Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

East Coast Area

Slán Abhaile

The Pilot Phase

February 2005

Acknowledgements

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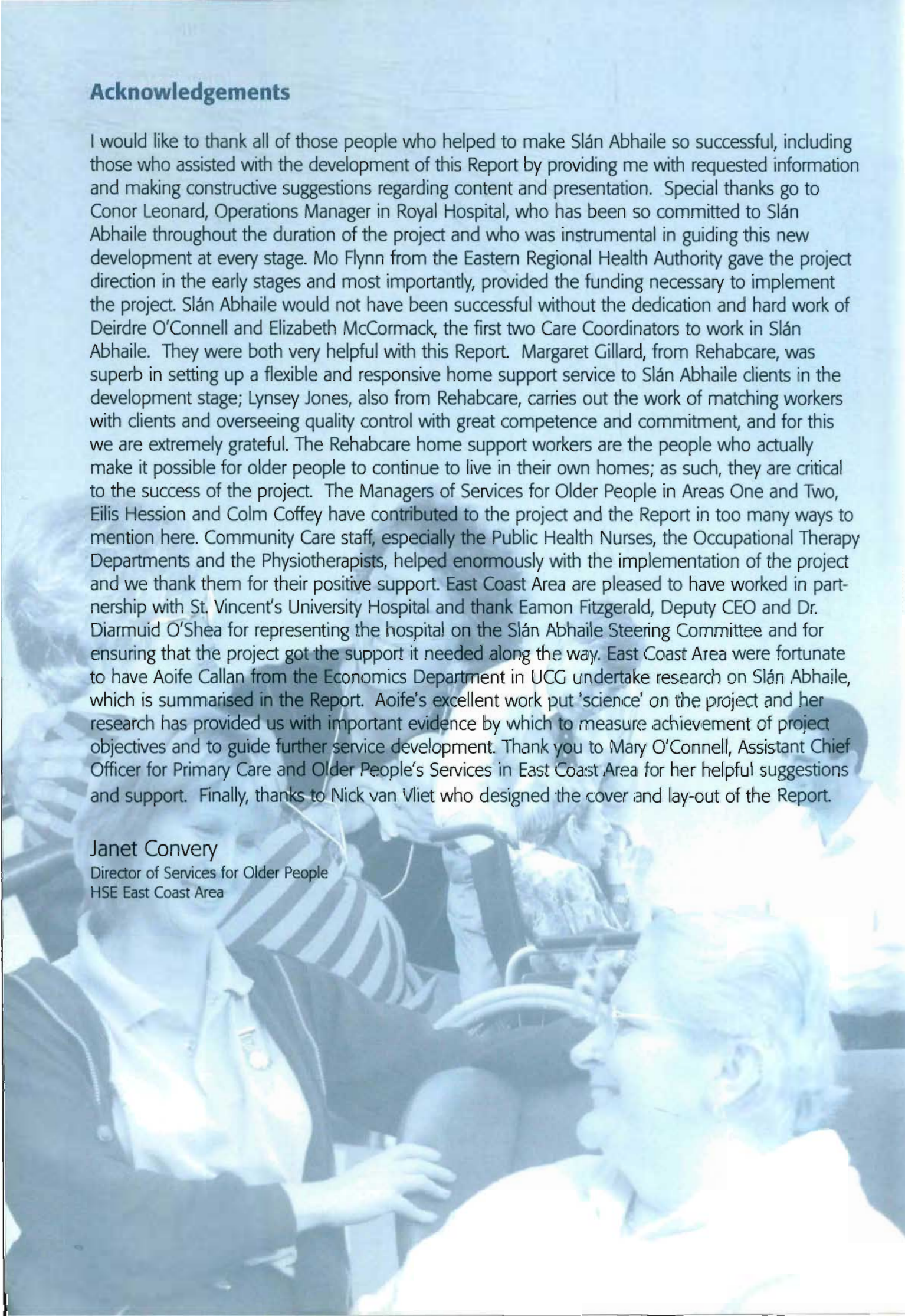

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Executive Summary: Slán Abhaile Pilot Phase: May 2003-December 2004

This report reviews the development of the Slán Abhaile project in East Coast Area Health Board and progress made, during the pilot phase, to achieve project objectives. Issues which require further attention are also raised.

Profile of Slán Abhaile service users

Slán Abhaile was targeted at older people who, in spite of their wish to remain living in their own homes, might be at risk of having to move into residential care in order to have their long-term care needs met. Sixty-two (62) older people received Slán Abhaile services during the first 18 months of the project. Of these, the average age of participants was over 82 years, women outnumber men (40 women, 22 men) and service recipients' needs ranged from moderate to high physical dependency with a significant minority with dementia related or other mental health problems. 37 older people were facilitated to leave hospital with Slán Abhaile support services; 25 clients were referred from the community and these included 12 people who were referred by the community nurses, 6 by the Psychiatry of Old Age service, 4 by the day hospital in St.Vincent's University Hospital, 2 by the hospital Out-Patients Department and 1 by the community social worker for older people.

Discharges

26 older people were discharged from Slán Abhaile between May 03 and December 04. Of these, 14 made the decision to enter long-stay residential care (nursing homes in most cases), 8 died while in receipt of Slán Abhaile services, and the remainder were discharged because of their ability to manage with other community services or the Home Care Grant. The length of time that older people received services before discharge ranged from one month to over 9 months.

Evaluation of Slán Abhaile: Added Value

Research undertaken by University College Galway Economics Department in 2004 demonstrates that Slán Abhaile is cost effective when the public expenditure costs are compared with the cost of nursing home and hospital care. The qualitative benefits of Slán Abhaile, as reported by health professionals, service recipients and their families in the course of the research include; provision of needed personal care services, security of knowing someone is visiting every day, improvements in quality of life, reduction in stress on carers, being consulted before decisions are made, flexibility of home support services and better coordination of services. In general, everyone involved expressed the belief that Slán Abhaile is successful in that it does enable people to remain living in their own homes who otherwise might not have that option. 15 of those clients currently in receipt of Slán Abhaile services have been supported to live at home for more than 12 months; one person has been on the programme for 23 months.

Continuing Challenges

The research undertaken by UCG and feedback from those involved in the project identified issues that merit further consideration at national as well as local level because they will impact on the development of new services like Slán Abhaile which are aimed at providing an alternative to nursing home or hospital long term care options.

1) Service capacity. The Slán Abhaile experience has been that, even with additional funding, it is not always possible to increase service capacity to the extent required to meet individual needs. Although Rehabcare are contracted to provide home support services which are critical to older people actually being able to remain at home, they continue to experience serious difficulties in recruiting and retaining home support staff and this obviously limits service capacity. There is evidence to suggest that home help organisations across Ireland experience the same difficulties and the reasons, we believe, include the fact that this work is poorly paid, it involves work that many will not find attractive (including personal care and domestic duties), and there is no career structure for home support workers. It is possible, in a hospital setting, to advance from hospital assistant into nurses' training, but the same does not seem to apply to domiciliary home support workers, although the work of hospital assistants is very similar to that of home support workers. Work needs to be done to; develop a career structure for home support workers (perhaps linked to third level education opportunities); to adjust salary scales accordingly; and to find new ways to support people who are employed in this capacity. Unless this issue is addressed, development and expansion of home care service options will be seriously inhibited, in spite of older people's preference for this type of care.

2) Scope of service. Slán Abhaile services are not sufficient to meet the needs of people who require overnight care or those who require all day supervision (e.g. people with dementia who live alone), for example. This is mainly a funding issue, i.e. the resources available will not stretch that far. If older people with such heavy dependency needs were to be accepted on to Slán Abhaile, then the numbers that could be accommodated on the programme would decline dramatically. Thought needs to be given, at national level, to define the extent of HSE responsibility for the long term care of older people and particularly its commitment to supporting older people to remain living at home. Should/can the health authorities be responsible for meeting older people's needs with no reference to staffing or other resource considerations? Should they provide 24 hour care if that is what is required? Should these services be available to anyone who wants them? In some countries in Scandinavia, when home care costs reach approximately 75% of the cost of residential care, the decision is taken to move the older person into a residential care setting. Even in Denmark, where older people have a right to receive health and social care services at home until they die, in practical terms, the system works to effect a move to residential care in most cases when costs become too high. These issues need to be considered seriously before schemes similar to Slán Abhaile are developed or expanded.

3) Equity between older people in similar circumstances. Slán Abhaile provides case management, fast track OT services and critical enhanced home care services to older people wishing to remain at home. There is no means test involved in the application for Slán Abhaile services: the assessment of need disregards the older person's financial circumstances and clients are not charged for any Slán Abhaile services. As such, Slán Abhaile clients are privileged compared to their counterparts in the community, many with similar needs, who may be means tested for services as basic as home help and who also may be charged for the same services. (There are others, of course, who cannot access services at all.) This situation is perceived by community health professionals as quite unfair, and certainly it needs to be addressed as new community alternatives to hospital and nursing home care are being considered.

4) Interagency/interdisciplinary cooperation and understanding. The large number of referrals which could not be progressed during the pilot stage (see text of Report) at least partly reflects the difficulty of developing new services at the interface between hospital and community and between and across health care disciplines. Slán Abhaile participants include three hospitals, two community care areas, a voluntary service provider and five or more professional disciplines, each with their own particular perspective on the way the project should be developed.

Establishment of the Care Coordinator positions posed the greatest challenge in the early stages, because no one involved had any previous experience of formal case management, and there was the perception among both the community nurses and the medical social workers that this role belonged to their respective professions exclusively. Pro-active effort was put into developing an understanding among the stakeholders of the Care Coordinator role; two day workshops were offered to relevant staff across agencies at the outset of the project, using an outside facilitator, and this helped to break down barriers and promote mutual understanding. Further one day workshops were offered several months later to provide people with the opportunity to give feedback on the progress of the project from their perspective, and it was interesting to note that after only a few months, people who had previously been quite negative were now very positive about the benefits of Slán Abhaile.

Other difficulties arose around definition of the role of the Slán Abhaile occupational therapist (who straddles hospital and community), and work also went into convincing community nurses and other groups that Slán Abhaile would not increase their workloads. Many meetings were held in the early stages of the project, and every effort was made to provide opportunities for interested parties to ask questions and also offer their views.

For new projects like Slán Abhaile, which aim to break down existing barriers to person-centred care of older people, time and effort must be devoted to the proper introduction of new service ideas, to the definition of roles, to the development of procedures governing the relationship between the various stakeholders, and to fostering mutual understanding between project partners. Consultation with staff and clients must be a constant feature of any such project and must be built in from the start. Most importantly, there must be strong commitment from senior management to the achievement of project objectives and to the allocation of necessary resources. Without all of these things, new service initiatives may not progress.

Outline of the Project

Slán Abhaile is a project undertaken by East Coast Area Health Board in partnership with The Royal Hospital Donnybrook, St. Vincent's University Hospital and Rehabcare. The project was developed with strong support from the Eastern Regional Health Authority in the context of; growing pressure on acute hospital beds, the perception that older people were blocking access to these beds, the sometimes inappropriate placement of older people in long-stay residential care facilities, and increasing evidence that older people wish to remain living in their own homes and have their needs met at home for as long as possible.

Slán Abhaile, like the Homefirst project developed in the Northern Area Health Board before it, aims to provide older people with a practical alternative to long-stay residential care by providing enhanced home support services and, in the process, to free up acute hospital beds where possible. The older person or their advocate is actively involved in the decision making process and service plans are tailored to the individual needs of the clients and their families.

Slán Abhaile supports both the principles and the objectives of the National Health Strategy in that it offers:

- Person centred care
- Coordinated planning between agencies/service providers
- Individual integrated service plans for older people
- Enhanced home support services (including evenings and week-ends)
- Support to informal carers

Project objectives

- To prevent, where possible, the inappropriate placement of older people in long-term care settings (including private nursing homes) by facilitating older people who wish to go home following treatment in an acute hospital, with the necessary home support services.
- To provide a timely and well planned discharge to older people in hospital, thus reducing the number of days spent in hospital following treatment.
- To prevent unnecessary re-admission to hospital.
- To support vulnerable older people to remain living at home.
- To support families who are caring for vulnerable older relatives at home.

Key elements of the project

I. Enhanced home support services.

Out of hours services

The provision of enhanced home support services is provided by Rehabcare under contract to the East Coast Area Health Board. Of particular benefit has been the fact that Rehabcare services are available to older people during the evening and at week-ends, unlike conventional home help services which are often available only during office hours. Rehabcare workers are able to get clients up in the morning, visit them up to 4 times a day and help them go to bed at night, as required. Thus they provide a service that is flexible, practical and responsive to individual needs, and this factor is critical to supporting older people's wish to remain living in their own homes.

Dual role of workers

The other major benefit to clients of Slán Abhaile home support services is that Rehabcare workers are trained to do both personal care and domestic care. Many home help organisations now confine themselves to doing domestic work primarily; if an older person also requires personal care it is then necessary to apply for a separate personal care service from the nursing department. This increases the number of workers going into the older person's home, which is more intrusive and also undermines service continuity and overall service effectiveness. Slán Abhaile provides a streamlined service to clients and also reduces the demand for community personal care services that can now be offered to those with less complex needs.

Flexibility of Services

The flexibility of Rehabcare Slán Abhaile services is illustrated by the case of a woman who, when asked what type of assistance she needed, responded that she would dearly love to be able to attend mass. This was built into the Service Plan and she was able to attend mass, accompanied by the home support worker, once a week.
While the nature of services offered to Slán Abhaile clients is often prescribed by the older person's basic physical care needs, staff availability, etc. Slán Abhaile does provide an opportunity to consider the older person's individual wishes and preferences and this is an important benefit.

II. Care Coordination/case management

Case management services are provided by dedicated, full time Care Coordinators whose job it is to;

- develop integrated Individual Service Plans* (care packages) for eligible older people
- advocate on behalf of the older person
- provide case management/coordination of services
- monitor and review of care Individual Service Plans

* A note about the terminology used in this Report. 'Individual Service Plans', also called 'care packages' include a schedule of all of the services that an older person needs in order to continue to manage living at home. These may include services provided by; the health authority, Rehabcare, other statutory or voluntary service providers (in the case of day care, meals on wheels, respite care for example), informal carers (husband/wife/daughter/niece) and even from the private sector. See Appendix 1 for an example of an Individual Service Plan. The 'Care Plan' includes a schedule of the duties of the home support worker, as agreed by the older person and/or their carer, and the home support provider(usually Rehabcare). See Appendix 2 for an example of a Care Plan.

The three full-time Care Coordinator posts, which were developed and funded under Slán Abhaile, are among the few such posts in the country, and they represent ECAHB's commitment to implementing the recommendations made in the National Council on Ageing and Older People report on case management for older people. (2001)

The Council therefore recommends that future national, regional and local policies on health and social care services for older people be developed to embrace a Care Management approach to service co-ordination and planning at a management level, and Case Management as the means by which health and social care services can be tailored and delivered to the target population of older people. (p.9-10)
(See Appendix 3 for job description of the Care Coordinators)

Care coordination tasks were originally divided between the two Coordinators in Areas One and Two as follows;

One Care Coordinator was designated 'Hospital Care Coordinator'. Her job was to take referrals from hospitals only, to assess candidate's eligibility and to develop the Service Plan for eligible applicants. She handed over responsibility for clients once they had returned home with a Care Plan in place and had been in receipt of services for 6-8 weeks.

The other Care Coordinator was designated 'Community Care Coordinator' and her job was to take referrals from the community and to take responsibility for all Slán Abhaile clients once they had been at home and in receipt of Slán Abhaile services for 6-8 weeks.

This structure has now changed and, from 2005, there will be one Care Coordinator in each of three Community Care Areas (LHO) who will take referrals from hospital or community, develop the Service Plan and do follow up reviews on eligible older people from their Area. Care Coordinators will also manage the Home Care Grant scheme in their areas and offer a case management service to appropriate applicants.

III. Occupational Therapy Services

Additional Liaison OT posts

Additional senior community occupational therapy posts were funded from the Slán Abhaile budget in all three Community Care Areas to liaise with acute hospital staff and to facilitate a 'fast track' OT service to older people who are at risk of having to move into residential care. These were developed in response to evidence that access to needed occupational therapy services was a significant barrier to older people's ability to remain living in their own homes.

Occupational Therapy Assistant posts in Area One and Two

Although additional OT posts were funded under Slán Abhaile, there remains a serious shortage of therapists, and the creation of assistant occupational therapy posts was aimed at making existing services more effective, by giving OT Departments someone to assist in service follow-up. Unfortunately only one of the posts was ever filled, mainly due to HR difficulties.

Equipment

An equipment budget was included in the Slán Abhaile budget from the outset, and considerable work has been done during the pilot stage to; create a pool of appropriate equipment to facilitate hospital discharge; to develop systems which break down communication barriers and other barriers between hospital and community care OTs; and to establish a new Action Van service for the delivery, instalment and retrieval of therapeutic equipment. Royal Hospital Donnybrook have taken the lead in this work which has greatly enhanced our ability to meet the occupational therapy needs of both Slán Abhaile clients and other older people awaiting hospital discharge.

IV. RGN and Care Attendant posts

Additional RGN and Care Attendant services were funded to support existing nursing services which are routinely in short supply. These services have not been allocated to Slán Abhaile clients specifically but are available to the general population of older people in ECAHB, and as such, they enhance existing services.

V. Social Work services

The only community care social worker for older people in ECAHB is situated in Area Two and is available to take referrals of Slán Abhaile clients in Area One and Two. Although the number of referrals from Slán Abhaile has not been high (6 cases) this service is a valuable complement to other Slán Abhaile services and a support to older people, family carers and other health professionals involved. The social worker deals mainly with cases where there were complex family or carer issues and assisted older people and their carers to make decisions about meeting future care needs.

VI. Physiotherapy services

Although the number of older people referred to Slán Abhaile who had a need for additional physiotherapy services was relatively small, a significant proportion of clients were already known to the physiotherapy service and some do require on-going physiotherapy services in the long term. A chronic shortage of community physiotherapists means that not everyone who could benefit from the service do receive it, although the Physiotherapy Departments have endeavoured to meet the needs of the most vulnerable older people in their Areas.

VII. Day Care Services

A significant proportion of Slán Abhaile clients have chosen to avail of day care services during the pilot stage. Day care services can be an important part of the Individual Service Plan because they offer the vulnerable older person an opportunity to leave the house for a short period, to meet other people, and to participate in social and therapeutic activities. Day care is also important to family and other informal carers because it offers a break from the routine of providing care for the older person. Even with the enhanced home support services provided by Rehabcare or other home care providers, the research demonstrates that informal carers may work 60-70 hours/week; the break that day care offers can be a critical support to carers.

VII. Meals on Wheels

While the number of Slán Abhaile clients whose Individual Service Plan includes Meals on Wheels provision is not huge, this service is obviously critical to people who live alone who may no longer able to prepare their own meals. While the home support workers can and do prepare meals for older people, Meals on Wheels frees them to do other duties when they are there and ensures that the older person will get a good meal, even when the worker isn't there.

Slán Abhaile Admission Criteria

Older people are eligible for Slán Abhaile services if they are;

- Male or female, aged 65 or over.
- Living in the East Coast Area Health Board catchment area*
- Patients of any of the Geriatricians in ECAHB who have been assessed as being suitable for discharge with home supports and who wish to return home.
- Older people in the community who are at risk of having to move into long-term residential care, who are referred by the Public Health Nurses, GPs or other. Self-referrals are accepted, subject to assessment by the health professionals involved.

* Because of budget limitations and other Human Resources considerations, Slán Abhaile has been limited to older people living in Area One and Area Two of the East Coast Area Health Board up to now. However, with the allocation of additional funding in 2004 and the employment of a Care Coordinator for Area Ten, the scheme will be expanded to include Wicklow in 2005.

Discharge from Slán Abhaile

People are discharged from Slán Abhaile when;

- they are no longer in need of enhanced home support services (ie their needs can be met with conventional community care services)
- they are admitted to acute hospital and remain in hospital for a prolonged period of time
- they are deceased
- the older person and/or their advocates decide that full-time residential care would now be the best option for them

* If Slán Abhaile clients become ill to the point where they need to enter acute hospital, they remain on the Slán Abhaile list for up to six weeks before being discharged. However, if they return home again, they can re-enter the programme and services will re-commence.

Slán Abhaile Structures

Steering Group

A Steering Group was established to guide the development of this service in the pilot stage, to make decisions regarding allocation of resources and to monitor and evaluate development progress. It was very important that key stakeholders from the hospitals and the community were given the opportunity to shape the development of the scheme and participate in decision-making regarding allocation of resources. Steering Group members included representatives from; East Coast Area Health Board (Director of Services for Older People, General Manager and Managers of Services for Older People); Royal Hospital Donnybrook (Operations Manager); St. Vincent's University Hospital (Deputy CEO and Consultant Geriatrician); and the GP Unit in ECAHB.

Implementation Committee

An Implementation Committee was also set up to oversee the operation of Slán Abhaile services and to negotiate any issues that arose about coordination of services. Membership included some of the above group plus representative heads of disciplines (Nursing, Occupational Therapy, Physiotherapy) and Rehabcare managers. The two Care Coordinators employed for Slán Abhaile attended frequently to answer questions and report on progress.

Rehabcare are under contract to provide home support services (including home help type services and personal care services) to Slán Abhaile. Rehabcare managers are responsible for managing that aspect of the service.

Since Slán Abhaile is now considered to be a mainstream service, the Steering Group no longer meets and the business of the Implementation Committee has been incorporated into Intake meetings, which take place regularly.

Integrated Care Committee

The decision was taken by the members of the Slán Abhaile Steering Committee to meet periodically from 2005 to focus on issues of continuing interest that impact on integration of hospital and community services. Conor Leonard, from The Royal Hospital Donnybrook, is being proposed as Chair of this group, which was re-named the Integrated Care Committee.

How Slán Abhaile works for individual older people

Consent

Health professionals in acute hospitals (medical social workers and geriatrician teams) and the community (mainly public health nurses) identify older people who might be eligible for Slán Abhaile services.

The older person is asked if he/she wishes to return to live in their own home or remain living at home and whether they would like to pursue the development of an Individual Service Plan which would enable them to do so. Discussion also takes place with family carers about the possible suitability of Slán Abhaile for their relative.

Referral

The older person's name is then forwarded to the Care Coordinator who sends out a referral form.

Formal Application

An application form is completed by hospital or community care staff, giving comprehensive information about the older person's specific care needs. This form is sent to the Care Coordinator in the Area in which the applicant lives.

Acceptance

The Care Coordinators assess whether Slán Abhaile services are appropriate to the older person's needs and make the decision as to whether a person is accepted on the programme. This involves; visits to the older person and/or their carer; discussions with hospital or community staff; requests for further information where it is incomplete; and consideration of availability of home support services versus the level of the individual older person's needs.

Matching of needs with available services

Applications are discussed at weekly Intake Meetings attended by the Care Coordinators, the Manager of Services for Older People, and the Rehabcare manager. The critical challenge to be resolved is identification of home support workers who are available to provide appropriate care services at required intervals; availability of home support workers is the biggest limiting factor in Slán Abhaile once people's eligibility for services is determined.

Development of the Individual Service Plan

An Individual Service Plan is developed by the Care Coordinator in consultation with the older person, family carers, Rehabcare and health professionals, outlining all of the services, including informal care, that are required in order to support the older person to return home/remain living at home. The older person's wishes and the views of carers are given priority consideration. A weekly schedule is developed outlining the services organised to support the older person to live at home. (See Appendix 1 for example of Service Plan.)

Implementation of Individual Service Plan

Referral to appropriate services

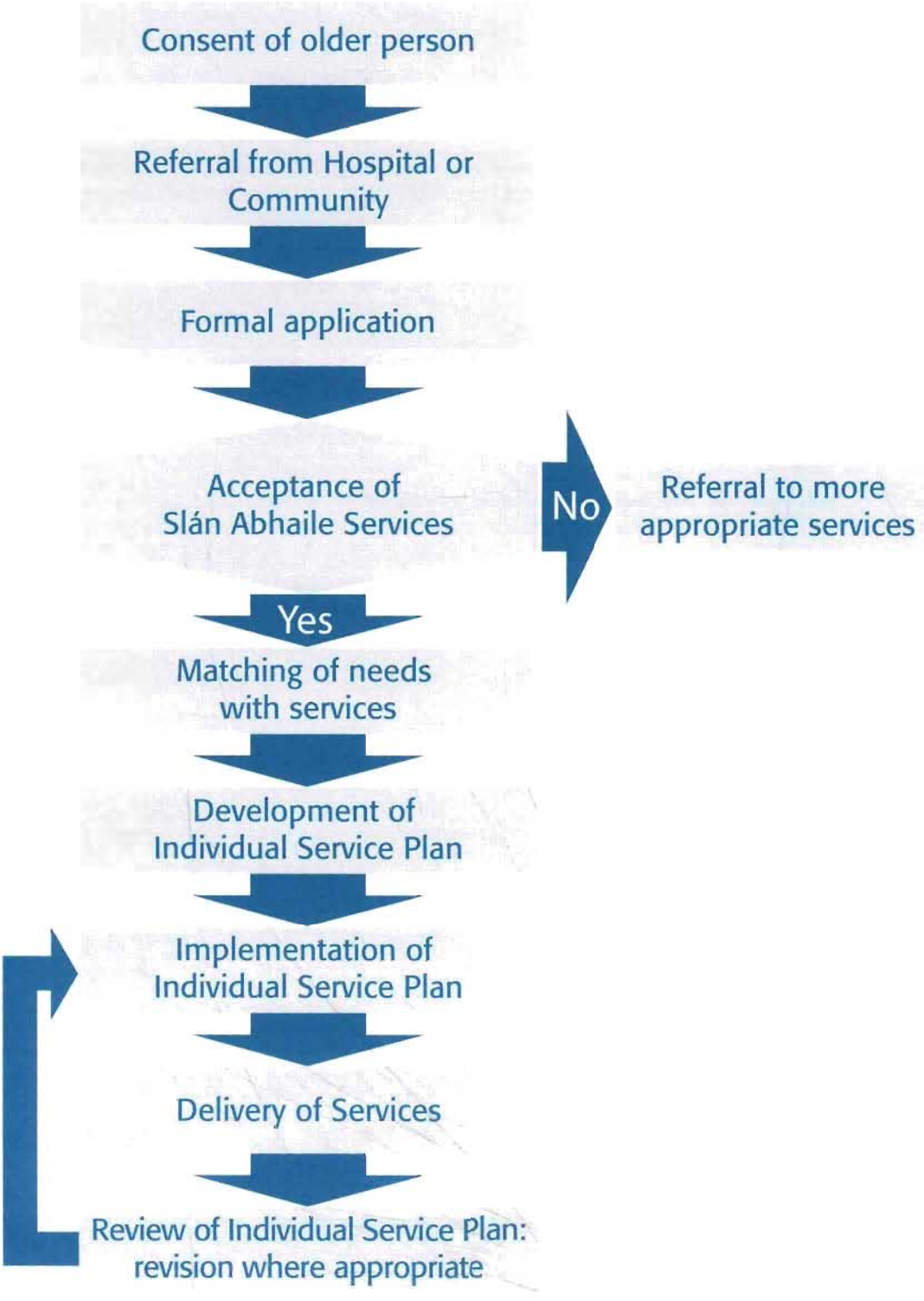
- If the older person needs to have equipment installed or made available in order to live at home safely, a referral is made to the Slán Abhaile community occupational therapist, who liaises with hospital occupational therapy staff and fast-tracks the referral to provide a timely service, i.e. before the person goes home from hospital or, in the case of people already at home, without their having to go on a waiting list.
- Considerable discussion takes place with the public health nurse or the community psychiatric nurse in the area where the older person lives in preparation for discharge home or commencement of services. Some applicants require nursing services as part of the Individual Care Plan.
- In some cases, a referral to the community physiotherapy department or social worker might be appropriate.
- There might also be discussion with other service providers in cases where day care, respite, or home help services are part of the Service Plan.

Delivery of home support and other new services

Home support workers begin work as specified in the Care Plan. The older person receives other services as included in the Service Plan. Details of the Service Plan are further refined in the first few weeks following consultation with the older person and her family, home care staff and management and other service providers, in order to better tailor services to individual needs.

Review of Service Plan

The Care Coordinators and Rehabcare manager review the implementation of the Service Plan through discussion with all involved, including the older person and their carer(s). Changes are made as required. Reviews continue to take place at regular intervals as long as the older person is in receipt of Slán Abhaile services.



Profile of Slán Abhaile clients during pilot stage

May 2003 up to 31 December 2004

Category	2003	2004
Referrals	96	121
Screened But Not Assessed	48	83
Assessed	48	38
Accepted	40	30
Not Accepted	8	8
Commenced*	33	29
Discharged	9	17

* Although accepted, some clients did not proceed as some changed their mind / their health deteriorated / they died or they decided themselves that they wanted to move into residential care.

The most common reasons for not assessing older people who were referred include;

- The Home Care Grant was considered to be the more appropriate option, i.e. the older person was able to meet her/his own needs with funding to employ private sector services.
- The older person's condition improved and services were not needed
- Community services (home help etc.) were sufficient to meet the needs of the client
- District Care Unit services more appropriate to needs
- Supervision rather than practical care needs required
- Older person or family changed their minds
- Older person's medical condition deteriorated or the person died in the interval between referral and assessment.

** The reasons for not accepting referrals once assessment was carried out include all of the above.

Number of clients who have received Slán Abhaile services since May 2003

Area One	36
Area Two	26
Total	62

Source of Referrals

37	Hospital – Medical Social Workers
12	Community Nurses
6	Psychiatry of Old Age Service
4	Day Hospital
2	Out-Patients Clinic SVUH
1	Community Social Worker

Gender

Female	40
Males	22

This ratio reflects the demographic reality that women live longer than men.

Average age of all Slán Abhaile clients

82 years 4 months 2 weeks

Age range of all Slán Abhaile clients

66 years 1 month	to	100 years 1 month

Number living alone:	21
Living with family*:	41

*The UCG research shows that informal carers are devoting considerable time to providing needed care services to vulnerable older people even after the introduction of Slán Abhaile services. Slán Abhaile may provide relatively small service inputs but these are considered critical to supporting carers to continue in that role.

Couples where both are in receipt of services:	4 couples

Dependency needs (data collected from self selected sample as part of UCG cost/benefit analysis in June 04)

High level of physical needs	24%
Moderate level of physical needs	28%
Dementia related needs mainly	9%
Dementia with physical needs	26%
Mental health problems mainly	7.5%
Mental health problems with physical needs	3%
Information incomplete	2.5%

Profile of primary carers of current recipients

Wife of older person	12
Husband	3
Daughter	15
Son	14
Other relative	14
Other/neighbour/friend	4

It should be noted that a significant proportion of informal carers, including spouses and siblings of the older person, are also over age 65.

Home Support (Rehabcare) Services Delivered to Individual Clients

(using one week in November 2004 as average)

Range of hours of home support services

Minimum: 6 hours/week
Maximum: 21 hours/week

Average number of hours Rehabcare services

13.85 hours/week

Range of number of Rehabcare visits per week

Minimum: 1 visit per day = 6 visits/week
Maximum: 3 visits/day for 6 days a week + 4 visits on Sunday= 22 visits/week

Occupational therapy

The majority of Slán Abhaile clients have required an Occupational Therapy assessment and equipment installation service after being accepted onto Slán Abhaile, and many would already have received a service in the past.

Social Work

Six (6) older people and/or their carers were referred to the community social worker because of issues arising around carer stress, decisions about long-term care and once following breakdown of formal care arrangements.

Respite Care

35 of 62 clients availed of respite care services as part of the Service Plan.

4 have availed of intermittent respite care (i.e. respite at regular intervals).

31 have availed of occasional respite care (2-4 weeks/year).

Day Care

21 clients have attended day care as part of their Service Plan.

Meals on Wheels

12 older people on Slán Abhaile have been in receipt of Meals on Wheels.

Physiotherapy

15 older people were referred for physiotherapy services as part of their Slán Abhaile Service Plan, although many more Slán Abhaile clients were already known to the Physiotherapy Department and had received physiotherapy services in the past.

Service Outcomes

Number of discharges from Slán Abhaile during pilot phase: 26

Breakdown of reasons for discharge since commencement of Slán Abhaile (up to 1 December 2004)

14	entered long-term care (10 entered a private nursing home while 4 entered public long-stay care)
2	discharged to community services
2	discharged with Home Care Grant
8	died while on the programme

Length of Time on Slán Abhaile before discharge

Older people who died while in receipt of services	1.5 to 9 months	Av. 4.32 months at home
Older people who were discharged into long-term care	15 days to one year	Av. 5.13 months at home
Older people discharged to community services	4 to 7 months 2 weeks	Av. 5.75 months

Length of time that current clients have been in receipt of Slán Abhaile services

15 people have been in receipt of Slán Abhaile services for longer than one year.

Longest period: 23 months

The figures above demonstrate that Slán Abhaile provides older people with a real choice to stay living at home, in the first instance, as their care needs increase, even if ultimately they decide to move into long-stay residential care. Slán Abhaile buys time for older people and their families and allows them space to consider and prepare for the future even if they ultimately move into residential care. The OCS Report on Residential Care for Older People in the Western Health Board (2004) suggests that involving older people in decisions about their long-term care contributes to a more positive outcome, even if a decision is made to take up a residential care option. We believe that Slán Abhaile offers that opportunity.

Case Studies (Names and some details have been changed.)

Mr. R

Mr. R is 80 years old, married and lives with his wife, who has also not been well. Mr. R. has a chronic disability and following a crisis precipitated by an injury, was admitted into respite care. Because respite care is generally limited to a two week period in any one setting, and because Mr. R's wife was unable to care for him on her own following the injury, Mr. R. was moved from one residential facility to another over a period of 2-3 months. Long term residential care was being considered but both Mr. R and his wife expressed a strong desire for him to return home.
Slán Abhaile was suggested and the Community Social Worker for Older People was asked to visit to determine the feasibility of Mr. R going home with support services. The Medical Director in the residential facility where Mr. R was staying was pessimistic about the possibility, but largely as a result of Mr. and Mrs. R's strong determination and Slán Abhaile staff's efforts to respect their wishes, he did go home with Slán Abhaile services in place. He initially received one visit of 2 hours/day, 7 days/week from the home support worker who gets him up, helps with his personal care as well as assisting with meal preparation. Mr. R is now receiving 2 shorter visits a day as it was decided after several weeks that two visits per day would better meets his needs. He has now been at home for 7 months with Slán Abhaile support.

Mrs. S

Mrs. S is 91 and lives with her daughter and son-in-law, who works away from home quite a bit. She is heavily dependent, requires peg feeding and is not mobile, but Mrs. S's daughter is insistent that she wants to continue to care for her mother. Mrs. S was in receipt of community services, including personal care and RGN services before she was referred to Slán Abhaile, but increasingly, conventional services were not sufficient to meet her needs.
Her daughter was managing but with greater and greater difficulty. Since being referred to Slán Abhaile, Mrs. S now receives 2 visits per day and the home support worker helps her daughter with the lifting of Mrs. S and with her personal care (bathing and dressing). Mrs. S has been hospitalised once since being accepted for Slán Abhaile, but after a short hospital stay, she returned home again following treatment. It is unlikely that Mrs. S would have been able to remain living at home without the introduction of Slán Abhaile services.

Mrs. W

Mrs. W is a widow in her 90's who has lived alone since her husband died. Until fairly recently, she was never sick. As Mrs. W got older, her friends helped out when she needed assistance. A crisis arose when one of the friends who provided the most help became ill herself. The PHN arranged for Mrs. W to go into respite care and she was referred to Slán Abhaile from there. Within 10 days, Mrs. W was back home and receiving 2 visits a day (am and pm) 7 days a week from the Slán Abhaile home support worker. The worker helps her to get up in the morning, helps with personal care including bathing and dressing, and prepares her for bed at night. The worker also helps with meals on the days that Mrs. W does not receive Meals on Wheels. Her friend continues to cook her dinner on Wednesdays. Mrs. W accepted a two week respite stay recently but has refused to go to day care, saying that she doesn't want it or need it.

The case studies: summary

These three case studies illustrate Slán Abhaile's success in achieving stated objectives. In each of these cases, the older person concerned would, more than likely, have had to move into residential care fairly immediately if Slán Abhaile services were not offered, in spite of the older person and their carers' wishes to remain at home. The studies also show that the critical factor to making home support possible is not necessarily the number of services or the number of hours' service available (although this is also a factor) but rather the ability of service providers to provide help when it is most needed. Slán Abhaile services complement existing services and support informal carers by providing services to fill in service gaps. And finally, Slán Abhaile provides a valuable advocacy service to older people and their families whose wishes might otherwise carry less weight when decisions are being made about long-term care.

Cost Effectiveness of Slán Abhaile Services: summary of research carried out by Aoife Callan, Masters candidate in Economics, University College Galway.

This study evaluated and compared the costs of Slán Abhaile and associated community service costs, including informal care, with other forms of long-term care, namely nursing home care, hospital long-stay care and acute hospital care. The quantitative research undertaken confirms that Slán Abhaile is cost effective compared these options. The qualitative research analysis demonstrates the beneficial impacts of Slán Abhaile as reported by the clients, carers and health professionals who participated in the study. The evidence suggests that Slán Abhaile is achieving most of its stated objectives. Most importantly, Slán Abhaile supports older people to remain living at home, which is the strong preference of older people in Ireland. (NCAOP 2001) The study concludes with recommendations for the future development of Slán Abhaile services.

Definition of Client Categories:

For the purpose of this study, the 32 clients receiving Slán Abhaile services at the time of analysis (June 2004) were divided into two categories of dependency, using the Roper Logan Tierney model of assessment (Roper 2000). Group A contains ten clients in the medium to high physical dependency category whereas Group B contains twenty-two clients with cognitive impairment, psychiatric illness or psychological problems. Some of Group B also had physical dependency needs.

Cost of Slán Abhaile Services

Table 1: Average Weekly Cost of additional Slán Abhaile services by Dependency

Average Weekly Cost of Slán Abhaile services in Euro €	GROUP A	GROUP B
Rehabcare Costs: (Average weekly hours per client)	(9 hours)	(10 hours)
Average weekly cost per client	208.00	230.00
Referral costs (value of staff time):		
Community [1]	249.76	
Hospital [2]	2127.40	
Other [3]	237.40	
Total:	2614.56	
Average Weekly Referral Cost per Client	**20.43**	**20.43**
Community care costs: cost per client per week		
OT care area 1[4]	29.32	12.68
OT care area 2	19.54	11.53
OT assist	9.9	9.90
Equipment	24.95	8.00
Standby equip	1.46	1.46
Clerical Admin	3.25	3.25
Fixed Salary Costs		
Hospital Care Coordinator [5]	44.72	44.72
Community Care Coordinator	25.27	25.27
Set Up Costs		
Admin	1.55	1.55
Advertising	0.29	0.29
Av. Weekly Cost per Client	**388.74**	**364.28**

1. Includes GP, PHN, occupational therapist, physiotherapist, speech therapist and dietician.
2. Staff includes: a consultant, nurse, social worker, physiotherapist, occupational therapist, speech and language therapist and dietician. The cost per hour of the OT and OT assistant is obtained by dividing the yearly salary
   Note: All salaries include PRSI and 30 per cent overheads.
3. Other referrals are from sources such as outpatients department in St. Vincent's, Accident and Emergency and day hospitals. Staff included: Nurse, social worker, physiotherapist, occupational therapist, speech therapist and dietician.
4. The OT and assistant salaries (includes PRSI, overheads and travel) are divided by 46 weeks and divided by the number of clients which is 32
5. The community care coordinator is 0.5 whole time equivalent for Slán Abhaile, therefore only half of the wage. Both salaries include PRSI, overheads and travel. Salaries are divided by 46 weeks and divided by 32 clients.

Quantitative Research: Determination of Costs

Cost of making referrals and development of the Care Package

The cost of referral and development of the care package includes; the time that hospital staff devote to doing assessments and making referrals to Slán Abhaile, the time of the care coordinators (meeting with the older person and their carers, consulting with people making referrals, getting the necessary information from relevant health professionals etc.), and the time of Rehabcare staff who match home support workers with clients and assign care tasks. Rehabcare staff costs are included in the average weekly Rehabcare costs per client, and the average weekly per capita cost of care coordinators' time was obtained from their salaries. Referral costs were determined after consultation with staff involved to obtain estimates of the additional time staff spent with Slán Abhaile clients. On average, there are eleven hospital referrals per month and two referrals from community and other sources respectively.

Community care costs

Community costs mainly consist of estimates of the time that the occupational therapist and occupational therapy assistant devoted to Slán Abhaile clients. When Slán Abhaile began in May 2003, two registered general nurses were employed out of the Slán Abhaile budget but these costs have been excluded from the monthly service cost because the registered general nurses are not directly involved in Slán Abhaile service provision. Equipment costs were calculated for three randomly selected case studies from Group A and Group B. Set up costs includes time of people involved and advertising for recruitment averages over an assumed 15 year life period of the programme.

Total per capita additional costs of providing Slán Abhaile services

Taking the additional cost of providing Slán Abhaile services (including referral costs, care coordination, enhanced home support services, and OT services only) for each group, the average weekly cost per capita was calculated. An average weekly cost of €388 per week was calculated for Group A, whereas for Group B, the weekly cost was €364 per week. (See Table 1) Group B were not receiving as many occupational therapy hours or equipment as Group A and therefore have a slightly lower weekly cost.

Comparative cost of Slán Abhaile services

When we calculate only the cost of additional services funded and provided by Slán Abhaile, the weekly cost of Slán Abhaile compares very favourably to other options of care. For example, the average weekly cost of a contract bed is €687 in the East Coast Area Health Board and the average weekly cost of hospital long-stay care was €1500 per week at the time that the research was carried out. (See Table 2)

Cost of additional community services

If we add the cost of additional community services that are provided outside of Slán Abhaile, i.e. those that are not funded through the Slán Abhaile budget, in our calculation of how much it actually costs to support Slán Abhaile clients to remain living at home, the cost will obviously be higher. (See Table 2) These additional services include; respite care services, day care services, PHN services; GP and chiropody services. Data regarding costs was available by dependency group for respite care, and day care services and family care provision. Because of the lack of available data on the remaining services, estimated utilisation rates have been obtained from Hughes et al (2004) and are used in this study as a proxy for usage by Slán Abhaile clients.

Cost of informal carers' time

If we put an estimated value on the work that informal carers undertake on behalf of people on the Slán Abhaile project, the costs are even higher, as the biggest cost component of community care is the cost of informal carers' time. There are three methods for estimating the cost of family time; replacement cost approach, transfer payments approach and the opportunity cost approach. This study uses the opportunity cost approach, as favoured by many economists, since it attempts to place a monetary value on the alternative use of carer time. The average hourly opportunity cost based on a weighted value derived by Hughes et al (2004) is €7.20 per hour; for the purposes of this research, carers' time is valued at this rate. Table 2 presents a full average weekly cost per client by dependency which is calculated by adding together Slán Abhaile costs, the costs associated with additional community services and the value of care provided by informal carers.

Table 2: Average Weekly Cost per Client by Dependency in Euros

	Cost of SA services	SA costs + community care costs	SA service costs +community care costs + cost of carers' time	Private nursing home costs	Public long-term residential care costs	Acute hospital costs
Group A	388.74	977.74	1323.34	967.70	1500	4088
Group B	364.28	918.04	1458.04	876.00	1500	4088

1. The nursing home cost is the average cost of 20 randomly selected nursing homes in the ECAHB. It is assumed that older people would consume the same amount of community services as if they were living at home. Therefore, GP, Chiropody and hospital costs are added to the average cost of a nursing home.
2. Long-stay cost is an average weekly cost from three long-stay hospitals in the ECAHB.
3. Based on data provided by Hughes et al (2004). Based on the average weekly cost of acute hospitals but weighted to reflect the lower cost of geriatric medical care.

The average weekly cost of care, including additional Slán Abhaile services, other public and voluntary services as well as the estimated cost of carers' time ranges from €1323 for Group A to €1458 for Group B. The provision of Slán Abhaile services thus accounts for only 25 to 30 per cent of the total estimated costs. The opportunity cost of informal carers' time is responsible for the difference in cost of care for Group B who would require extra supervision because of cognitive deficits and the risks associated with leaving these clients at home alone. The public expenditure costs show the average weekly service costs excluding informal care time. With the cost of family care included, Slán Abhaile is more expensive than nursing home care but still compares favourably with hospital long stay care costs or especially to the cost of acute care.

Qualitative Research: feedback from health professionals, older people and carers

Health Professionals

The service providers from St. Vincent's University Hospital, Royal Hospital Donnybrook, the ECAHB and Rehabcare were asked to outline their experiences of the Slán Abhaile programme in structured interviews. Overall, Slán Abhaile is considered to be a very positive development which achieves most of the project's stated objectives. Below are quotations from health professionals interviewed;

Strengths of the Programme;

- Slán Abhaile makes efficient and effective use of community and hospital resources.
- Slán Abhaile provides a high quality of coordination between clinical, administration, community and hospital staff and management.
- It offers a realistic choice to older people who would otherwise be in long-term care by providing a coordinated service, with a client-centred needs led approach to care.
- It provides enormous support to carers.
- Overall it takes a holistic approach to care.
- It continues to be managed in the community by the community care coordinator after services have initially been organised and each case is continuously reviewed.
- There is a good team approach to the service which makes it flexible and responsive to the clients' needs.
- The security and social aspects of someone visiting each day are of enormous benefit. It gives people on the programme a more diverse and interactive lifestyle.
- Rehabcare is a huge strength of the programme. The care coordinators do not have to source home support workers themselves, which makes the service much more flexible and efficient.
- It provides quick access to equipment. People do not have to wait long periods of time for equipment or possibly delayed discharge as the equipment is more readily available.

Limitations of the Programme as perceived by Health Professionals;

- There can be long waiting lists and it reduces the hopes of all involved. It makes it difficult to decide whether to refer to the service or not because it raises expectations of the patient and they might never receive the service.
- There appears to be a long time between the point of referral and the time the person gets onto the service.
- There are some administration problems in that if one of the care coordinators is on leave there is no temporary cover.
- There are a huge amount of inappropriate referrals, which reduces the response time of the care coordinators.
- The recruitment of home support workers can be a limitation as expansion of care hours and the service rely on recruitment and availability of home support workers.
- There is no night cover, which restricts a lot of people being suitable for the service. In the future, some clients will need a night service and this should be taken into consideration.
- A huge inequity exists, as Slán Abhaile is not means-tested [and other available services, for example the Home Care Grant, are means-tested]. An inequity also exists in terms of the fact that residents of one Community Care Area cannot currently avail of the service due to resource limitations.

2. Clients: older people in receipt of Slán Abhaile services

Strengths of the programme;

The main benefits to clients of the programme, obtained through questionnaires and interviews, are:

- The additional support to remain living at home
- Being allowed to be discharged from hospital and live at home
- The security of knowing someone is visiting everyday
- The provision of a personal care service
- The provision and installation of equipment to allow improved mobility
- Improvement in quality of life

Older people in receipt of Slán Abhaile services were asked to rank the benefits of the programme in order of importance. The most highly regarded benefit of the Slán Abhaile programme is providing support so that they can remain living at home. Slán Abhaile also increases quality of life and provides an additional social aspect to clients' lives, which is greatly valued by clients.

Limitations of the programme;

A small number of the older people who participated in the research noted problems with individual workers around time-keeping but they were overall extremely positive in their remarks about the services they received.

3. Carers

Strengths of the Slán Abhaile programme are:

- Reduction in stress and strain of providing care
- Improvement in the quality of life
- Having psychological and emotional support
- Provision of a personal care service to the person they are caring for
- Having an extra person to help with physical care
- Being consulted about services
- Knowing the person they are caring for is safe and well looked after

Caring often entails mental and physical strain and any reduction in this for carers is perceived as a huge benefit. The majority of the carers who participated in the study indicated some form of improvement in their quality of life and reduction in the stress and strain of providing care as a result of the additional Slán Abhaile services. It should be noted that 25% carers who responded to the research questionnaire are themselves over age 65, while 37% are aged 55-65.

Recommendations for Future Development of Slán Abhaile

Several issues were identified in the interviews which require further attention:

- Slán Abhaile is not means-tested; eligibility is determined mainly by an assessment of physical dependency and need for services. This differs from other long-term care options including the Home Care Grant Scheme and the private nursing home subvention which all involve means testing. Therefore, huge inequities exist between people with similar needs in terms of their ability to access needed services. There should be some consistency applied across all schemes whether it is means testing or universal provision of all services and programmes available in the Health Board, regardless of financial circumstances.
- For development of Slán Abhaile type programmes, recruitment of sufficient numbers of home support workers is a challenge. Some career structure should be developed in order to attract more people into this type of work and to retain workers who have been recruited and trained. Continuity of care is currently diminished by the high turnover of staff. This is a global problem and not specific to Slán Abhaile.
- It is recommended that the programme be expanded to accommodate a greater number of older people. The programme is achieving its stated objectives however, it is currently a pilot programme and it is only achieving those on a relatively small scale. [Note: Slán Abhaile has been mainstreamed since January 2005 and service capacity is expected to increase from this year.]
- Data collection and recording should be improved in order to facilitate service monitoring and evaluation.
- There is the perception by some health professionals that more clarity is required around criteria for admission to the programme. This needs to be addressed. Some possible suggestions include information leaflets, better contact at meetings, improvements in communication and the development of some kind of filter system for referrals from the hospitals.

Appendix 1

Individual Service Plan / Slán Abhaile Programme

Name: Jane T
Address: Dublin 6
Age: 83 yrs

Date commenced on programme: 01/07/2004

Care Plan: 3 visits each day / 7days per week from Rehabcare worker except on Wednesday when client attends Day Care Centre & Sunday when she visits with family.

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Home Support Worker RehabCare to do domestic and personal care.	10am. 1.30pm. 6pm	10am. 1.30pm. 6pm.	9am. x 6pm.	10am. 1:30pm. 6pm.	10am. 1.30pm. 6pm.	10am. 1.30pm. 6pm.	10am. x 6pm.
Day Hospital/R.H.D. Transport collects @ 9.00a.m. on Wednesdays			Early visit to prepare for day care.				
Meals on Wheels	✓	✓	Meal @ Day Centre	✓	✓	All Meals Prep. By Home Support Worker.	Sunday Lunch With Niece & Family.

Informal Care: Niece visits 2 or 3 times each week to do the laundry / housework / shopping & collect prescription medication if required. She has not allocated any specific days for her visits as she has a young family and works a schedule around them.
Friends visit regularly.

Respite Care: Miss T. avails of Respite Care on a needs basis only to allow her niece to go on holiday. She books into a Nursing Home in Athlone Co. Westmeath. She is originally from there & joins a cousin who is a resident there. She pays the fee herself. She has refused to avail of respite care locally in Dublin.

Key Contacts:	
G.P. Dr. Kevin O'Neill	Tel. 4852000
Niece: Penelope Coyne	Tel. 3219871
RehabCare Manager: Mary Ryan	Tel. Mobile 085 3512559
Care Co-ordinator: Kate Bell	Tel. 6607349

Client has been referred to the following Health professionals:	**Seen & Assessed**
Consultant Geriatrician; Dr.Stephen Maxwell	12/05/2004 = S.V.U.H.
O.T. Vera Sinnott / Client known to service	27/5/2004 / Please see report /Awaiting list of equipment supplied & installed.
P.H.N.Catherine O'Brien/Client known to service previously.	03/06/2004: No nursing care required at this time.

Client has a Medical Card; Also in receipt of Chiropody & Dental Service.

Please refer to detailed Home Support Care Plan for assistance required with Personal Care / A.D.Ls

Appendix 2

Home Support Care Plan

Care Plan: Jane T:

Identified Care Need	Intervention Required	Frequency/Comment
Requires Assistance with:		
1. Personal Care	Assist with wash & personal hygiene	At each visit
2. Toileting	Assist with toileting	At each visit
3. Dressing	Assist with dressing & undressing	At each visit as required
4. Mobilisation	Hoist to be utilised for all transfers	As required
Family will attend to Housework; Shopping; Prescription & Medication.		
Carer to attend to the cleaning and general hygiene of her/his work area.		
I agree with the Care Plan as outlined above. Signed: Client / Family Member Care Co-ordinator: Date:		

Appendix 3

JOB DESCRIPTION: Care Coordinator

Position: WTE Community Care Co-ordinator (Older People's Services)

Reporting Relationships

The Community Care Co-ordinator will report to the Manager of Services for Older People in East Coast Area Health Board.

Role

The Community Care Co-ordinator will be responsible for working with the older person and her carers to develop a Service Plan, for co-ordinating, monitoring and reviewing the delivery of services to older people being discharged from hospital or to those living in the community who are at risk of going into long-term residential care. She/he will act as an advocate for the older person, to ensure that her wishes are respected and represented when decisions are being made, especially in cases where the older person cannot participate directly in decision-making.
The Co-ordinator will work closely with hospital and community care staff as well as with older people and their carers.

Responsibilities

To collaborate with hospital and community care staff, including the Public Health Nurses and home help/home care services, to develop and review individual care plans. To co-ordinate the delivery of needed services to older people in the community and manage the Home Care Grant Scheme.

To monitor service delivery and outcomes.

To facilitate case conferences, as appropriate, in order to develop/make necessary revisions to the care plan.

To be available to deal with difficulties that arise in the co-ordination of the required care packages to clients.

To advocate for the older person with regard to her/his wishes, requirements.

To meet with family members, where appropriate, so that their views and circumstances over time are taken into consideration in any care plans/changes in care plans.

To establish client satisfaction with the services being provided.

To ensure that all the older person's records and documentation are well written, comprehensive and produced on time, and that all information concerning the older person is help in strictest confidence and shared on a 'need to know' basis only.

To encourage links with local and voluntary groups who provide services to older people.

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

East Coast Area