge in a home at any given time is a nurse,
 - (c) a sufficient number of competent staff, including nursing staff, are on duty at all times having regard to the number of patients maintained therein and the nature and extent of their incapacity.
13. The person carrying on a home and any person concerned in the management thereof shall-
- (a) allow adequate and reasonable times during which patients maintained in the home may be visited,
 - (b) indicate in all written communications the name and address of the home, and the name of the person in charge of the home,
 - (c) cause to be displayed at all times in a conspicuous place in the home a notice stating –
 - (i) the number of ambulant and of non-ambulant patients for whom accommodation is provided,
 - (ii) the number of single rooms, of shared rooms and the maximum number of patients to be accommodated in shared rooms,
 - (iii) the hours during which visiting is permitted,
 - (iv) the name of the person carrying on the home,
 - (v) the date on which the health board has been notified of the home in pursuance of section 3 of the Act.
14. A health board shall on demand supply to any person the name and address of each home notified to it under section 3 of the Act and the name of the person in charge thereof.
15. These regulations shall be enforced and executed in the functional area of each health board by that health board.
- 16.

GIVEN under the Official Seal
of the Minister for Health this day of
1985

Minister for Health

APPENDIX 8

REPORTS ON THREE SELECTED GERIATRIC UNITS

1. *St. Joseph's Geriatric Assessment/Rehabilitation Unit, St. Vincent's Hospital Athy, Co. Kildare.*

10th October 1983 - 9th October 1984 (incl)

St. Joseph's Geriatric Assessment Rehabilitation Unit, St Vincent's Hospital, Athy was planned and developed in 1983.

Twelve beds and ancillary accommodation in a small separate former maternity unit at St. Vincent's Hospital were converted for use as an admission, assessment and rehabilitation unit. A small pre-fab building was added for physiotherapy and occupational therapy. Cost of these adaptations was £12,000.

Staffing of the unit is as follows:-

- 1 Ward Sister
- 6 Nurses.
- 4 Attendants.
- 1 Physiotherapist.
- 1 Occupational Therapist (Yet to be appointed)

The basic concept underlying the operation of the Unit is that all persons will be assessed from medical, nursing or social view-point in their own home environment prior to admission, with the emphasis on retention in the community with appropriate supports. For those admitted, the process of assessment allied with rehabilitation, will continue so that as many persons as possible may return home. Length of stay in the Unit will not normally exceed 6 weeks.

The necessary interaction between hospital and community care staff is achieved through a joint Team approach, consisting of the following: -

- | | |
|--------------------------|-----------------------------------|
| Hospital Medical Officer | Community Physician |
| Hospital Matron | (Registrar in Community Medicine) |
| Hospital Administrator | Sup. Public Health Nurse |
| Unit Sister | Liaison Public Health Nurse |
| Physiotherapist | |

The Team meets weekly in the Unit.

The Unit Sister, Physiotherapist and Liaison Public Health Nurse are assigned wholetime to the project. The remain4er are involved on a part-time basis.

All General Practitioners in the area were visited personally by the Registrar in Community Medicine prior to the commencement of the project and continuing liaison is maintained with them.

There is no longer any direct admission to long-stay beds for the elderly at St. Vincent's Hospital. Since 10th October, 1983 all persons coming into long-stay beds will first have been admitted through the Assessment/Rehabilitation Unit. After their period of stay in the Unit, patients will be discharged either:

- Back home
- to other hospitals
- to long-stay bed for elderly at St Vincent's, Athy
- to other bed at St. Vincent's, Athy. (Respite care or terminal care).

Details of Admission and Discharge Procedures are given in Appendix A.

Adaptions or repairs to existing housing accommodation or the provision of special housing accommodation may be necessary to provide a suitable environment for the patient to return to, along with essential back-up services such as home-help service. Such matters are arranged largely through the liaison Public Health Nurse in response to specific needs identified by the Team.

The following changes in the characteristics of the service at St. Vincent's Hospital have occurred during the year October 1983/October 1984:-

- (i) Number of long-stay beds for the elderly reduced from 310 to 274 during the year. The reduction of 36 made it possible to close 17 beds in an old building and to re-deploy another 19 beds for use as follows:-

Respite Care	8)	
Terminal Care	5)	All Age Groups
Young Chronic Sick	6	
	<hr/>	
	19	
	<hr/>	

(ii) Bed turnover in hospital as a whole has improved:

	October 1982/1983	October 1983/1984
Admissions including	173	422
First Admissions	155 (direct to long-stay)	59 (through new unit)
Total Discharges	274	431

(iii) No waiting list for admissions now.

(iv) Capacity of St. Vincent's Hospital to respond to crisis admission or other needs has improved. Respite care, terminal care and young chronic sick beds now available.

(v) "Bed blockage" problem at Naas General Hospital has disappeared.

(vi) No direct admission to long-stay beds. Clear admissions policy allied to assessment and rehabilitation programmes.

Statistics

St. Vincent's Hospital Assessment/Rehabilitation Unit

October 1983 - October 1984

Number of beds -	12
Number of persons assessed for admission -	212
	<hr/>
Number admitted-	169

Source of admission

General Practitioner	104
Naas Hospital	53
Dublin Hospitals	6
Other	6
	<hr/>
	169

Discharges:

Returned home	54
To other hospitals and nursing homes	20

To St. Vincent's Hospital

Long-stay bed	59
Respite Care bed	12
Terminal care bed	3
RIP.	<u>15</u>

163

Still in Unit on 9th October, 1984	<u>6</u>
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169

Total Number of Patient Days	3228
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Statistical Analysis

Average number of patients treated per bed	14
Average length of stay	19.8 Days
Average bed vacancy interval	7.06 Days
Average daily occupancy	8.84
Percentage Bed Occupancy	73.66%

Distribution of age-groups among the admissions

Age-Group	Admissions	% Admissions
Under 65	17	10.06%
65-69	10	5.92%
70-74	35	20.71%
75-79	52	30.77%
80-84	34	20.12%
85-89	13	7.69%
90-95	7	4.14%
Over 95	<u>1</u>	<u>.59%</u>
	169	<u>100.00%</u>

Geographical spread of admissions:

Area	Admissions	% Admissions
Athy	57	33.72%
Newbridge	25	14.80%
Suncroft	4	2.37%
Naas	27	15.98%
Castledermot/Moone	14	8.28%
Monasterevin	9	5.33%
Kildare	18	10.65%
Kilcock & Surrounds	7	4.14%
Remainder	3	1.77%
Other Counties	5	2.96%
	169	100.00%

Community Care services which were made available to the 54 patients discharged home from the Assessment Unit are as outlined:-

Public Health Nurse	-	54
Home Help	-	25
Meals on Wheels	-	10
Day Care	-	5
Boarding Out	-	1
Domiciliary Oxygen	-	1
Family Support	-	35
Good Neighbour Support	-	10

Progress of long-stay patients in St. Vincent's Hospital is monitored on an on-going basis by the Hospital Medical Officer and patients whom he considers are medically fit for discharge are brought to the attention of the Assessment Team. In the year ending 30th September 1984, it was possible, with the full cooperation of the Community Care Programme, to successfully discharge 17 patients from the long-stay Units.

Final Comment

One of the outcomes of the project will be to quantify specific needs, for various alternatives to institutional care and needs for support services in the community, such as:-

- (i) Housing accommodation - special/sheltered
- (ii) Group Homes, boarding-out

(iii) Public Health Nurse and Home help services

(iv) Community Physiotherapy, and occupational therapy.

(v) Improved system of home repairs.

The need for earlier identification of those in need of treatment and rehabilitation has also been recognised.

The committee recognise as critical the role of the Public Health Nurses and the Liaison Nurse in the success of the Unit and also the importance of the continued close cooperation between the General Hospital and Community Care Programmes.

APPENDIX A Admission and Discharge Procedures

1. Requests for admission should normally be directed to the Matron who will pass some on to the Superintendent Public Health Nurse. (In an emergency situation the Matron may, at her discretion make a decision to admit a patient).
2. The Superintendent Public Health Nurse will arrange for the Liaison Public Health Nurse to carry out an initial back-ground investigation of the applicant.

The Registrar in Community Medicine will also be involved at this stage and may, in an emergency situation, bring the matter to the attention of the Matron to effect an emergency admission.

'Transfer Requests' from Naas General Hospital will be received weekly and investigations will be carried out as outlined and reported on.

3. On the basis of information supplied by the Registrar and the liaison Nurse the 'Assessment Team', at their weekly meeting, will assess all applicants as to whether or not they should be admitted to the 'Unit'.
4. On the Assessment Team's decision to admit, a patient's local General Practitioner will be advised, by way of letter from the Matron.
5. A copy of the letter as described in (4) will also be sent to the appropriate Public Health Nurse, who will inform the patient and his relatives of the admission.

6. Before admission relatives will be requested to sign a statement of understanding that the patient will be discharged into their care following treatment. Treatment would not normally be expected to take longer than six weeks.
7. Where a decision is taken by the Assessment Team *not* to admit a patient, the local General Practitioner will be verbally informed by the Registrar in Community Medicine.
8. On admission to the 'Unit', the Registrar and the Liaison Public Health Nurse will continue their investigations into the home environment of the patient with a view to having all the necessary community back-up services available to the patient on discharge.
9. The "Assessment Team" at their weekly meeting will be given the following reports:
 - a. Patient Progress: by the Medical Officer of the hospital.
 - b. Frequency or otherwise of visits to patients:- by the Ward Sister.
 - c. Investigations carried out: - by the Registrar and the Liaison Public Health Nurse.
10. The Medical Officer of the hospital will advise the Assessment Team when a patient is ready to be discharged from the 'Unit'.
11. The 'DECISION' as to where the patient will be best discharged to will be made by the 'Assessment Team' based on the information presented to them by the Registrar in Community Medicine and the Liaison Public Health Nurse.

Source: Eastern Health Board, November 1984.

2. ASSESSMENT UNIT ST PATRICK'S HOSPITAL, CASHEL

Text of address given by Dr. William Ryan to members of the National Council for the Aged on the occasion of their visit to St. Patrick's Hospital, Cashel on 13/9/1982.

Theme of Address: -

"How we cope with the needs of the Geriatric Population which we serve and the Service we provide"

How our present Service began: -A Sub-Committee of the South Eastern Health Board was formed 4-5 years ago under the Chairmanship of Dr. H. O'Brien-Moran with Dr. J. Solan as Director of Community Care for South Tipperary, to ascertain how the almost routine institutionalisation of old people could be avoided, when ever they developed any physical, mental or social incapacity. At that time admission to long-stay units was the routine.

The challenge was offered to us here in St. Patrick's to set up a Special Unit - the purpose of which was to sort out the problems of the elderly in our catchment area, with emphasis on accurate diagnosis, treatment and rehabilitation, with discharge of the well or greatly improved patient to his own home or family, but at any rate, to avoid automatic admission to a long stay unit.

You might say it took a long time for this idea to be born or at least to strike us, but it must be remembered that the first attempt to sort out the problems of old people in long stay Institutions, only began in 1935, when Dr. Marjorie Warren set about the task in the 'Work House-County Home' setting. The first mention of the word 'Geriatric Medicine' was made in the country by the late Mr. Thomas Adrian Bouchier-Hayes (Surgeon to the Mercer's Hospital) when he addressed the Biological Society of the Royal College of Surgeons' A.G.M. in October 1948. People had to look up the dictionary to see this new word and to familiarise themselves with the meaning.

The object then, of this new Unit at St. Patrick's Hospital became to assess the Physical-Mental-Social problems of the elderly patient admitted to the Hospital. All first-time admissions, with very few exceptions, come through the special unit.

The assessment of the newly admitted patient is a combined effort which is shared amongst myself, the Sister-In-Charge - Sr. M. Cantwell, and her nurses, the Community Care Team of Dr. Marie Ryan-Carew and her nurses and staff and the Physiotherapist - Mrs. P. Fahy. An excellent spirit of cooperation exists amongst us.

In other words, the idea is that the patient comes into the hospital for treatment like a patient in any other hospital, and he will go home when he is well or at least much better. This idea is impressed ab-initio on the patient and particularly on the relatives. In the past we had quite a successful Medical Care Service but there was no mechanism by which the treated patient could be discharged without the very explicit co-operation of the relatives - which

in many cases was difficult to obtain. In order to institute a service of this kind which was breaking new ground - in having this co-operation between the Hospital Services and the Community Care Services, and also to rid ourselves of the stigma attached to Institutions of this kind (Work House - Poor House - County Home) we had, in my opinion to fulfil the following criteria -We must satisfy and be seen to satisfy without any degree of equivocation or ambiguity:

- (a) The patient himself or herself and their needs.
- (b) Potential Patients - who must get the message that we offer the best and most appropriate treatment for them.
- (c) Relatives and friends, especially those who have or will have a deciding role as to where an elderly relative may go when he develops some illness or incapacity.
- (d) Our Professional Colleagues who seek our help - and let them see we get results and that we have a worthwhile service to offer them in the management of their patients' problems.
- (e) Motivate our own staff and let them be aware of the worthwhile contribution they are making in tackling the problems of old age.
- (f) We must satisfy the Health Board (who pay us) and the tax payer and let them see and be aware that they are getting value for their expenditure.
- (g) We should maybe in time contribute something to research and to the scientific evaluation of the problems of old age. This need not be anything exotic or expensive - because little is known or has been written about such things as the ideal length of walking sticks, types of wheel chairs etc., etc.
- (h) Teaching - Student nurses etc. They will in turn disseminate the techniques and theories they learn here.

How do we operate:-

- (a) *Admission* All through Matron or Assistant Matron Sources of Admission -
 - (1) Family Doctor/G.P. in the main
 - (2) Other Hospitals - Acute - for pre-op. or post op. treatment, Post coronary treatment etc. Chronic - District Hospitals, in Welfare Homes etc. send us patients for physiotherapy and other acute therapies - in view of making them fit for discharge.
 - (3) Community Care Team pick up patients whom they refer especially for physiotherapy.
- (b) *On Admission* - An Evaluation Assessment - Physical: Mental: Social: of the state of patient is made. Aids to diagnosis are ordered, based on the individual clinical findings and not on a routine blunderbuss series of tests. Most of the patients are diagnosed, treated and discharged from us. (See attached figures.)
- (c) *Referrals from us*
 - (1) Early - usually for treatment of some surgical condition which comes to light early on - usually at the initial examination.
 - (2) Late - for cases that behave atypically or who require peripheral vascular system evaluation or such treatment as prostatectomy.
- (d) Whilst in Hospital continuous assessment goes on with interchange of our respective views - nurses, physiotherapist, Community Care personnel Extra home problems may come to light or a depressive element in the illness may become apparent, which may not be obvious in the first evaluation of the patient's condition. Late discovery of alcohol dependence may be an important discovery.
- (e) Community Care - From the start they are involved so as to assess what structural or other changes may be needed in the home or what support services will be needed to support the patient at the time of discharge -and they begin to arrange all this from the start. This is important because failure of any support service in the early days following discharge will lead to relative resistance and requests for early re-admission with failure of the whole exercise.
- (f) We bring in the relatives to the hospital prior to discharge to show them the problems they have to cope with and to teach them 'tricks of the trade' in the hope that this will facilitate their management of the patient. We use a single room to assess how a person living alone will cope alone when they return home.

The vast majority of our patients return to their own homes (see figures). Some go to our own long-stay wards - Welfare Homes - Nursing Homes etc. A significant percentage of those patients are subsequently discharged home after a brief stay in those Institutions.

A point of paramount importance is to re-assure the relatives, that re-admission is possible should they fail to cope with a patient, (this applies to the more feeble and disabled patients) whom we discharge.

I think we give an excellent service in the management of stroke cases - especially those cases we get early on - following the onset of the episode. Very few return within six months and even few within one year. Re-admission is usually for (1) a new illness (2) to touch up the physiotherapy exercises (3) give the relatives a break or a rest.

With all honesty I can say we have had very few abject failures. Thanks is due to Mr. P. McQuillan C.E.O. and especially to Mr. V. Millett and Mr. E. Lonergan and Mr. J. Cooney for their excellent and continued help to us and for their pleasant availability on all occasions. Thanks to Dr. H. O'Brien-Moran and his colleagues for offering us the challenge. To Dr. J. Solan and our Matron - Sr. Gerard for accepting the challenge on our behalf and for adopting a positive approach to the task which lay ahead of them. Thanks to Sr. Cantwell and the Nurses, the Physiotherapist - Mrs. Fahy and to all the ancillary staff and the Community Care Team for their help and kind co-operation. Thanks to our Hospital and G.P. Colleagues for their continuing support and for speaking well of us and for recommending their patients to enter our Hospital.

Finally let me say that a good team spirit is vital and we have it. This method of operation gives a comprehensive Geriatric Service of acute treatment, re-habilitation and follow up service in the home or community. This latter is done in the home by the District Nursing Service, Home Helps etc. The rights of the Family Doctor is respected absolutely and is not infringed upon in any unhelpful way. Such a service is given by marrying the Hospital and Community Care Services.

We think that our problems are new; but the problems of old age, dementia, hypothermia and maybe hypothyroidism were known in the Old Testament and I quote from 1st Book of Kings - Chapter 1 - Verse 1 to 4:

“Now King David was old and advanced in years and although they covered him with clothes, he could not get warm. Therefore his servants

said to him 'Let a young maiden be sought for our Lord the King, and let her wait upon the King and be his nurse; let her lie in your bosom that my Lord the King be warm'. So they sought for a beautiful maiden throughout all the territory of Israel, and found Abishag the Shunammite and brought her to the King. The maiden was very beautiful and she became the King's nurse and ministered to him; but the King knew her not."

ST. PATRICK'S HOSPITAL, CASHEL
ANNUAL REVIEW OF GERIATRIC SERVICES
LONG-STAYBEDS ONLY

	IN-PATIENTS	Year Ended 31/12/1983	Year Ended 31/12/1984
1.	Number of Available Beds	205	191
2.	Total Number of Patient Days	67594	63903
3.	Average Daily Number of Patients	185	175
4.	First Admissions Male First Admissions Female	30M 42F 82+49 readm.	41M 50F =93+3 readm.
5	(a) Discharges - Male Discharges - Female	33M 27F	25M 19F
6.	(b) Deaths Male Deaths - Female	30M 56F	26M 31F
7.	Rate of Bed Occupancy	185	175
8.	Source of Admission: (a) Own Home/community (b) Assessment Unit (c) Acute Hospital (d) Other	44 26 39 6%	27 19 26 3%
10.	Breakdown of Mobility (by Percentage) (a) Totally Immobile (b) Partly Mobile (c) Suitable for Welfare Home or Sheltered Housing	48% 44% 4%	65% 35% Nil
11	Age of Admission Under 65 years – male Under 65 years – female 65-75 years – male 65-75 years – female Over 75 years – male Over 75 years – female	13 9 11 23 25 50	3 1 17 9 23 41
12.	Number on Waiting List - Male Number on Waiting List - Female	Nil Nil	3 Nil

ASSESSMENT UNIT/SHORT-STAY BEDS

	IN-PATIENTS	Year Ended 31/12/1983	Year Ended 31/12/1984
1.	Number of Available Beds: (a) Assessment Unit (b) Other Short-Stay Beds (Re-Hab)	13 8	13 8
2.	Total Number of Patient Days	5817	6415
3.	Average Daily Number of Patients	15 (6M+9F)	17 (8M+9F)
4	Admissions - Male Admissions - Female	88 =187 99	92M =201 109F
5	Discharges: Home/Community Welfare Home Long-Stay Bed (S.E.H.B. or Private Acute	112 3 31+11 Acute Hospital Deaths	88M+101F=189 127 4 43+15 Acute Hospital 20 (14M+6F) 17 (10M+7F)
6.	Rate of Bed Occupancy	76%	85%
7.	Average Duration of Stay (Days)	31	32
8.	Source of Admission: Community/Own Home Acute Hospitals Other Hospitals/Homes	107 70 10	88 88 25
9.	Age of Admission Under 65 years-Male Under 65 years - Female 65-75 years - Male 65-75 years - Female Over 75 years - Male Over 75 years - Female	18 10 31 39 39 50	15 9 38 36 39 64
10	Number on Waiting List - Male Number on Waiting List Female	Nil	1M 1F

Source: Special Tabulation prepared for National Council For the Aged, 1985.

3. ST COLMANS HOSPITAL, RATHDRUM~ CO. WICKLOW

As part of a countrywide programme for the provision of workhouses during the 1840s a large complex was built here on this site of St Colman's. The workhouses provided shelter and maintenance for the destitute as well as providing for the aged and infirm, fevers and maternity. These buildings were designated as County Homes at the time of the foundation of the State in 1923, and many of them still remain in use throughout the country as homes for the aged; some have been extensively re-furbished and are still in use as general hospitals, many more like the complex here in St Colman's have been demolished to make way for modern buildings, more in keeping with the needs of the community in providing for long-stay nursing care.

At the time the Eastern Health Board was established in April 1971, proposals had been under consideration by Wicklow County Council in whose care the hospital had been for the previous thirty years, for the building of a new hospital to replace the old buildings, many of which had fallen into disrepair.

In September 1972, a start was made on the demolition of the older buildings and the provision of a ward block and service area which provides accommodation for approximately 80 patients and forms the nucleus of the present development. The present hospital complex which has a total bed complement of 156 was completed in five stages over a period of ten years. Included in the new facilities is the smaller TB hospital which has been extensively refurbished and now provides accommodation for 46 patients. A Day Care Centre, Physiotherapy and Occupational Therapy Units, small X-Ray Department and 12 sheltered housing units complete the development.

The most recent development completed at the end of 1982 is the 12 sheltered housing units - financed and operated by the St Colman's Elderly Citizens Trust - a voluntary organisation of local residents and including some officers of the Board.

The main buildings have been constructed in the traditional style to a standard module at medium cost and are designed to blend with the out-standing scenic beauty of the area. Expenditure to date is approximately £1,000,000 of which approximately one-third has been provided through the efforts of the voluntary organisations in County Wicklow.

Our visitors will note the high standard of equipment and furniture throughout the hospital. The efforts of the voluntary organisations - supplemented by funds provided from the Department of Health have contributed in no small way to achieve this.

Catchment Area

St Colman's Hospital is situated in the South-East Dublin/East Wicklow catchment area with the main hospital at St. Vincent's, Elm Park and general hospitals at St Michael's, Dun Laoghaire and St Columcille's, Loughlinstown.

It is estimated that by 1986 the number of persons aged 65 and over in the catchment area will be 33,000 approximately, of which about 6,500 will reside in the immediate area serviced by St Colman's. The upper age group i.e. persons aged 75 and over will, it is estimated, total about 13,000 of which approximately 2,500 will be from the immediate area serviced by St Colman's.

Day Care

Due to the mountainous nature of the surrounding countryside the population tends to be scattered and this means that many of the elderly people are living in isolated houses especially those whose families have left. About five years ago it was decided to go ahead with the establishment of a Day Care Unit and here again the voluntary organisations contributed substantially towards the cost of this development. At the moment about 160 persons attend each week, based on a five-day week with a smaller attendance, mainly locals, at weekends.

The services provided cover personal care to include, bathing, laundry, chiropody, hairdressing, dressings changing etc. as well as physiotherapy where possible. Those attending the Day Care Unit are encouraged to participate in occupational and diversional therapy. A mid-day meal is supplied and every possible advice is given on diet etc. Overview is given by the Medical Officer with referral to the Consultant Physician, if indicated. Routine Xrays are also provided.

Since many of the people attending live remote from shops they avail of the hospital shop for many of their immediate needs.

Personnel from the Day Care Unit travel on the mini-bus and maintain a general overview of home conditions. They liaise with the voluntary organisations where indicated to ensure that people are not allowed to remain at risk for any undue length of time, particularly during the winter months, and constant liaison is maintained with the public health nursing staff.

Apart from a minority of the patients the Hospital provides for extended care of the elderly. Most of the patients are in receipt of Social Welfare benefits such as the Old-Age Pension, of which the Board retains approximately 75%. The remainder is available directly to the patient and his immediate relatives for the provision of comforts - personal clothing and similar. The voluntary organisations co-operate with the Hospital Administration in regard to visiting and, where appropriate, outings and short holidays away from the Hospital.

Source: Eastern Health Board.

APPENDIX 9

The Benefits of Intermittent Admission Facilities for Geriatrics - Conclusions

Drawn from a Questionnaire Survey

The concept of 'floating beds' or 'intermittent admission beds' was referred to in 4.3 of the report - The following are the conclusions drawn from a questionnaire survey entitled *The Benefits of Intermittent Admission Facilities* carried out at St Mary's Hospital, Phoenix Park, Dublin.

The survey set out to discover the degree of 'consumer satisfaction' which exists among those who were familiar with the use of the Intermittent Admission Bed facility provided at St Mary's Hospital.

The principal result of the research was to show that among the four groups dealing with the service –patients, patients' families, General Practitioners and Public Health Nurses– the level of satisfaction was very high and the level of complaint low.

The secondary result of the research was to show that both of the health professional groups we surveyed were of the opinion that the principal benefit confirmed by the facility was the reduction of stress in the patient's home. Given this occasional relief of stress, care for the elderly can then continue to be given in the home.

Thirdly, the research served to remind us that the patients themselves do not choose to be in the facility and experience some upset and loneliness when in it.

Generally speaking, the Intermittent Admission Bed Facility at St. Mary's Hospital can be considered to be a pilot project which is testing the feasibility of providing a geriatric service intermediate between total hospitalisation and total home care. It can, therefore, be seen as part of the general trend towards community medicine and to a less institutional approach to health services.

The benefits of such an approach are usually thought to be financial for example in the case of the Intermittent Admission Bed it is cheaper to maintain a geriatric patient for 52 days in hospital per year than for the full 365 days. Yet, without the facility, it is very likely that the patient would have to be hospitalised. One bed in the Intermittent Admission Bed can serve five or six patients who might otherwise be in long-stay occupancy.

The benefits are not only financial. The social benefits are also substantial. It is obvious from the survey that the patients in the facility would much prefer to be at home. It is also evident from the survey that the patients' families do not want to commit them to hospital. Home care combined with occasional back-up greatly extends the period in which an elderly person remains happy in his or her own familiar environment.

Ultimately, a society is judged by the quality of the consideration and care it gives to its weakest members, the children and the elderly. In providing an

improved quality of care to the elderly, at a reduced cost, the Intermittent Admission Bed facility is demonstrating the potential of an alternative approach to conventional geriatric care. In this approach the institution reaches out through the General Practitioners and the Public Health Nurses and supports care in the home rather than waiting for a crisis to propel a patient into permanent care within the institution. This survey shows that there is considerable satisfaction with the facility among General Practitioners, Public Health Nurses and patients' families. It seems unfortunate therefore that facilities of this nature are not more widely available.

Source: Birchall, E. and Byrne, M. *A Questionnaire Survey of Professional and Patient Satisfaction with a Specialised Geriatric Service at St Mary's Hospital, Phoenix Park, Dublin*, unpublished, 1984.

APPENDIX 10

The Development of the Family Placement Scheme for Elderly People in Leeds

THE PAST

The Short-Term Family Placement Scheme for elderly people was launched by Leeds Social Services in 1977, one year after the successful start of a similar scheme for mentally handicapped children. Initially it began as a pilot scheme joint funded by the local authority and area health authority. Each substitute family or carer was to be paid a weekly allowance for each client, and the client made a flat-rate contribution towards the cost. No financial assessment was made. The scheme was, in the early days, co-ordinated by the Principal Adviser, Boarding Out, and the initial preparation, recruitment and placements were undertaken by a working group. Serving on this group was a Divisional Officer, a Senior Social Worker, Officer in charge of an old people's home, a Social Worker and the Adviser. It was not until 1979 that a specialist post was created to manage and develop the scheme. There has always been a qualified social worker in this post. The experimental scheme was declared a success, and support and funding were shared between Leeds Social Services and Area Health Authority and the scheme became an established resource.

The table below shows the steady growth of the scheme.

Year	No. Clients	No. Placements	No. Substitute Families
1977	8	8	6
1978	45	62	10
1979	92	122	24
1981	191	280	34
1982	271	401	45

The aims of the scheme remain the same. It offers a further resource to accommodate elderly people on a short-term basis, and an alternative form of care to the traditional institutional setting. In so doing, the scheme is testing the availability and willingness of 'ordinary people' in the community to care for such people, by recruiting, supporting and paying them an allowance to do this. For the client, the scheme offers a choice in terms of the type of short-stay care.

In accommodating elderly people in this way, the scheme is essentially meeting one of two basic needs. One is respite relief for relatives caring for an elderly family member. Secondly, the scheme offers support to elderly people who might be living alone. It can, for some, simply mean a change or opportunity for some company and additional interest in an otherwise lonely or isolated existence.

THE PRESENT

Over the last two years, the Family Placement Schemes in Leeds have grown and developed, and at the same time come closer together to form a Family Placement Team. There are currently five social workers, each holding a specialist post and responsible for a specific scheme and separate budget: but together the team offers what is gradually developing into a generic, 'non-ageist' service available to a growing number of client groups and able to some extent to respond to particular needs as identified by referring social workers.

The schemes are centrally based in Head Office and cover the whole City. The resource is available to anyone living within the Leeds City boundary.

The short-term scheme for elderly people currently pays carers £64.25 (July 1984) and this allowance is reviewed annually. The client now pays £27.25 towards the cost; this is the minimum charge for Part III accommodation as laid down by the Department of Health and Social Security. There is still no financial assessment. No money passes between client and carer: the contribution is collected by the social worker and payment in full is made by cheque to the carer from the Department just before a placement is due to begin. The Scheme Manager controls when the payment is made to the carer and this is vital, as it hopefully ensures that they are paid correctly and on time. Carers can come directly to the Scheme Manager if there are any problems over payment.

Carers are covered by the Department's insurance for public liability. Thus, if they were sued for negligence, they would be covered in the same way that local authority employees are covered. This would be negotiated through the local authority's legal department. Carers are not protected by the Department for damage to their own property and are advised to obtain household contents insurance and to check that existing policies cover them adequately.

Taxation presents problems. Leeds has not been able to reach a blanket agreement with Inland Revenue, who insist that carers be assessed individually. At present, however, the payment is liable for taxation. Any carer in receipt of statutory benefits is advised to notify DHSS.

Referrals must come through a social worker employed by the Department, although they may, of course, be initiated by anyone. The Scheme Manager receives an application form, supplemented by any further discussion required over the telephone. A copy of the application will be given to the carer. On the basis of this information a carer is selected and contacted. The importance of the matching process cannot be over-emphasised, and it is the basis of a successful placement. The initial contact with the carer to discuss a proposed placement is always done by the Scheme Manager. The field social worker can, inadvertently, place undue pressure on a carer to accept a placement; It is easier for a carer to say 'no' to the Scheme-Worker and that option must be facilitated. For this reason all negotiations over bookings, dates, changes in dates, extensions, etc., must come via the field worker to the Scheme Manager

and not directly to the carer. This aspect of control is very important. Experience tells us that carers find it very difficult to say 'no' to requests for help. There are no firm criteria for establishing a person's suitability and eligibility for the scheme. The scheme for elderly people considers any client over the age of 65, although there are three basic reasons for refusing a placement as unsuitable for family placement. People who are bed-fast would not be considered. Double incontinence presents enormous problems to carers coping in their own homes and families are not asked to do so. A third problem is that of night wandering, where carers are disrupted at night. Such conditions, where experienced in the past on the scheme, have not been tolerated and often led to irretrievable breakdowns of the placement and distress to carer and client. Clients presenting such problems would not be considered suitable. The Scheme Manager acts as initial filter for referrals, refusing those which are clearly unsuitable and protecting carers from unreasonable demands. After that stage, it is the carers themselves who decide on a person's suitability: if a carer is willing to try with 'a difficult' client, then the client will be placed; and it is all credit due to these remarkable people who deal so admirably and successfully with what appear to be quite daunting problems. Calculated risks can pay off! It is important, however, that the Scheme Manager assumes this role as buffer, protecting carers from unreasonable demands-and sometimes also from their unrealistic expectations of their own capacity to cope. On occasions the Scheme Manager may, for instance, have to insist that a carer take a break.

The Leeds Scheme has, over the years, refined and developed its practices and continues to look critically at itself, for there must always be room for further development and improvements. It is important that the scheme remains flexible, as that quality is one of its assets.

Recruitment and training is one area where the Leeds Scheme has made considerable advances. The underlying principle is that of self-selection, and the initial work is done on a group basis. The most significant response has been advertisements in the local press in the job column. A contact card is used to record all enquiries, and everyone who responds is invited to a preliminary introductory meeting. Here more detailed information is given about the scheme and those present are able to listen to and ask questions of established carers who attend the meeting with the scheme workers. Details of the subsequent four training sessions are given and an open invitation extended to everyone still interested to attend. At this point there is a large drop out rate: at least 50% can be expected. Four two hour training sessions follow, one per week, at the end of which all who have completed the sessions are given an application form. They are asked to send in the completed form if they wish to apply to become a carer. It is stressed throughout the course that anyone can withdraw at any stage and no follow-up will be made. Every opportunity is given for people to withdraw easily. Only when a completed

application is received, and references are taken up is the applicant visited individually in their own home by the scheme worker. At this stage they should be clear about the commitment they will be making. Valuable time is saved by seeing people in a group and allowing them to select themselves out during the initial training programme. The timing of recruitment should be considered. Ideally new carers should be approved during the scheme's busier periods, from spring and through the summer months, to ensure that a placement can be made as soon as possible. Great care is taken to ensure, as far as is possible, that first placements will present as few problems as possible for new carers, who will have enough coping with their own anxieties and the strangeness of having their first 'guest' to stay.

OTHER DEVELOPMENTS

Bookings for the full year are displayed on a special board, using colour-coded cards to indicate the carer, the dates of each placement, the sex of the client and type of booking (i.e. provisional, confirmed, phased care), thus at a glance the Scheme Manager can see what vacancies there are for each carer at any particular time for the complete year. This board also shows the periods when carers are not available, due to holidays, illness, etc.

It was felt important to keep increasingly detailed information and records about carers to ensure that this information is not simply stored in one worker's mind, but available to anyone involved in the running of the scheme. A file is, therefore, kept on each carer, holding their original application details and copy of the application form for each client they have taken. Notes on visits and significant information are recorded by the Scheme Manager and updated regularly. A separate card is also kept on each carer, in a box file, giving brief details about the family, their accommodation, the type of client they will take, to facilitate matching for anyone unfamiliar with the carers. This is particularly useful for new workers joining or taking over the scheme.

In looking at the need to further support carers, a number of projects have been developed. Support groups were instigated. Four groups were formed and each carer invited to the one for their area in an attempt to draw carers together informally living in the same area. Attendance at each group remained low, but those who did attend enjoyed the meetings and soon each group was meeting in one of its members' houses. Initially it was hoped these groups may become self-supportive but it soon became evident that a worker would be required to coordinate the meeting. A newsletter is produced by the Family Placement team and sent to all carers on all schemes. These are produced two or three times a year. As well as giving news and views, this circular has provided an ideal forum for giving out general information to carers, and advice on such issues as taxation, insurance and so on.

A one day training session is normally organised annually to which all carers are invited. Here instructions may be given on first aid, lifting techniques, such topics as mental infirmity in old age and medical problems in old age.

THE FUTURE

The Family Placement Scheme for elderly people has just had a second full time social worker appointed and it is hoped that the scheme will continue to expand. There is a limit to the size of any scheme that one worker can manage without compromising on standards of practice and quality of service offered. Although emphasis will remain on the expansion of the short-term scheme, the extra manpower will also allow for the development of the existing but small long-term scheme for elderly people. Demand for this resource is present with a steady flow of enquiries and applications from social workers.

Improvements in the publicity material and information leaflets are constantly being looked at and existing forms revised as necessary. A leaflet aimed at the client has been produced to give basic information about the scheme.

Still in the process of being produced are 'photo profiles' on each of the carers. The aim is to have an information sheet on each carer, having a photograph of the family members and one of the house on one side and brief written details about the family on the reverse. Once an initial match has been made, the social worker would be given a photo profile of the appropriate family to give to the client to help alleviate initial anxieties and introduce the idea of the family to the elderly person. It also helps to redress the balance of information, as the carer receives a copy of the elderly person's application.

A system of receiving client feed-back about their stay on Family Placement is being looked at with a view to initiating a pilot project to assess the feasibility of the system and usefulness of the information.

These are just some of the future developments planned for the scheme. What is important is that the scheme does not fall into the trap of becoming inflexible and stagnant. Feed-back from all quarters is valuable, be it from clients, relatives or social workers, and complaints as well as ideas and positive feed-back is encouraged. The scheme workers try to maintain close links with field workers and attend team meetings to talk to social workers about the scheme. This is just as valuable in an established scheme as it is when a new scheme is developed.

The Leeds Family Placement Scheme for elderly people has come a long way since its small but significant beginnings some seven years ago. It has surely proved that such an approach to the short-term care of elderly people is not only needed, but that it works, and gives a service that is valued not

only by the elderly people who are cared for, but also by their relatives, and as so many carers say, they get so much satisfaction and pleasure from the scheme as well.

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APPENDIX 11

Health Act, (1970) Sections 25 and 26

25(1) Where-

- (a) a local authority is of opinion that it would be more convenient that any power, function or duty which may be exercised or performed by it should be exercised or performed, whether generally or in a particular case, by a health board, and
- (b) the health board is able and willing so to exercise or perform the power, function or duty,

the authority and the board may, with the consent of the Minister for local Government, make an arrangement for the power, function or duty to be so exercised or performed on behalf of the authority by the board, and it shall thereupon become so exercised or performed by the board.

(2) The making of an arrangement under subsection (1) shall be a reserved function of the local authority.

(3) Where a local authority is of opinion that it would be convenient for duties in relation to its powers and functions to be performed by an officer of a health board, that duty may be assigned to that officer by the chief executive officer of the health board in the same way as duties relating to the powers and functions of the board.

(4) Where the chief executive officer of a health board is of opinion that it would be convenient that duties relating to any of the powers or functions of the board or its officers should be assigned to an officer of a local authority, those duties may be assigned to such an officer by the local authority in the same way as duties under the local authority.

Arrangements by health boards for provision of services

26 (1) A health board may, in accordance with such conditions (which may include provisions for superannuation) as may be specified by the Minister, make and carry out an arrangement with a person or body to provide services under the Health Acts, 1947 to 1970, for persons eligible for such services.

(2) Two health boards may make and carry out an arrangement for the provision by one of them on behalf of and at the cost of the other of services under the Health Acts, 1947 to 1970.