The Health (Nursing Homes) Act 1990

Health Services Resource Centre
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on

THE HEALTH (NURSING HOMES) ACT 1990

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INTRODUCTION, CURRENT POLICY ISSUES

1. This paper sets out the main provisions of the 1990 Health (Nursing Homes) Act and attempts to locate the Act as a policy instrument in the wider policy debate on service provision for the elderly. In the analysis and comment which accompany the outline of the Act's contents, some important aspects of implementation are examined and the consequences of particular provisions for the implementation process at health board and national level are given some practical consideration.

The paper begins with a discussion of the factors which are shaping international health policy for the elderly. These include: demographic and social structural changes; the emerging critique of the biomedical bias in the care and treatment of the elderly and the new emphasis on more integrated, flexible models of care. The remainder of the paper examines and discusses the objectives and detailed provisions of the Act. Some important questions are addressed in the course of this analysis, for example:

- should publicly managed welfare homes be subject to independent inspection?
- should the inspectorate be centrally based?
- what are the implications of this shift in policy towards a more diverse delivery system?
- what are the implications for the health boards of their new role as regulators of care?

This briefing paper is intended to serve as a practical guide to the 1990 Act and as an evaluation of the proposed mechanisms for regulating the non-statutory sector.

Current Policy Issues

(a) Demographic Influences

This section examines some current policy issues in health and welfare policy for the elderly. Population composition is an important determinant of the need for health and welfare services and levels of health and welfare expenditure. It is also an important determinant of the type of health service likely to be required at any one time. On the basis of recent demographic projections, most OECD countries, including Ireland, will face substantial ageing of their populations over the next 30 or 50 years. In 1980, for instance, 12.20% of the population on average in OECD countries was 65 and over; by 2010 OECD projections suggest, this percentage is set to increase to 15.27 and by 2030 to 20.5. The respective figures for Ireland were 10.72, 11.08 and 14.74 (OECD 1987). While our projected figures are much lower than the figures for other OECD countries, we are nonetheless facing similar and increasing demands for both short and long term services for the elderly. The expectation at OECD level is that the need and demand, in particular, for formal long term services for the elderly will increase significantly as a

consequence of a decline in the most important traditional source of care for the elderly, namely the family. The OECD has identified four main factors relating to family structure which account for this trend. These are: family size, mobility, decline of the extended family and women working increasingly outside the home. These factors, given present trends, apply with equal force to the Irish context. The high levels of emigration experienced here will further deplete the number of available carers. It may also be the case that women who have for the most part provided family care for the elderly, and often at great sacrifice to their own health and well being, are less willing to make such sacrifices today.

(b) Illness Trends

The elderly as a group are much more likely to suffer from chronic illnesses than the general population. A survey of general practitioners referred to in **The Years Ahead**, for instance, shows that the most common treatable illnesses suffered by the elderly were high blood pressure and heart failure, sleep disturbance, anxiety and depression, infections, arthritis, gastro-intestinal tract and respiratory disorders. Chronic conditions such as these often lead to limitations in the activities of daily living (e.g. dressing, bathing or walking) among the elderly. Very high levels of functional limitation may and very often are experienced by those aged 75 and over. Activity limitation, which is clearly related to the health status of the elderly, therefore requires in many cases intermittent spells of acute hospital treatment and varying levels of formal long and short term care. Health care systems provide services to the elderly who require nursing and welfare care but remain biased towards acute care. It is argued in the more recent literature from the United States in particular, that the biomedical model, which is oriented towards treating individuals who have short term conditions that can be fully reversed, still inappropriately dominates the treatment and care of the elderly. Wallace and Estes (1989) for instance point to the fact that long term chronic conditions are more likely to require supportive and palliative care, and environmental modifications. Quintrell and N. Owen, commenting on the treatment of sleep disturbances and anxiety among elderly residents in aged care accommodation, make similar criticisms of an overreliance on drug therapy and they point to the need for the "judicious use of drugs and the integration of drug therapy with appropriate environmental, social and educational strategies" (Community Health Studies 1988).

The challenge of developing and providing the appropriate care, treatment and mix of services for the increasing elderly population is shaping and redefining health policy responses both in Ireland and elsewhere. Older models of care and treatment are being questioned on both quality of care and cost grounds.

(c) Long - Term Care

Up until recently most institutions providing long term care for the elderly in Ireland and elsewhere, provided that care relatively independently of community care and short term care facilities. In fact long term care for the elderly was modelled very much upon the hospital care model. Institutionalisation tended to increase over time the dependency of residents of long term care. Research and literature on the problems of institutionalisation have demonstrated the many undesirable consequences of certain models of care and treatment for groups such as the elderly, mentally handicapped, psychiatrically ill and children. Fortunately this body of research and literature has also provided important insights into how policy makers and service providers might avoid the danger of institutionalising clients. It has pointed towards more appropriate and responsive systems and types of service provision.

The report of the Department of Health's working group **The Years Ahead** on services for the elderly is an example of this new thinking on policy for the elderly and of its application to the actual planning and coordination of service provision. The care assumption underlying the approach adopted in this report is that formal and informal care can and should be employed in a coordinated way to support and enable elderly persons, for as long as it is feasible, to live with dignity in their own homes. The report acknowledges the fact that unhealthy levels of dependency can be service induced. It argues however, that this problem can be avoided if an imaginative and flexible mix of supports and services is developed and if services are based on planning and on rigorous methods of need assessment. A coherent approach is regarded as essential. Such an approach implements service objectives that apply equally to public, private or voluntary facilities, where private and voluntary organisations are providing publicly funded services. The boundaries between different types of care are thus weakened. The notion that long-term care is discrete and separate from short-term care and support is considered by the working party to be an outdated notion.

(d) Flexible Continuum of Care

The model of care proposed by **The Years Ahead** is a continuum of care which is flexible and responsive. In this model, short-term respite care becomes an important aspect of care provided by the new community hospitals and the links between community hospitals and the community are strengthened in various ways so that residential care develops an important role in nurturing and supporting care in the community and in the family.

The projected increase in the numbers of the elderly in the 75 and over age groups will lead to an increase in the need for residential care for dependent elderly persons. The increase in demand is already evident from the growth in recent years in the number of private nursing homes, particularly in the Eastern Health Board region. However, the

growth in the numbers of private nursing homes may not in itself be an accurate barometer of the need for long stay residential care facilities; **The Years Ahead** makes the point that many persons in health boards, voluntary or private nursing homes were in fact inappropriately admitted to residential care for social rather than medical reasons. Nonetheless the growth in private facilities for the elderly, it is now recognised, does require a policy response.

(e) Licensing of Nursing Homes

The Years Ahead called for the licensing of nursing homes which would enable health boards to monitor more effectively standards of care in these private and voluntary nursing homes. It also recognises the growing importance of these private facilities in providing for the needs of the dependent elderly population. The Working Party welcomed the idea that a mix of public, private and voluntary care facilities would meet the need for residential care. However, in the context of funding, it also pointed to the need for an integrated approach to the admission of the elderly to nursing homes. For this reason, it proposed changes to the existing funding arrangements which would enable health boards to vary the level of subvention according to the patient's needs.

The 1990 Nursing Home Act is a response to the need, identified in The Years Ahead for regulation of the private care sector and it also seeks to ensure that the public funding of private care facilities will form part of an integrated approach to the care of the elderly.

2. THE HEALTH (NURSING HOMES) ACT 1990 IN CONTEXT

The preparation of this Act may be seen as a response to, and recognition of, the relatively new and increasingly important role of the state in regulating the growing private welfare sector. This sector will in future play a significant role in the delivery of state funded services.

One of the most notable developments in the Western European welfare state is the transformation of the role of the state from funder and provider of social, including health, services to that of regulator of state funded services. This change is in response to the demand for greater diversity, choice and flexibility in delivery mechanisms. The subvention of private welfare is also very often a less costly option.

In Ireland we have a strong tradition of voluntary social service provision which continued in the post 1960 period when there was a major expansion and development of statutory health and social services. The voluntary sector benefited from, and expanded in tandem with, the expansion of state welfare and the 1970 Health Act provided a statutory basis for funding voluntary and private welfare provision. Of course, the voluntary welfare homes and institutions for the elderly, the mentally handicapped and for children were an established part of a state funded service well before the 1970 Health Act and they continue to play an important part in the provision of health and welfare services. However, many of these institutions are essentially non profit making and their ethos and raison d'etre are that of service to the community. The fact that they were, for the most part, run by religious orders further underlined and was seen to guarantee their commitment to the service of the community. The question of statutory regulation and control of standards in these institutions did not arise. Under the Health (Homes for Incapacitated Persons) Act 1964, the Minister may make regulations to govern the operation of nursing homes managed for profit, but nursing homes managed by voluntary bodies do not come within the scope of the legislation. The 1988 Working Party recommended that the 1964 Act be amended to include the operation of nursing homes run by voluntary bodies.

The growth of the private for profit welfare sector is one of the main reasons why it is argued that a strengthening of the regulatory role of the state is now required on behalf of a vulnerable client group such as the dependent elderly population.

While welcoming the growth of this sector and commending the high quality of care provided in so many of these private nursing homes, the 1990 Act seeks, in a positive and non intrusive way, to ensure and support a high quality of care in both voluntary and private nursing homes. It also seeks to make these care options available to a wider sector of the dependent population within an integrated framework of service delivery for the elderly.

3. THE MAIN PROVISIONS OF THE HEALTH (NURSING HOMES) ACT 1990

The Act provides for:

(1) Making the registration of homes a statutory duty of health boards;

(2) Bringing nursing homes under a common system of registration and inspection;

(3) Regulations about the standard of care in nursing homes;

(4) Reforming the existing system of health board subvention of dependent persons in nursing homes;

(5) Establishing a statutory basis for boarding out arrangements for elderly persons;

(6) The repeal of the Health (Homes for Incapacitated Persons) Act 1964 and section 54 of the Health Act 1970.

For the purposes of the Act, a dependent person is someone who, for physical or mental reasons, needs help with normal daily activities such as eating, walking and washing.

3.1 What Constitutes a Nursing Home under the Terms of the Act?

The Act defines a nursing home as 'an institution for the care and maintenance of more than two dependent persons'. It goes on to clarify the definition by indicating what types of institutions are excluded from the legislation.

The following are excluded:

(a) a home managed by or on behalf of a Minister of the Government or a health board;

(b) acute hospitals;

(c) maternity homes;

(d) mental institutions

(e) non profit institutions for the mentally handicapped which are grant aided by the Minister or a health board;

(f) children's homes providing services for a health board;

(g) Certain premises in which the majority of residents are members of a religious order.

The Nursing Homes Act provides a legal framework for boarding out arrangements. Boarding out is for elderly people who are not dependent as defined in the Act.

The Act also enables the Minister to include classes of homes by regulation within the definition of 'nursing home'.

The main changes which the 1990 Act will make will be the registration of nursing homes, the introduction of a new subvention system and the registration of nursing homes which are run on a charitable basis. These were excluded from the 1964 Homes for Incapacitated Persons Act.

Comment:

This section of the Act proved to be somewhat controversial when it was debated in the Dail. Some concern was expressed at the exclusion of health board welfare homes, retirement homes and homes run largely for members of a religious community. The Minister did however say that the Bill will enable health boards to inspect retirement homes where they have reason to believe that dependent persons requiring nursing care are residing there. There is a fee of £50,000 for any person convicted of running an unregistered nursing home.

The exclusion of health board homes is a more contentious issue. Patricia Day (1988), writing about the state regulation of welfare homes in the United Kingdom, argues very strongly in favour of extending regulation to public institutions. She cites the evidence provided by the public sector inspectorates in the United Kingdom as proof that the public managed institutions are no less scandal prone than their private sector counterparts. According to Day: "In recent years the work of the public sector inspectorates, the Health Advisory Service and the Social Services Inspectorate have cast doubts on the assumed high standards in the public sector services, particularly for the more vulnerable in institutions not subject to regular and systematic scrutiny. The Inspectorate have found a significant number of instances of bad quality of care and even corrupt and exploitative practices. Some of those problems have erupted into full-scale scandals matching anything found in the private sector. In many inquiries the lack of public accountability has been cited and, in some extreme cases, charges of cruelty and even suspected unlawful killing have been lodged against public providers" (Day 1988). Davies and Knapp, in their contribution to the Independent Review of Residential Care Committee, concur with Day on this point. They suggest that the case for regulating the private sector is mirrored in the public sector. "There is no room for complacency about quality of care in any sector, as the social work service study of London homes revealed and as was highlighted by events in Southwark during 1987." (Davis and Knapp 1988). The evidence from the UK and expert opinion strongly and equally support the case for the regulation of publicly managed welfare homes. The notion of regulations for publicly managed institutions is not an entirely new one in the Irish context and, in the case of psychiatric services, the public psychiatric hospital sector is inspected by an inspectorate centrally located in the Department of Health.

While the evidence of abuse and low standards in public welfare homes, mentioned above, relates to the UK context, there is no reason to believe that publicly managed welfare homes in Ireland are beyond reproach. The existence of a central inspectorate in the area of psychiatric care suggest that there is a recognition of the potential at least for problems relating to standards of care to arise in services managed by public authorities. (1)

3.2 Unlicensed Nursing Homes

The Act prohibits the establishment of unlicensed nursing homes or the operation of homes where the licence has not been renewed. A breach of this section of the Act will be an offence. The proprietor or manager or person in charge of the home may be prosecuted under this section of the Act.

Comment

Mr. Ivan Yates T.D. raised an interesting point in relation to this section (4) of the Act and a subsequent section (13) when he questioned the wisdom of holding a manager or person in charge of an unlicensed home responsible for the legal status of the premises or any contravention of a condition of the licence in respect of a home (section 13). The culpability in total, he claims, must rest with the person who owns the licence and not, as he points out, with a staff member. Mr. Yates' point is an important one in that if culpability were to be confined to licence owners, this would help ensure that persons setting up nursing homes have a commitment to, and interest in, the provision of the actual service itself. (2) Licences will be granted for a three year period and will then expire.

3.3 Licences and the Licensing Authorities

For the purposes of this Act health boards are the designated licensing authority in their own functional areas with the power to grant or revoke licences.

A licence may be revoked or refused by a health board only if it is of the opinion that:

(1) the premises to which the application applies do not comply with the regulations;

(2) the operation of the nursing home will not be or is not in compliance with the regulations;

(3) the person has withheld information sought by the board in connection with the application.

(4) the person in charge of the home has been convicted of an offence which is likely to render him/her unfit to manage or carry on a nursing home.

Registration may be withheld until the prescribed fee is paid to the board.

Health boards may attach conditions relating to the operation and functioning of a nursing home at the time of registration or subsequently a health board may attach different conditions to different nursing homes. Similarly a health board may amend or revoke a condition of registration.

Comment

In his speech to the Dail the Minister gave assurances that the type of information boards will require as to the suitability of the applicant, the person in charge of the home, the standard of accommodation, etc., will be standardised between all health boards. He further clarified the situation in regard to the regulations by promising new regulations. In fact, he said, officers in his Department are currently working on them.

Despite these assurances, there was some criticism of the designation of health boards as the registration authorities. Mr Ivan Yates argued that health boards could not operate a uniform system throughout the country. Instead he called for the centralising of the inspectorate in the Department of Health. Mr Yates was very critical of the boards on the grounds that there is already considerable regional variability in the quality of health care and it is largely on the basis of this consideration that he called for a central licensing authority.

The location of the inspectorate centrally is unlikely to guarantee uniform standards : the problem is in fact much more complex than this. In the United Kingdom where local administration in the form of district health authorities and social service departments of local authorities have responsibility for the registration and inspection of nursing homes and residential homes respectively, lack of uniformity has been blamed not on the fact that the system is locally administered but on what Klein and Day (1985) describe as the problem of a lack of detailed guidance for the registering authorities about how they should carry out their general responsibilities for maintaining standards. Since 1984 in the case of Residential Care, and 1985 in the case of Nursing Homes, a more detailed code of practice provides the necessary guidance which, Day and Klein believe, will lead ultimately to the emergence of national standards.

The provision of detailed guidelines (3) on standards however may also in turn create its own problems if the implementation of a code of practice leads to rigidity and inflexibility and stifles innovation. There is clearly a balance to be struck here and it may well be that a system of local administration and regulation is in a better position to judge this balance, in view of the experience of local personnel in the provision of services and of their closeness to delivery mechanisms. In relation to the regulators themselves, there may be a temptation to define standards in terms of what is easily measured, i.e. in terms of inputs and processes rather than outcomes.

Public regulation is also likely to have an impact upon the cost of service if there is generally, as a consequence of regulation, an insistence on higher standards. Some consideration should be given to this issue in drawing up regulations.

The difficulty in planning service provisions where a plurality of delivery mechanisms is employed has been well documented in the literature. This problem is not new to the Irish health care context where voluntary organisations have traditionally provided a range of services to health boards. The increasing use of, and reliance on, private and voluntary welfare homes by health boards may in itself make it more difficult to achieve a uniform level of service across the country. In fact, there may be a case to be made here for strengthening the legislation so that health boards, or the Department of Health, can regulate the size and location of the private and voluntary home sector.

3.4 Appeals Procedure

There will be an appeals procedure for people applying for registration. It will also apply to decisions of a board following inspection. Where a health board decides to refuse to grant a registration or to revoke a licence or attach a condition to a registration, it must notify the person concerned of its proposals and the reasons for them. The applicant then has 21 days in which to make representations in writing to the health board. These representations must be taken into account by the health board before it makes its final decision. The decision and the reasons for it must be given in writing to the applicant. The applicant has the right to appeal within 21 days to the District Court. The health board will be obliged to notify the person of his right of appeal to the District Court, and of his right to make written representations to the board. The district court may confirm the decision or direct the health board to grant or restore the licence or to delete or modify a condition attached to the licence. There will also be a right of appeal to the Circuit Court on a point of law.

Registration will remain valid for a period of three years. Fees will be charged for the award of a licence.

Registration certificates will be granted to individuals and will not be transferable.

Comment.

During the Dail debate on the Act, some deputies, notably Mr. Flood and Mr. Wyse, questioned the duration of negotiations and made the point that the two year period of registration (which was originally proposed) might create some uncertainty among clients who might worry about the prospect of having to find alternative accommodation in two years. Mr. Wyse argued in favour of a 5 year licence period. The Minister conceded a three year period at report stage. It also emerged during the second stage debate that the Irish Private Nursing Homes Association and individual private nursing home owners consider the licence duration a handicap which may affect the value of their business and its viability; this problem is exacerbated, they claim, by the fact that licences are nontransferable. It is also instructive to note that Deputy Flood, who raised these points, did not himself agree with them and in fact pointed to the overriding concern of the legislature, which was to protect dependent persons living in nursing homes.

3.5 Regulations with Regard to Standards in Nursing Homes

The Act will enable the Minister to make regulations and standards in nursing homes which will cover the following broad areas: accommodation, food and the care of dependent persons. This section of the Act allows for detailed prescriptions to be drawn up regarding: standards of care and maintenance of dependent persons; staffing levels and qualifications; standards of design, maintenance, repair, cleaning, heating, ventilation and lighting of nursing homes; standards of accommodation including space and washing facilities; dietary requirements of residents; the display of written information on the nursing home; the keeping of records and the inspection of such records by any officer of the health board; the provision of interviews and examinations of residents and nursing home staff where a health board has reason to believe that a resident is not receiving adequate maintenance or care; the right of access by health board personnel to any premises which is, or which they believe is, providing nursing home care; the provision by health boards of training for staff of nursing homes; a complaints procedure; the provision of services to nursing homes by health boards. Any contravention of the regulations will be an offence.

Within six months of a conviction a health board may apply to the Circuit Court for an order disqualifying the person convicted from being involved with a nursing home for a specified period of time.

Comment:

Dr. O'Hanlon, in his explanation of this section of the Act, made it clear that he favoured developing a 'code of good practice for nursing home care' which would help go beyond the notion of minimum standards. The intention would be to establish 'the best practice to which all homes should aspire.' Dr O'Hanlon indicated his intention of circulating a code of practice with the regulations made under the Act.

In the United Kingdom, with the publication of A Handbook for Health Authorities (Regulation and Inspection of Nursing Homes), NAHA Birmingham,1985, and the DHSS Code of Practice for Residential Care, published by the Centre for Policy on Ageing (Working Party) in 1984, the emphasis has switched from the physical environment to a concern with the quality of care and life of residents. In her introduction to the DHSS Code of Practice, Lady Avebury makes it clear that the Code of Practice 'attaches considerable weight to the underlying philosophy of care, and to the tenets which give substance to the philosophy. Concepts such as privacy, autonomy, individuality, esteem, choice and responsible risk-taking provide the foundation and a reference point for good practice,' (DHSS,1984). One of the major strengths in the DHSS Code of Practice is its detailed examples of how these principles might apply in practice. Good clear guidelines are therefore available which, as Day and Klein (1985) point out, will eventually lead to

the emergence of national standards. Klein and Day suggest that the enforcement of the code is an aspect of registration which merits some attention. The British model to date has tended to rely very much upon allowing for local discretion and variation. Inspectors in the U.K. are more likely to emphasise the advisory, consultative nature of their role as opposed to their role as policemen. Achieving the correct balance between these two apparently conflicting roles would appear to be the secret of success. This balance in turn depends on the ability of staff and indeed on the time available to them to develop the skills necessary to implement guidelines in a flexible and imaginative manner. Klein and Day reinforce this point when commenting upon the advantages of the British approach which, they argue, relies more on bargaining and negotiation than on strict enforcement of the law. "When administered by first-class staff with a sense of mission, this system has great advantages. It allows standards in the private sector to be improved by a process of flexible bargaining and negotiation, taking into account the special characteristics of each home and its clients. However, when administered by inadequate or overworked staff, such a system can be a recipe for disaster." (Klein and Day, 1985)

Culturally, the U.K. approach would be seem to be the most appropriate one in the Irish context. However, the practice in the U.S of performing an annual survey of nursing homes to determine whether they comply with Federally mandated standards of care might usefully be employed here to monitor standards at national level.(4)

3.6 Temporary Management of Nursing Homes by the Health Boards

Where a health board considers that a nursing home is failing to comply with the regulations, it may, with the consent of the registered owner, or by getting an order from the District Court, take over the running of the home itself for a specified period not exceeding three months. The health board may recover the cost of the salary of the person appointed to manage such a home from the registered proprietor of the nursing home concerned.

3.7 Health Board Subventions

The Act will enable health boards, following an assessment of a person's dependency and circumstances to contribute towards his or her maintenance depending upon the level of dependency and the means and circumstances of the person. The Minister may by regulation determine what the payments shall be, having regard to degrees of dependency and the means or circumstances of dependent persons.(5)

Comment:

The change in the method of subvention of private and voluntary nursing homes is indeed a welcome and very necessary change. It will enable health boards to target scarce resources more effectively and it will also give health boards more say over the

type and quality of care they are funding. This should ensure that the private and voluntary care facilities, which receive funding to provide care for health board clients, provide it in the context of wider health policy objectives for the elderly. Health boards or the Department of Health will, however, have to decide how best to integrate and utilise these facilities in the context of their overall policy for the care of the elderly.

3.8 Register of Nursing Homes

Each health board will be obliged to keep a register of nursing homes in its geographical area. This register will be available for inspection by the public.

3.9 Boarding out of Persons by Health Boards

The Act will regularise the current practice of boarding out dependent persons in private households. It will enable a health board to make boarding out arrangements for dependent persons within or outside its functional area. This section of the Act will also give the Minister power to make regulations regarding the inspection of dwellings where persons are boarded out; the supervision by health board officers of the care, maintenance and welfare of persons boarded out; the investigation of situations where a board has reason to believe that a person boarded out is not receiving appropriate care.

Comment:

The formal recognition of boarding out as a care option for the elderly is a significant policy development. It will facilitate the important policy objective of enabling the elderly to live as long as possible and to be cared for in the community. It will broaden the range of care options available to the elderly and it will make it easier for many of them to accept the care they need when it is available locally.

Boarding out is likely to be a less expensive form of care. However it is important that financial considerations do not lead to an excessive emphasis on this form of care; very dependent persons would still require the type of care more appropriately provided by nursing homes with fully trained staff.

Where families take a dependent elderly person into their own home, they will need support and advice from health board professionals from time to time. Caring for a dependent elderly person can be disruptive to normal family life and can over time be a source of stress. It is therefore vital that respite care is an option which is available to families who contract to take on the care of an elderly person, and that other forms of support and advice are available to them from time to time. Investment in support for families who contract to care for an elderly person will help ensure greater continuity of care.

Consideration should also be given to the use of relatives in boarding out arrangements.

This has worked well in the area of child care (see Gilligan, 1989) and the principle has already been established through the payment of the Prescribed Relatives' Allowance.

3.10 Penalties

A person who is guilty of an offence under the terms of the Act may be fined up to £1,000 or imprisoned for three months or both if convicted by a District Court, or a fine of up to £50,000 and/or two years imprisonment if convicted on indictment (i.e., in the Circuit Court before a jury).

3.11 Repeals

The Act provides for the repeal of subsection 2, section 54 of the Health Act 1970 and the 1964 Act.

4. CONCLUDING REMARKS:

All the indications are that regulation of welfare providers, especially in the health and social care areas, is likely to become a more important and more demanding function of the health boards in the future. Indeed, the 1990 Act will significantly increase the workload of the existing inspectorate but it will also increase substantially the responsibilities of health boards. The monitoring and registration of existing and new nursing homes and the implementation of the new arrangements for the subvention of nursing home care for dependent persons, are likely to increase considerably the resource requirements of health boards. The registration fee should certainly help defray some, though by no means all, of the costs of the comprehensive and highly professional approach which the proposed legislation envisages for the inspection and registration of homes. The availability of sufficient additional resources could make a great deal of difference to the operation of the proposed legislation at local and national level.

The enforcement of the code of practice raises important issues. The impact of this legislation will be very strongly influenced by the training, development and education of the inspectorate. Inspectors will carry an important burden of responsibility for ensuring high quality and appropriate care for the elderly. Their role, responsibility and overall approach to the enforcement of the code of practice should therefore be given serious consideration at the most senior level in the health boards and the Department of Health. The impact of the legislation will be influenced much more by the calibre of the inspectorate than by its location i.e. centrally or locally based.

The successful implementation of a complex piece of legislation such as the 1990 Act is not by any means solely dependent upon the availability of additional resources. Its success as a policy instrument will also depend very much on the quality of local plans for implementing an integrated care package for the elderly. This package will include a well thought out role for the private and voluntary nursing home sector. The extent to which health boards will need to rely on nursing home care as a source of long or short term care will also in turn be affected by the infrastructure of community and support services available to the elderly and their carers in the community.(6) The decision of relatives to seek a place in a nursing home for a dependent elderly person, rather than continue the care of that person themselves, may very well depend, in some instances at least, on the availability of support services in the community, including day care and respite care. The eventual mix of services provided and the range of options open to the elderly, including the extent to which the preferred option of remaining at home or in the community is available to them, will very much depend upon the planning of an integrated system of care to meet local need in the context of the policy objectives outlined in **The Years Ahead.**

The publication of the 1990 Nursing Homes Act signals an important shift in public policy making. It is part of a wider questioning of the role and responsibility of State health and welfare institutions. In the future we may be moving closer to the American model which places much more emphasis on the State as regulators and less on its role as provider of services. Whatever the future scenario, the current legislation highlights the need for regulation to ensure high quality appropriate care for the dependent elderly. In the absence of a similar system of regulation for the State sector, one may point to a possible danger that a dual standard of service will emerge, with the private and voluntary homes only benefiting from the advice, experience and judgement of the inspectorate. This danger could be averted, however, by the extension of the regulation system to health boards. Such an extension would maintain public confidence in this sector and help homes to improve their standards.

NOTES

(1) Health board institutions including hospitals and homes for the elderly are subject to a system of public accountability. If a hospital or home run by a health board is giving cause for concern the Minister may have the institution in question inspected. The Minister is of course also accountable to the Dail. However, one might still legitimately question the effectiveness of this reactive system of accountability in ensuring and promoting good standards of care on an ongoing basis.

(2) It is possible however, that this section of the Act will deter nurses from accepting positions in a nursing home which is unregistered.

(3) A draft code of practice is being finalised by a working group representing the nursing homes, the health boards, carers and the Department of Health.

(4) The current US Federal nursing home survey process entitled Patient Care and Services (PACS) concentrates on evaluating patient care. As part of the survey process, in depth patient care assessment including both interviews of residents and reviews of records is carried out. At least 10% of residents in each home are interviewed. The survey process also includes a Facility Tour, the Drug Pass Observation (administration of medication and verified compliance with physician day orders) and the Dining Area and Eating Assistance Review, (Spector, W.D. and Drugovich, M.L, 1989). The American option has the dual objective of ensuring that public money is appropriately spent and that of protecting the consumer through its focus on the care of individuals.

(5) Nursing homes have been inspected here every six months for many years. This section of the paper considers the role of inspection and the form it might take in the future in the light of UK and US experience.

(6) The National Council for the Elderly have commissioned a study on this issue.

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