Services for older people: review of the implementation of the ten year action plan for services for older people 1999-2008

Services for Older People

Review of the Implementation of the Ten Year Action Plan for Services for Older People 1999 - 2008

Eastern Regional Health Authority | October 2001

Eastern Regional Health Authority
Údarás Réigiúnach Sláinte an Oirthir

REVIEW GROUP MEMBERSHIP

Mo Flynn, Service Planner, Older People, ERHA (Chair)
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Ian Carter, Deputy CEO, St James Hospital
Celine Deane, Head Medical Social Worker, Beaumont Hospital
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Ginny Hanrahan, Clinical Services Manager, Beaumont Hospital
Paula Lawlor, Manager for Older People, SWAHB
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Eddie Matthews, Director of Services for Older Persons, NAHB
Barry McGinn, Information Analyst, ERHA
Mary McGuire, Manager for Older People, NAHB
Helen McHenry, Research Officer, ERHA
Dermot O'Shea, Consultant Physician, St. Vincent's Hospital
Patrick Smyth, CEO Leopardstown Park Hospital
Philip Weihe, GP, Primary Care Unit, ECAHB

A number of people were seconded into the sub groups.

Users and Carers sub group
Mary Prendergast, Public Health Nurse
Eimear Ryan, Manager for Older People, SWAHB
Carol Ivory, ERHA
Shiela Simmons, Irish Association of Older People
Niamh O'Daly, Irish Association of Older People
Sr. Stella Fitzpatrick, User

Acute Hospitals and Long Term Care Sub-group

Mater Hospital	Dr J Duggan, Consultant Care of the Elderly Physician Ms P. O Neill, Patient Services Officer Mr B.Conlan, Deputy Chief Executive Officer
Naas Hospital	Dr M. Smew, Consultant in General Medicine Mr L. Scully, Deputy Manager
St Columcilles Hospital	Ms B Slattery, Social Worker Ms B. Mennis, Assistant Director of Nursing Mr T. Mernagh, Hospital Manager

Beaumont Hospital	Dr. C. Donegan, Consultant Care of the Elderly Physician Ms G. Hanrahan, Clinical Services Co-ordinator
Tallaght Hospital	Dr D. O Neill, Consultant Care of the Elderly Physician Mr D. Rogan, Director of Programmes
James Connolly Memorial	Dr. O. Mc Carnan Consultant Care of the Elderly Dr. C. Donegan Consultant Care of the Elderly Mr. S. Brennan, Assistant Hospital Manager
St. Vincent's/St. Michael's Hospitals	Dr. D. O'Shea, Consultant Care of the Elderly Physician Mr. E. Fitzgerald, Deputy Chief Executive Officer
St James's Hospital	Dr J B.Walsh, Consultant Care of the Elderly Physician Dr C. Cunningham, Consultant Care of the Elderly Physician Ms. C. Murphy, Business Manager MedEl Directorate

Workshop

A one day workshop was held to finalise the recommendations. In addition to the review group members, the following people attended:

Jim Breslin, Senior Commissioner, ERHA
Colm Coffey, Manager for Older People, ECAHB
Janet Convery, Director of Services for Older People, ECAHB
Brenda Hannon, Director of Services for Older People, SWAHB
Patricia Kelly, Manager for Older People, NAHB
Angela Kerrigan, Senior Commissioner, ERHA
Tom Mahon, Manager for Older People, SWAHB
Valerie Nagle, Health Economist, ERHA
Louise McMahon, Senior Commissioner, ERHA
Mary O'Callaghan, Manager for Older People, SWAHB
Aileen O'Doherty, Irish Association for Older People
Jim O'Riordan, Manager for Older People, NAHB
Patricia Smith, Senior Human Resources, ERHA
Eimear Sweeney, Manager for Older People, SWAHB

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SERVICES FOR OLDER PEOPLE

1. BACKGROUND

The Eastern Regional Health Authority since its establishment on 1st March 2000 has statutory responsibility to plan, arrange for and oversee the provision of services in its functional areas.

A priority objective must be the provision of a seamless service through greater co-ordination between statutory and voluntary providers. The authority would also wish to engage fully with community groups involved with the care of older people.

The Health Strategy document 'Shaping a Healthier Future' published by the Department of Health and Children in 1994, set as a primary policy objective ' to maintain older people in dignity and independence at home, in accordance with the wishes of older people as expressed in many research studies'. It would be the Authority's intention to plan services so that the wishes of older people to remain in their homes and community can be met to the maximum extent possible.

The ERHA considered that it was timely to conduct a review of current service provision and future needs, in the light of the new organisational structures and the projected demographic changes.

The review was required to consider the implementation to date of the '**10 YEAR ACTION PLAN for Services for Older Persons 1999 – 2008**' and to comment on any other areas not covered by this plan. Mental health services for older people will be considered in a separate review.

The review aimed to identify existing good practice in the care of older people and the building blocks for an integrated care system across acute, community and primary care services.

1.1 TERMS OF REFERENCE

- To carry out a detailed assessment of the service requirements for older people over the next 10 years
- To advise on service developments to enable older people to maintain their health status, in particular, physical activity and diet
- To carry out a detailed assessment of community support services needed to enable older people to live at home in dignity and independence, which would include, home helps, public health nursing and other support services
- Make recommendations on how the quality of care provided, both residential (public and private) and community can be assessed and improved where necessary
- To consider the quality of the care pathway for older patients from their home through the acute hospital sector to their eventual discharge destination.
- To review the discharge policy for older patients within the region and arrangements for provision of follow-up care.
- To examine any gap in service provision and collaborative links and liaison with the health boards, local authorities, voluntary and private sector agencies.

1.2 METHODS

The aim of this review was to facilitate service improvement and development. The main objective was the identification of key strengths and weaknesses in local services.
The review process for this review was based upon evidence based processes for the conduct of strategic and service reviews and was underpinned by current research and standards for services for older people.

A variety of methods, both quantitative and qualitative were used and also multiple levels of description. This enabled the Authority to triangulate different sources of information and different perspectives on care, so as to identify the common themes and distinct viewpoints.

A multi-disciplinary group (23) representing all the main service providers, voluntary organisations and users and carers conducted the review. It split into five sub-groups, each with a specific care area to examine in more detail. Over the review period these groups met with approximately 200 people. These included medical, therapy, nursing, and administrative staff in community care areas, acute hospitals, residential and nursing units, both public and private, and independent organisations.

Users of the services were also consulted. In addition to this, research was undertaken into the functioning of the District Care Units. A number of professional groups also made submissions about their services.

The main sources of information used are as follows:

- Written information and documentation concerning operational data, policies and procedures, service profiles and provider plans and other relevant reports
- Questionnaires to users and staff
- Demographic data
- Meetings and focus groups with a range of practitioners, managers and representatives of different agencies, local service users and carers
- The review of care pathways through the health and social care system, using stroke as the trigger condition

1.3 ACKNOWLEDGEMENTS

The review was carried out by a large group of people who gave an incredible amount of time and energy to the process. For this the Authority is extremely grateful, as without their contribution this exercise would have been impossible.

Specific thanks to Jennifer Doran, Alastair Graham, Paula Lawlor, Barry McGinn and Helen McHenry for co-ordinating the work of the sub groups. Ian Carter commendably managed to get all of the acute hospitals together. Dr. Catherine Hayes collated all of the supporting evidence for stroke services without which it would have been very difficult to develop the proposals.

Our thanks also go to everyone involved in meetings with the review group. We were greatly helped by the time commitment given by so many staff and users/carers to meet with us and the open and frank contributions that they made to our discussions.

SECTION 2

MAIN FINDINGS

2. THE 10 YEAR PLAN: WHERE IS IT NOW?

The 10 Year Action Plan has now been in operation for three years. This has been used comprehensively by the three Area Boards to underpin their planning process and many of the initiatives outlined in it are in the process of development. It continues to be a robust document. However, the implementation of the plan has been adversely affected by a number of issues/events.

2.1 STAFFING

A considerable element of the plan required a substantial increase in staff both in acute and community services. While funding has been provided over the last couple of years for recruitment, major difficulties have been encountered in actually finding staff. The reasons for these problems are well known and do not need to be revisited here.

However, the impact on service development and indeed on maintaining existing levels of service has been profound. The actual infrastructure on which the 10 year plan was based has in many areas been weakened, if not actually eroded. This has been particularly evident in home care services, public health nursing and community therapies.

The position with many of the home care services such as home help and meals on wheels has been further compounded by the increasing incapacity of the voluntary provider organisations to meet existing service needs, let alone expand to meet rising demand. This has primarily been due to the age profile of the volunteers and in some cases lack of capital investment in facilities.

The closure of extended care and respite beds, through nursing shortages, has also impacted adversely on the system, although this situation is being currently addressed through overseas recruitment.

2.2 CAPITAL DEVELOPMENTS

The plan was particularly concerned with the need to provide new community units for older people and also to replace outdated and unsuitable accommodation. It recommended that 29 new units be constructed over the 10 year period. Since 1998, four units have come on line and construction of a fifth has commenced. Very little progress has been made in relation to the replacement or refurbishment of existing buildings, many of which pose health and safety risks as well as being unable to provide a quality environment for care.

The capacity of the Authority to fulfil these aspects of the plan are clearly linked to the availability of NDP and minor capital funding. Given the current NDP allocation, combined with building inflation, it is very unlikely that the original recommendations will be met. It is therefore incumbent upon the Authority to investigate other avenues for the procurement of funding for these developments.

SECTION 3

COMMUNITY CARE

The provision of a wide range of health and social care services in the community is essential if the aim of maintaining the majority of older people in their owns homes is to be achieved. A range of methods was used in order to gain an overall picture of current provision. These are as follows:

- Research was carried out into the current functioning of the District Care Units.
- Questionnaires were completed by each Area Health Board in relation to the provision of home helps, home care attendants, day care and respite services.
- Meetings were held with older peoples care groups in each community care area
- Written submissions were made by a variety of professional groups in the region

3. KEY ISSUES RAISED

3.1 ACCESS TO SERVICES

The review was concerned with whether older people have access to the full range of services to meet their needs. In particular it examined whether older people can readily access services offering a range of specialist expertise and if these services are easily accessible and available over 24 hours, 7 days a week, 365 days a year.

What was apparent from the outset is that access differs according to discipline. Some services (dietetics, speech and language therapy, clinical psychology) have so few staff that their ability to provide a service is severely limited.

For other community services access is generally through the Public Health Nurse, Hospital, or GP, or by ringing the Health Centre (usually leading to contact with the PHN). The Public Health Nurses would then refer an older person on to the relevant discipline, if required. However, even after initial referral users are faced with extensive waiting times.

Concerns were expressed about the lack of information for the public regarding the available services and more importantly there is a need to improve the route of access to make it more user friendly. However, in rural settings information on access is very well known through local knowledge.

The lack of transport is a major difficulty for older people in accessing services. Older people are often dependent on family, neighbours and friends to transport them when attending for hospital appointments. Transport of patients to out patient's appointments takes a full day for people from rural areas.

It is anticipated that the extension of eligibility to a medical card to all people over 70 will impact hugely on demand for services e.g. demand for appliances, chiropody and ophthalmic services.

3.2 PRIMARY CARE SERVICES

General Practice, as well as providing medical care, is also perceived as being the main access point to other services for older people or their carers. Many people when they are becoming increasingly frail rely on their GP for support and advice and it is therefore very important that the practice is working closely with PHNs and other community and acute services.

The Inner City Partnerships are models that work very well linking primary care and community services. The NICP will have occupational therapy, nursing and social work posts coming up which should further improve links.

However, links with GPs outside these partnerships are not as good with many being dependent on individual relationships. Generally links are better where the GP works from the local health centres. Of primary concern is the lack of formal liaison between community services and primary care. While nursing links are generally in place with primary care, other disciplines only link directly if there is a crisis.

In terms of screening for illnesses such as diabetes, incontinence and dementia, there is evidence to support early intervention. Systems need to be introduced to provide for screening services in primary care for older people in conjunction with health promotion activities such as self-help groups and ongoing education.

Currently a GP is more likely to refer to a hospital for services (including therapies) with the resulting impact of pushing primary care to hospitals or to private services. There are difficulties for those who cannot afford to pay for private services but may then do without a service resulting in long term problems.

While the age related services in the acute hospitals are seen as good there is the factor that many GPs are being deskilled in terms of specialist knowledge about the management of care of older people. There is a need to move towards a shared care model, especially with the current lack of community geriatrician sessions. This will require the provision of training facilities.

GPs have a major role to play in the provision of care to older people in nursing homes. This is a continuing and pressing problem. The majority of older people in nursing homes are very dependent and vulnerable and they are entitled to expect a high standard of care by GPs.

The increased GMS payment now being made for the care of nursing home patients should hopefully ensure that patients are provided with a higher standard of care than is currently being experienced. Many nursing home patients are being unnecessarily moved to acute hospital facilities. While there are nursing issues to be addressed around the administration of intra venous therapy or warfarin in nursing homes, GPs are in a position to take a lead role in supporting the development of such services.

3.3 CARE PLANNING

Individual care planning is essential for ensuring that complex care packages are designed and initiated to enable older people to be cared for in their own home, with the aim of maintaining their independence and preventing admission or re-admission to hospital.

A care plan outlines the aims and objectives of care for the individual, and what actions and interventions have been arranged in order to achieve them. Carer's needs are also assessed and arrangements are made to enable and support them in their role of caring for an older person.

The review found that it is expected that care planning would be done through the public health nursing service. After an initial assessment if follow-on services are required these are referred to the appropriate discipline. Otherwise care planning happens informally among disciplines. It is not currently practice to have case meetings and there are no procedures in place for review or follow up. The District Care Unit (DCU) is the only avenue available where structured care planning is carried out.

There are assessment meetings held for admission into the residential facilities and a multidisciplinary group does this. The residential facilities were task orientated but this model has been recently changed to focus on patient allocation. This is a positive step towards care planning for older persons.

3.4 SERVICE PROVISION

3.4.1 COMMUNITY SERVICES

All agencies identified the lack of an integrated, well-developed and responsive range of community services as a fundamental delay in the discharge of older persons. Specifically they pointed to a lack of home help services, care attendants and meals on wheels, all of which were acknowledged as pivotal in successfully maintaining older people within their own homes.

There was considerable variance in the range of services available across community care areas and indeed, differing levels of flexibility and responsiveness in the operation of these schemes.

There was a resounding belief that waiting lists for these services and their absence in particular geographical areas hindered timely discharges and, in some cases, removed the possibility of a discharge home. Participants acknowledged the pressure these services were under but also pointed to the effect that their current configuration, or lack thereof, had on re-admission rates to acute hospitals.

3.5 HOME HELP SERVICES

Community Care Area	1	2	3	4	5	6	7	8	9	10
No. of Home Help Organisations	2	1	6	2	3	2	8	6	1	4
No of Staff	106	64	355	266	389	218	451	431	1200	340
Weekly HH hours Average: Max: Total:	2205	800	698	4900				1744		4.5 20-25
Average nos waiting	46	52	25	0	0	0		40	20	15 - 20
Average waiting time	1week – 6 months	2-3 weeks	1 week – 8 weeks	0	0	0	1 week	1 week – 2 months	3 – 8 days	1 week – 6 months

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There were calls for greater flexibility in the role and remit of home help services in order that they could respond to need on a range of levels.

There are a number of major problems regarding the delivery of home help services in the region. These centre on the following areas:

- The shortage of home helps available in the work place due to the current economic climate. At present it is difficult to develop/expand the service due to staff shortages. The lack of a formal employment structure has a considerable impact. There is a need to improve the working conditions for home helps by offering a guaranteed number of hours paid work each week. Currently home helps are only paid for the exact number of hours worked with each client. There is no hourly rate paid for time taken travelling from one client to another, or when one of their clients is admitted to hospital or goes away on holidays.

- Unclear job descriptions and roles and functions

- The low ratio of home help organisers to the population and their age profile

- Unclear eligibility criteria for the service and inconsistent financial assessment procedures

- Training for home care attendants and home helps needs to be developed to be available when required

- Inability of organisations to provide a 7-day service or to cover holiday periods

- The welcomed increase in the hourly rate paid to home helps has resulted in home helps entering into the income tax system. This has resulted in some home helps reducing the number of hours worked so that they earn the same wage as they did before the increase. There may be other reasons for wishing to remain earning the same wage, e.g. Corporation/County Council rent would be increased with wage increase, medical card eligibility may be affected, state benefit of spouse/partner may be affected. However, this initial reaction should settle down and it is expected that the number of home helps available in the future should increase.

3.6 HOME CARE ATTENDANTS

Community Care Area	1	2	3	4	5	6	7	8	9	10
No of attendants	6	4 (2wte)	14 wte	8 (4 wte)	8 (4 wte)	29 (14.5 wte)	12 (6.5 wte)	11 (6.1 wte)	15 wte	11 (5.5 wte)
Hrs per client per week	1 -10	10	10 max (24 special cases)	10 –12	14	4.5		1 - 7		2
Waiting list	No list kept		No	Yes	No	Yes	Yes	No		Local to PHN

As can be seen from the above table home care attendants (HCAs) are currently a scarce resource and yet they are seen to have a key role in enabling an older person to remain at home. A proportion of the HCAs listed above work exclusively in day centres. HCAs in the community are undertaking many tasks previously carried out by RGNs.

There are inequalities in the service delivered due to the number of HCAs available across the region. The current service does not provide an evening or weekend service, which is vital as all day care centres are closed and healthcare services in general are reduced. For many carers the service is not sufficient to meet their needs.

The review found that there is universal agreement that their numbers should be increased in the community so services can be further developed e.g. twilight services and 24 hour community support services.

The two main issues for consideration are their conditions of employment and the relationship of this service to home helps.

HCAs have been employed since 1990, but many are still on temporary contracts. Their pay and structure needs to be examined especially regarding comparability with home helps. HCAs undergo specific training and generally carry out more complex tasks. However, many home helps informally carry out personal care when there are no HCA services available. What is evident is that neither service is adequately meeting the needs of the older population.

Consideration needs to be given to the possible amalgamation of home care attendants and home helps into one service. The development of a properly constructed personal care service with its own clear identity and role could do much to enhance the standing of home care services as well as strengthening its position as a key element of the overall provision for older people in the region.

3.7 NURSING

Against a backdrop of increasingly severe staff shortages, the liaison PHN service was acknowledged as working very well in most cases and their involvement in multi-disciplinary case conferences were very valuable. However, there was a feeling that, where possible, liaison should occur on a one to one basis rather than collecting paper referrals. Also an absence of an integrated community/acute patient administration system for tracking meant that patient's referred to the PHN had their details recorded manually.

The review found that the absence of a 24-hour nursing service within the community was a significant deficit. Twilight services were limited but were to be encouraged. It was also felt that the profile of gerontology could be raised in the community if appropriate funding and secondment arrangements could be made for the development of clinical nurse specialist posts.

It was acknowledged that PHNs are increasingly spending more time on child-health issues and that this changing trend had implications for the traditionally holistic approach taken by this profession toward the older patients under their care.

3.8 RGNs and TWILIGHT SERVICE

It is evident that PHNs are being used more for children and RGNs more for older persons and therefore it was felt that there is a need for more RGNs in the community to add to the base complement even if the vacancies would be difficult to fill.

An increase in the number of RGNs would help to keep people in the home, could provide a twilight service, be more available to the DCU and take on more early discharges. Earlier hospital discharges were giving rise to more work for RGNs such as wound care (which needs to be provided immediately with no waiting time).

A twilight service is currently only available in CCA 4 and has been in existence there since the1980s. It is provided up to 8pm and later in summer.

Some of the issues to be addressed if this service is to be further developed are:

- The shortage of RGN posts
- Need to renegotiate the RGNs hours so that nursing staff are available outside of 9-5, Monday -Friday
- Safety at night (need to explore use of taxis, working in pairs etc)
- Payment for nursing out of hours. Currently nurses are given time off in lieu and part payment for working weekends or evenings. The impact of this can be that 40% of the nursing complement is actually off on any one day

3.9 OCCUPATIONAL THERAPY

Occupational therapy is a fundamental element of the care for older people and its importance in enabling older people to maintain independence should not be underestimated. In recent years the paucity of staff and a number of working practices that have developed have meant that the service is not functioning as efficiently as desired.

A number of factors were found to have impeded a seamless discharge from the acute sector to the care of community occupational therapists

(a) There was considerable frustration around the process of the double-assessment of patients awaiting discharge to their own homes.
(b) No direct access to equipment in the community was cited repeatedly.
(c) The limited service available within the community given significant staff shortages hindered effective liaison and intelligence sharing around patients

Where liaison posts did exist, they worked well and gave rise to better working arrangements between acute and community. Where they did not, relationships were underdeveloped and frustration was compounded by unnecessary joint-visits, at the expense of an already over-burdened clinical workload.

Some therapists suggested that, in the absence of liaison posts, colleagues in community and acute's 'shadow' one another for a week or so to get a better understanding of each other's workload and perspective.

OT waiting times are generally longer than for physiotherapy and similarly waiting lists were made up of a majority of older people. In some areas it can take up to 3 years for small adaptations to be carried out. Other major issues are in relation to accessing equipment and the waiting times for suppliers.

3.10 PHYSIOTHERAPY

Waiting time for physiotherapy varies considerably and can be up to 3-4 months, with older people comprising about 70-80% of the general waiting list. CCA 4 has no community physiotherapy.

There were similar concerns raised by physiotherapy staff about the level of staffing in the community and in some cases their own staffing levels. The physiotherapist's also pointed to difficulties in sharing intelligence given the absence of liaison posts and the dearth of/limited service available in some areas. In some areas private physiotherapy sessions have been contracted in order to provide a basic service.

3.11 SPEECH and LANGUAGE THERAPY

Community speech and language therapy services to date have been directed towards children. A limited out patient service operates from some of the acute hospitals. A recognised need for a community based service for older persons was expressed by all agencies.

3.12 SOCIAL WORK

A significant deficiency identified at acute hospital level was the absence of link social workers for older people in the community. The lack of follow up in relation to the social and psychological needs of older patients post discharge was a concern for all hospitals. All departments of social work called for appropriate emotional support for patients and their families including bereavement counselling. They envisaged a role for the community social worker in crisis intervention, anticipatory care and after-care and could work with the PHNs and GPs in identifying 'at risk' patients and those requiring long-term care in the community. The first posts in this area are currently being advertised.

3.13 DIETETICS, PSYCHOLOGISTS

It was acknowledged that these elements are an important part of any multidisciplinary intervention within the community and in the acute hospital but they are currently limited. Area boards need to identify appropriate structures to establish these services on a more settled footing.

3.14 DAY CARE SERVICES

There are currently approximately 2000 day care places available in the region. While this may appear a large number of places, in reality many of these places are only available a couple of days a week. The range of services provided varies from one day care centre to another and this distinction is particular between the statutory and voluntary organisations.

In general, the following range of services is provided among the centres operating: - personal care, physiotherapy, occupational therapy, chiropody, social activities, meals, nursing care, health advice, social work service, aromatherapy, yoga, art classes, social outings, chaplaincy service, dancing and exercising to music. Transport to and from the Day Care Centre is provided at most centres.

There is a serious deficit of day care services in Wicklow, especially in North Wicklow. In the whole county, there are only two voluntary day care services; one in Carnew and a 3 days/week Alzheimer's Society day care centre in Avoca, which caters for 10 clients/day. North Wicklow has no statutory or voluntary day care services at all: there are a total of 12 places/day in private nursing homes in Bray that are financed by the health board and limited numbers of people can access the day centre in St. Joseph's Crinken Glen and in Loughlinstown Hospital. There are day hospital services in St. Colman's Hospital, Rathdrum and in Wicklow District Hospital.

Some agencies maintained that their day hospital was in some cases, supplementing the absence of appropriate day care facilities within their catchment area. All agencies cited the value of appropriate day care and respite services within their environs as fundamental in maintaining people in their own homes.

Appropriate day care support may provide a range of medical and social facilities to provide social interaction, respite facility for carers and ongoing maintenance and monitoring of health and functional level. The full range of day care models are required to provide the range of support required for older persons with varying degrees of dependency. These include: Active Retirement Clubs, Day Centres, Day Care Centres and Day Hospitals.

3.15 RESPITE CARE

Community Care Area	1	2	3	4	5	6	7	8	9	10
No of respite beds	2.5	50	13	4	6	32*	14*	1*	11	21 + private purchased
Level of respite available		2 weeks per year	2 weeks but can be extended	2 weeks, frequency depends on bed availability	V. limited due to staff shortages	2 – 6 weeks per year	2 weeks per year	2-4 weeks per year	On demand	Recurrent 2 week periods over year
Beds accessed through: GP Geriatrician			√ √(initial)	√	√	√ √(initial)	√ √	√		√ √
Waiting List	Yes	Yes	Yes	Yes	No	No	No	Yes	Yes	Yes
Weekend Respite			Yes							Yes
Home Respite			Yes (home first pilot)							Yes

* beds shared between 3 CCAs

As can be seen from the above table there is a general lack of respite facilities in the region and certainly not enough to meet the needs of the areas. Two weeks once a year is not enough for most clients but there is little flexibility in the system to provide a planned programme, outside of Area 10.

Certainly heavily dependent patients who are discharged requiring 2 people's service 7/52 for 1-3 hrs per day need to have a built in respite facility at time of discharge. Older people living in CCA 8 have to go to respite facilities outside of the area and as these beds are shared with other areas, places are limited.

There is an issue of a lack of places in North Wicklow. Clients have to travel to Rathdrum to access the service and many refuse because of the stigma of the poorhouse (St. Colman's was the local poorhouse) and because there is no public transport from North Wicklow to Rathdrum.

Currently waiting lists for respite do not appear to be pressing, but it is believed that there are a considerable number of people who could do with the service but don't know about it. In order to access most of these facilities a geriatrician must assess an older person and in reality a geriatric assessment may take several weeks. Many older people who require respite are not known to geriatricians, thus prolonging the process. There is a tendency in some areas for respite beds to turn into long stay beds, leading to a decrease in turnover rates for the beds. Hence the insistence on a geriatric assessment.

There was a recognised need for home respite especially for people with dementia. The pilot home respite service has highlighted the need and effectiveness of such a service. In some facilities people with a tendency to wander cannot be accommodated and there is generally considerable difficulty in accessing respite for Alzheimer patients. Physical premises in some of the older establishments such as Baggot St and Sir Patrick Dunn's limit client type.

3.16 REHABILITATION

3.16.1 ACUTE SERVICES

In the vast majority of cases, acute based rehabilitation services were limited. Staff shortages impacted hugely on the ability of the hospitals to provide the optimum rehabilitation inputs. Where dedicated teams for the care of the elderly existed, they provided an excellent service. Referrals to the age related services were limited by capacity as at any one time up to 1/3 of their beds could be occupied by patients awaiting extended care placements.

Access to the Royal Hospital Donnybrook, St.Mary's Hospital etc. was limited as many rehabilitation beds were occupied inappropriately. However steps have been taken over the last few months to address this situation and it has improved. The NRH rarely accepts patients over 65.
Rehabilitation is also available in some of the day hospitals but these services are very limited and are generally targeted towards people in crisis. When a patient requires a more comprehensive package they are inevitably admitted to hospital.

3.16.2 DISTRICT CARE UNIT

The District Care Unit provides the best community based rehabilitation option available. They meet the needs of a wide range of people and have facilitated the discharge home of many older people. A comprehensive study of the DCUs was undertaken in order to establish current provision.

While the DCUs are carrying out very valuable work their services are very stretched. The service has been hit by the current staff shortages with many of the therapists being required to work in the general service as well, thus reducing their availability for specialist rehabilitation. This has inevitably impacted on their ability to meet demand levels. Other parts of the DCU have continued working with patients for many months after their recommended discharge date because of the unavailability of other community support services. (Appendix 1)

Whilst all agencies cited the DCU as a valuable service, there was significant variance in agencies satisfaction with the responsiveness of the team: uncertainty about a patients acceptance to the care of the team prior to discharge and a time-lag of between 8 and 11 days for an initial visit following discharge were to the fore in some agencies experiences. This uncertainty about acceptance by the DCU meant the difference of families' agreement of a home discharge on occasions. There were also calls for flexibility in the assessment criteria used.

3.16.3 AMPUTEE SERVICE, JCMH

An Amputee service for people over 65yrs operates in JCMH. Currently 50% of referrals to this service are from outside ERHA. It could be developed as a national service.

Currently the service is experiencing difficulties with funding approval for limbs, which comes from the referring hospital or the patient's community care area. These delays impact on patients. Dedicated beds are required to facilitate a reduction in waiting time and the establishment of appropriate funding arrangements for limb fitting.

The review considered that there should be a range of flexible and responsive rehabilitation services, which offer older people opportunities to optimise their independence and maintain and/or improve their functional ability.

Rehabilitation services should cover domiciliary support, community rehabilitation schemes, rapid response emergency care, discharge and cushioned discharge arrangements, and intensive rehabilitation activities. Inpatient rehabilitation beds are used for this purpose. It is important that there are effective links with other specialist services in the hospital and between hospital and community services.

3.17 RECOMMENDATIONS

1. The ERHA in conjunction with the Area Boards needs to establish and agree basic principles around the provision of services for older people. In particular a commitment to developing and ultimately providing flexible 24 hour/7 day a week services should be incorporated into service plans.

2. Establish a personal care service within each Area Health Board incorporating home help and home care attendant services. In order to achieve this it will be necessary to:

- Agree principles for service delivery with the boards
- Audit current providers taking into account organisational feasibility, future options, cost effectiveness
- Identify providers through partnership arrangements, service contracts and the private sector
- Address IR issues re employment status, job equity, terms and conditions and training opportunities
- Identify process for assessment and review of service provision

3. With the care group approach and the DCU model as a basis, establish specialist community services for older people.

- A care services group will have responsibility for the assessment, care planning and management, review and placement of older people. The group will have open membership, but fundamental to it shall be ring-fenced posts for older people. A manager will have responsibility for the co-ordination of the work of the group. The group will act as the entry point to all services (except personal care) and will develop close working relationships with primary and secondary care services. To achieve this it will be necessary to:
    a. Agree composition and objectives of the care groups
    b. Address professional issues particularly where staff shortages require more flexibility in jobs and responsibilities and an eradication of duplication of assessment
    c. Audit existing community staff and job functions
    d. Undertake an organisational impact analysis

- The District Care Units should be enhanced with staff appointed solely to those posts. Its role in providing rehabilitation services should be paramount, with any current chronic care service transferred to the personal care section. The DCU should aim to further develop, in conjunction with Home First an early discharge programme.

- Opportunities to develop rapid response services so as to avoid hospital admission for older people should be explored and developed when the above groupings are in place

4. Consider specialist nursing posts for older people. This has in some ways been happening by default with more Asst Director PHNs taking on this role. However this needs to be expanded into the general service with more emphasis on specialist clinical intervention.

5. Current disincentives to flexible working arrangements for nurses need to be addressed such as payment for out of hours and weekend working

6. Expand respite services to include the provision of home respite and increase the number of respite places provided.

7. Improved transport arrangements should be put in place

8. Elder abuse and management of it need to be given more attention and resourced.

9. Well elderly clinics, exercise groups, health promotion, involving schools in the active age concept, hypothermia programme, accident prevention all need to become established programmes within the boards. Many of these programmes have been run in the past but funding has not continued. Health promotion is essential for maintaining older peoples independence

10. Capital investment in day care facilities is required to ensure the expansion of the services

SECTION 4

ACUTE CARE

Effective discharge planning is central to the delivery of seamless, integrated, patient-centred care. The achievement of a successful care-pathway is a multi-facetted and cross-functional process that involves close working relationships amongst health professionals, ongoing consultation, counselling and advice for patients and carers and a thorough knowledge of roles and responsibilities in effecting discharge.

4. METHODOLOGY

The Acute Care/Rehabilitation Group was charged with examining the following:

1. The current discharge protocols, systems and process in place
2. The obstacles impeding timely discharge
3. The various liaison arrangements in operation and their effectiveness
4. Identify models of best practice/recommendations

4.1 THE DISCHARGE PROCESS

4.2 CURRENT DISCHARGE ARRANGEMENTS

It was widely acknowledged that within agencies, dedicated Departments of Geriatric Medicine or Age Related Health Care provided the 'Gold Standard' service for older persons.
Multi-disciplinary interventions were generally assured within the Department. However outside, generic rehabilitation services were limited.

Delays in referrals for rehabilitative input resulted in protracted length of stay. In some cases referrals for Multi-Disciplinary Team input were made when the patient had been diagnosed medically fit by the admitting consultant and when it was perceived that long term care was the only option for the patient.

The majority of agencies already operate a waiting list prioritised on need for generic rehabilitation services. In many cases this contributed to discharge without rehabilitation.

In many cases, this need also prompted the first referral to the Geriatric Service.
The review recommends that early referral to the Geriatric Service (where appropriate) be encouraged so that the rehabilitative capacity of the patient be maximised.

Discharge planning beginning as early as possible was the desired standard though both internal and external factors militated against timely discharge.

4.3 INTERNAL OBSTACLES TO DISCHARGE

The absence of medical input to case conferences in particular agencies caused concern amongst participants. This often led to redundant care planning and confusion.
In a number of hospitals there were delays in referral to the multi-disciplinary team (MDT). Early referral is vital and the MDTs need to have flexibility in accepting referrals from different disciplines.

Many agencies pointed to the absence of 'ring-fenced beds' for older people as a contributing factor. A view that beds for older people were 'expendable' was a common response. Almost all pointed to a reduction in their bed cohort over the years.
The review felt that protected care of the elderly beds were of vital necessity if the philosophy of geriatric medicine were to take root, both for its patients and its staff.

In the majority of agencies, patients over 65 (where applicable) were not automatically identified on admission as requiring a geriatric consult. The referral system was computerised in some agencies but not in the majority.

The absence of a fully staffed MDT was a critical issue for some agencies. The review group recommends that ideally the MDT should have physiotherapy, occupational therapy, speech and language, social work, psychological and dietetic input.

All disciplines involved in the MDT identified the lack of social work service in the community as a major block to comprehensive discharge planning and ongoing psychosocial support for both patients and their carers. Discharge Plans coordinated in the hospital require a community based social work service to maintain continuity and support.

4.4 EXTERNAL OBSTACLES

The group felt it necessary to distinguish between obstacles to discharge home and discharge to a long-term care placement in a residential setting.

A. Discharge Home

The delivery and availability of community services affected delays in discharging patients home. These were outlined in Section 3.

B. Discharge to Long-Term Care

All agencies pointed to the scarcity of extended care beds and difficulties in accessing contract beds as a real problem in effecting a timely discharge for their patients.

There was confusion around eligibility criteria for contract beds with most agencies convinced that comparatively, they were 'worse off' than their contemporaries in terms of their allocation. Many participants felt that private nursing homes 'cherry-picked' the
patients and often this led to several visits before a 'suitable' candidate was found. The principal issues were

- the need to accelerate the re-opening of closed public beds and the fast-tracking of envisaged new developments in this regard
- that there be an agreed/common assessment tool used in establishing the appropriateness of referrals to all facilities, public, private and voluntary

- that this assessment tool has global clinical recognition and that levels of dependency are agreed by all with funding matched to dependency.

- that the allocation of all public/voluntary/private beds be done centrally in a transparent and equitable fashion on an Area Board basis, with a percentage of beds earmarked, in rotation for community admissions
- that consideration be given to the levels of care currently available within private nursing homes in contract beds with a view to community/hospital personnel providing services here on an outreach basis including paramedical, chiropody, inputs and appliances
- that these contract beds be contracted on the basis of the individual rather than the bed
- that data to support the placement of patients be shared amongst hospital and community on a periodic basis in a timely fashion.

4.5 DISCHARGE POLICY

Six agencies had some form of a written discharge policy, some of which were under review.

The review group recommends that all agencies should have a current discharge policy, available to all stakeholders and understood fully by hospital staff. The policy should comprise the following elements:

- Recognition of the necessity to continually inform and update patients/carers of changing care-plans
- Explicit identification of the role of each profession in the discharge process.
- A 'check-list' of mandatory inputs that must be in place prior to discharging a patient i.e. discharge summaries etc., post-discharge care
- Strict protocols for notifying GPs of discharged patients
- All patients should be aware of their aftercare plan on discharge, complete with contact details of PHN, home help, hospital social work etc. Ideally they should be aware of the times, frequency of follow-up visits, prior to discharge, possibly in a personalised explanatory leaflet.
- Ultimately, the review group supports the notion of a 'patient passport': transferable records, which the patient has in his/her possession.

4.6 DAY HOSPITAL

The Day Hospital provides an excellent model for assessment, consultation, rehabilitation, and follow up after discharge when fully operational. In the majority of the acute hospitals the day hospital operated five days per week. However, many are badly resourced both in terms of physical space, equipment and staff such as a dedicated medical registrar and MDT in place, thus draining the resources of the geriatric rehabilitation team. It is recommended that as a matter of urgency day hospitals be established in all acute hospitals, which should operate to full capacity with its own dedicated multidisciplinary team. The availability of day hospitals permits the full diagnostic workup and treatment of a high percentage of new patients presenting to the service and also permits the earlier discharge and post discharge care and rehabilitation of many the inpatients. An active day hospital on an acute campus has the advantages of providing all the treatment and work-up facilities that are required thus enabling maximal utilitisation of the inpatient beds in the hospital. It provides a viable alternative to accident and emergency departments for older people in need of health services.

Benefits to the hospital

- Prevention of admission and re-admission.
- Better utilization of acute beds.
- Facilitate discharge (and hence reducing length of stay). Linking into the discharge planning process.

- Provision of multidisciplinary rehabilitation e.g. patients with falls and postural instability
- Pivotal link at interface between the hospital and the community in the provision of services for older people

The establishment of day hospitals, bridging the interface between the hospital and the community, will serve the aspiration of an increasing older population to remain in their own homes for as long as possible. Some consideration needs to be given to the development of more integrated service centres for older people that will incorporate the facilities of the day hospital with more general medical and social care services. This was a view advocated by some of those consulted during the review.

4.7 RECOMMENDATIONS

1. The development of an effective 24-hour responsive range of community services, modelled on the principals of the 'Home First' pilot in Beaumont hospital. In addition, emphasis should also be placed on the provision of minimum supports, which are very scarce.

2. Enhanced DCU service with pre discharge decision regarding acceptance and immediate response assured.

3. The acceleration of the appointment of Discharge Co-ordinators (as per the recommendations of the 'Final Report of the Review of Accident & Emergency Services in the Eastern Region').

4. In parallel, the establishment of agreed protocols and procedures for discharge planning across the region with the computerisation of the discharge planning system to support this. Where possible, this system should identify potential delays in discharge on admission and be used to refer patient for multi-disciplinary interventions.

5. Provision of liaison posts in all Community Care Areas across disciplines in order to facilitate better working relationships. Integrated information system to support this electronically generating discharge letters etc. In the interim, allowing counterparts in the community and the hospitals to shadow one other.

6. Transparent allocation of extended care places based on agreed assessment criteria. This to include contract beds. Consideration to be given to levels of care currently available within Private Nursing Homes.

7. Site visits to proposed nursing home places with member of MDT and patient (where possible) to introduce patient to new environment.

8. Explore possibility of using cost of contract bed or subvention to secure private home care.

9. The extension of day hospital services within the region with fully staffed MDT interventions. Where possible, should be some continuity between staff providing Geriatric services on in-patient basis and in day hospital. Explore possibility of taking bloods etc. prior to admission for assessment.

10. Protected 'Care of the Elderly beds'

11. The bed norms for acute assessment and secondary rehabilitation outlined in the '10 Year Action Plan' should be re-examined in light of the population increase.

SECTION 5

STROKE SERVICES

The review was concerned with reviewing the care pathway for patients with stroke as they present in the health care system. Many different bodies had highlighted the inadequacy of stroke specific services within the ERHA.

5. METHODS

- Literature review and needs assessment (Appendix 11)
- Geriatricians submission to the National Health Strategy
- Meetings with hospital and community teams
- Meetings with the voluntary sector

5.1 MORBIDITY

There were 1854 cases where stroke was recorded as the principal diagnosis (using ICD codes 430-4 and 436) admitted to hospitals in the ERHA region in 1999, see table.

No of discharges with Stroke as Principal Diagnosis in (patients aged 65+) by Acute Hospital within Eastern Region (HIPE data 1999)

Hospitals	Males	Females	Total
Beaumont	200	168	368
JCM	33	38	71
Mater	128	151	279
St James's	191	197	388
St Vincent's	153	190	343
AMNCH	61	73	134
Loughlinstown	31	53	84
Naas	50	53	103
St Michael's	33	49	82
Other	1	1	2
Total	**881**	**973**	**1854**

In addition there were 875 cases in those aged <65 years in the ERHA region, yielding 2729 cases for all ages.

5.2 KEY FINDINGS ON CURRENT STROKE PROVISION IN THE ERHA

- The care pathway for people with stroke is very different in each geographical area with the resulting impact on mortality and morbidity.
- There are few protocols in place in the hospitals for the immediate management of a patient with stroke. The lack of speech and language therapy means that some patients can wait for days for a swallowing assessment. This results in a number of people remaining on a drip unnecessarily. In AMNCH and St Vincent's nurses have been trained to carry out swallowing assessments.

- After initial treatment most patients are admitted to any available bed rather than a specialist facility. Only AMNCH has 10 specialist beds for stroke patients. The Mater plan on establishing 6 specialist stroke beds from December 2001. Some of the hospitals have put in place rudimentary procedures such as trawling through the hospital to find stroke patients and then trying to move them all to the same ward.
- There is very little multi-disciplinary assessment available, and in some hospitals there are no rehabilitation services. St Vincent's established a stroke rehabilitation team 10 years ago, which is effective. However, there is inconsistency in referral patterns to the team.
- Patients under 65 have even less access to specialist rehabilitation than older people. Baggot St community team tries to meet these needs.
- Primary care services for stroke patients are very limited and little has been put in place for secondary rehabilitation. Patients who experience TIAs (trans ischaemic attacks) are frequently not referred for scans or specialist opinion at an early enough point.
- Support services for patients and families are provided by the volunteer stroke scheme, but this service is very underfunded.

5.3 BED REQUIREMENTS

The typical district of 250,000 is likely to require about 30 beds to the care of stroke victims who have recently had a stroke.

Bed requirements in the ERHA region based on an estimated requirement of 30 beds per 250,000

Year	ERHA total population	Est. no. of beds
1996	1,295,939	155
2001	1,412,468	170
2006	1,508,848	180
2011	1,586,015	190

Bed requirements will be higher in the East Coast region relative to the other two boards.

5.4 STROKE UNIT DEVELOPMENT

A stroke unit is a service where the acute and rehabilitation care of the patient with stroke is under the direct care of a specialist with training and expertise in stroke management, in conjunction with a dedicated interdisciplinary team.
Although this does not of necessity imply a distinct geographical location for the service, it is preferable to group as much of the service as possible into one area, so as to facilitate a philosophy of care, specialist nursing care and efficient and directed working of the interdisciplinary team.

There is sufficient evidence to support the setting up of well organised services for acute stroke patients. The evidence indicates that these services should provide comprehensive care centred on an integrated multidisciplinary team who have a specialist interest in stroke rehabilitation. The way in which this is achieved is likely to reflect local circumstances. Stroke unit care does not apparently increase the time spent in hospital.

The stroke unit approach places the patient under the direct care of a team led by a physician with specialist expertise in stroke. Acute treatment and rehabilitation should ideally take place as part of a continuum. In the Irish setting, stroke specialisation takes place among geriatricians, rehabilitationists and neurologists. The precise contribution of each specialty will relate to local resources and strategic interests.

5.5 RECOMMENDATIONS FOR ACUTE TREATMENT AND REHABILITATION IN HOSPITAL

The Stroke Council document makes a number of recommendations re the following:

- the care of all patients with stroke should be under the care of an interdisciplinary team led by a physician with specialist training in stroke, in the setting of a stroke unit, with a clearly defined continuum of care
- all patients with stroke should have access to timely CT/MR scanning, as well as modalities such carotid duplex scanning. Senior personnel need to be trained in the reading of CT scans in acute stroke
- procedures for thrombolysis in Irish hospitals need to be developed in conjunction with primary care if thrombolysis is licensed for the treatment of acute ischaemic stroke.

5.6 REHABILITATION IN THE COMMUNITY

The National Clinical guidelines for Stroke in the UK recommend the following:

1. Specialist stroke services can be delivered to patients, after the acute phase, equally effectively in hospital or in the community, provided that the patient can transfer from bed to chair before going home

2. Specialist day hospital rehabilitation or specialist domiciliary rehabilitation can be offered to outpatients with equal effect

3. Each district conducts a needs assessment exercise to determine the level of care so that all stroke patients in the area have access to the same standard of care

4. Patients not admitted to hospital should be seen by a specialist rehabilitation team

Stroke-specific community rehabilitation is of limited availability at present. The Stroke Council recommends the following in relation to community rehabilitation:

- Full out-patient rehabilitation should be made available for all patients of all ages in each Area Health Board area, on the basis of 250-300 patients discharged to the community/year per 250,000 population
- Transportation should be made available for Out-patient care
- Community services should be developed to encompass the full interdisciplinary team and appropriately supported to enable teamwork. Current models in Baggot St and the District Care Units should be enhanced
- Other strategies should be developed for rural areas where distances are greater and domiciliary services may be more appropriate
- The activities of the Volunteer Stroke Scheme should be developed and supported
- On-going therapy needs of those in long-term care must be fully supported

SECTION 6

EXTENDED CARE SERVICES

This chapter reflects two different components of the provision of extended care services. Firstly, findings are presented from the examination of the process for assessment and access to extended/long term care for older people. In the second section of this chapter a detailed analysis of the range of extended care facilities in the region is provided.

In relation to the assessment and access arrangements the following areas were considered:

- identification of current requirement for extended/long term care
- implications if requirements for extended/long term care not met
- Access and eligibility for extended/long term placements
- criteria and methodology used by hospitals to identify and transfer patients to extended/long term care placements
- key problems with current operational arrangements relating to selection and placement of older patients in extended/long term care placements
- Initiatives that could be developed to improve current status quo (including initiatives operating on a pilot basis, currently being developed, or that could be adapted from institutions external to ERHA).

6. IDENTIFICATION OF CURRENT REQUIREMENTS FOR EXTENDED CARE PLACEMENTS

6.1 Table 1 summarises the current monthly requirements for extended/long term care placements for older people.

Table 1

Beaumont	Mater	Naas	SCH	Tallaght	SVH|SMH	JCMH	SJH	TOTAL
25	20	16	20	12	25	15	26	149

This is based on current requirement to effect timely transfer and thereby minimise inappropriate acute bed occupancy.
It is recognised that this requirement would be significantly reduced if initiatives identified previously in **Section 3 and 4** were implemented.

There are implications for hospitals if the requirements for extended/long term care are not met. **6.2 Table 2** identifies the number of patients aged 65+ who were medically assessed as being appropriate for transfer to extended/long term care facilities and subsequent % of inappropriate acute bed occupancy. [source ***"A& E Hospital Returns"*** (ERHA) w/e 08.07.01]

TABLE 2

HOSPITAL	Beaumont	Mater	Naas	SCH	AMNCH	SVH	JCM	SJH	Total
Long term Care Patients	52*	58	7	13	28	14	19	46	237
Acute bed Complement	654	469	108	135	418	471	153	510	2918
% Inappropriate Occupancy	5%	11%	6%	9%	7%	3%	12%	9%	8%

[* includes 20 patients who are in contract beds sourced by Beaumont Hospital to release acute beds]

For the six month period 07.01.01 – 08.07.01 an average of 7% of ERHA total acute bed compliment were occupied by patients awaiting a long-term placement. The total bed days inappropriately occupied for the period were 35838.

In terms of implication for hospitals it is generally considered that the current level of Emergency Department admissions and ongoing delay in transferring older patients were the main causal factors for elective inpatient cancellations. The total cancellations for period (w/e 07.01.01 – 08.07.01) based on a weekly average of 223 were 3798.
Based on an average length of stay range of 6–9 days, the bed day requirement to accommodate this group of patients is (alos 6 days) 22788 – 34182 (alos 9 days).

Accordingly it would be inappropriate to assume a straightforward replacement - inappropriate bed day occupancy/elective inpatient bed day requirement and ignore the impact of Emergency Department admissions. The review identified that it is likely that the majority of elective patients cancelled for this period could have been admitted, should there have been a rapidly accessible alternative accommodation facility for older patients assessed as having completed the acute phase of their treatment.

6.3 CRITERIA AND METHODOLOGY USED BY HOSPITALS TO IDENTIFY AND TRANSFER PATIENTS

Medical assessment in terms of identifying appropriateness for transfer to extended/long term care facility is undertaken by Care of the Elderly Physicians and the multi-disciplinary team with the exception of Naas where the Consultant General Physician undertakes assessment.

The assessment includes current medical status, previous medical history, ability in terms of ADL's and potential for rehabilitation/physical/mental improvements. The available family support, community support, patient wishes and current accommodation status is also considered. Currently no formal financial assessment is made by the hospital.

Patients are identified for transfer to beds authorised/identified by the relevant Area Health Board. The criteria for selection by hospital are:

- length of time waiting (from time of initial identification)
- geographical proximity of patients/relatives residence to extended care bed
- patient need i.e. hospital or contract bed in nursing home

The criteria for acceptance of patients by the designated nursing home/public unit (based on unit staff visiting hospital to assess patients) are:

- gender mix [within unit]
- dependency of patient
- MRSA status
- patients / family accepting designated unit

Patients are routinely given two choices and the overall process (bed identified ➔ patient transferred) can often take 7 – 14 days

The following key problems with current operational arrangements were identified by the acute hospitals in the region. These views are not necessarily in line with the policy operated by the Area Boards, but they are important in identifying the different perceptions regarding the management and usage of public and contract beds. They also contain significant recommendations in terms of addressing the existing difficulties within the system.

6.4 Access to extended/long term care beds

- insufficient availability of placements to meet current ongoing requirement
- absence of a systematic proactive approach to provision of extended care/contract beds.
- no agreed / negotiated hospital specific annual / monthly quota identified for extended / long term care beds
- instead – ad hoc reactive response to hospital requirements
- no transparency as to how beds are allocated to specific hospitals
- placements authorised are routinely geographically inappropriate / difficult to access for patient's family.
- patients are not accepted by Units (despite being bed authorised by Area Health Board) unless personnel from designated unit have first assessed them. [This process routinely takes > 1 week.]
- the cost of private nursing home care in the ERHA area means that patients will be forced to use the public system increasingly, as will the provision of medical cards to all people > 70, resulting in a likely increase in demand
- Absence of (readily available) information relating to extended / long term care facilities combined with current allocation / placement methodology and hospital's requirement to ensure prompt transfer, largely negates hospital's ability to provide advance / timely and clear information relating to selected extended / long term care facility

6.5 SERVICE PROVISION

The existing extended/long term care facilities provide *"support"* and do not generally provide or resource rehabilitation services. This is particularly important in terms of patients (potentially) regaining independence skills necessary for a less supportive environment or even return home.

The extended/long term care units routinely do not accept high dependency, immobile, confused patients or patients with MRSA, regardless of the contract negotiated by the health board.

The lack of transport facilities for this patient group is an issue particularly where there are unnecessary delays often causing distress to patients and their families. It is perceived that older patients are often not seen as a priority by transport services.

It is often unclear what medical support will be provided by the nursing home. This results in concerns relating to medical treatment continuity. When a patient becomes ill and requires hospital admission, (particularly when the patient has been accommodated in a facility outside of the hospital's own catchment area), it is unclear as to which hospital the patient should be readmitted to. Routinely the patient is admitted to the nearest hospital.

The absence of a systematic ongoing review mechanism for patients transferred to extended/long term facilities (particularly private nursing homes) is of concern. There are no opportunities for considering their transfer to less supportive accommodation or home, if their level of dependency decreases.
There is also no formal review of patient/patient's family satisfaction with placement.

6.6 Initiatives that could be developed

(including initiatives operating on a pilot basis, currently being developed or that could be adapted from institutions external to ERHA.)

6.6.1 Provision of extended / long term care facilities

The Group identified that the primary requirement was the provision of sufficient appropriate extended/long term care placements. Placement value should form an integral part of the area health board provider plan and should be based on the requirement identified by the hospital and be specific for each hospital where the necessary hospital requirement can be validated.
Beds should routinely be within a hospital's own catchment area and/or close to a patient's residence. This should enable appropriate annual/monthly placement projections to be identified and a degree of synergy to develop between the hospital and extended/long term care facility, which is not currently present. The Group recognise that this will require additional funding and the existing area health board extended care facilities to resume normal operations.

The Group recommends that a Discharge Coordinator (Older Patients) be appointed for each hospital, thereby ensuring appropriate, prompt and informed transfer to extended care facilities (this initiative is currently being piloted at St. James's).

6.6.2 Alternatives to extended care placements

The Group identified that in the absence of alternative community facilities/services and/or appropriate levels of support for the patient at home many patients were being inappropriately listed and subsequently transferred to extended / long term care facilities.

Three key facilities/services, which would significantly reduce reliance on extended care facilities, are identified as follows:

1. provision of sheltered housing

2. enhanced provision of and direct access to rehabilitation services. The aim being to ensure restoration of sufficient skills (ADL's) / ability to return home / be appropriate for sheltered housing
3. enhanced provision of support services necessary for patient to return home and stay there. A specific initiative is the Home First Project currently ongoing in Beaumont Hospital in conjunction with the Northern Area Health Board and funded by the ERHA. This project aims to offer alternative options to nursing home care to patients and their carers when going home. It is a needs led service and not service driven. In conjunction with a private provider, care packages to meet the person's needs are put in place to support remaining at home. The pilot is being carefully researched and should be reporting next year.

The Group recognise that for these initiatives to be successful in terms of reducing reliance on extended / long term care facilities they would need to be rapidly accessible.

6.6.3 Prevention of Primary Acute Hospital admission

The Group also identified the need to develop initiatives that were designed to prevent or reduce the current level of older persons being admitted to acute hospitals. These initiatives centred on the following areas:

- enhanced respite facilities - including where appropriate direct admission to extended / long term care facilities from community / home

- rehabilitation services, including where appropriate, direct access to rehabilitation services from community

- Day Hospital facilities

- Development of a Falls Clinic
  Development of a service designed to minimise current unacceptably high level of acute admissions arising from falls. [Pilot exercise developed at St James's, validated by ERHA and awaiting confirmation of funding]

- Development of an Osteoporosis Clinic Service
  The impact of osteoporosis and necessary methodologies to reduce its impact, particularly in terms of reducing acute hospital admissions is well documented [Pilot exercise developed at St James's, validated by ERHA and awaiting confirmation of funding]

6.6.4 Planning and integration of services for older people

A Task Force should be established within each area health board, comprising appropriate representation from the area health board, acute hospitals and other relevant local authorities with a remit to develop a local comprehensive strategy for the management of older people within the area health board. The areas to be considered would be:

- An agreed level of extended care facilities required

- To develop and effect joint initiatives designed to ensure appropriate alternatives to extended / long term care facilities. This will include identification of appropriate age related medicine facilities

- To develop necessary audit methodologies and appropriate performance indicators for older patients managed within hospital and community sectors. This would include evaluation of initiatives introduced and ongoing usage of extended care facilities

6.7 LONG STAY HOSPITALS/HOMES, COMMUNITY UNITS AND WELFARE HOMES

6.8 Methodology

6.8.1 Quantitative

Questionnaires were sent out to each long stay hospital/home, community unit and welfare home. Questions were asked on the following areas:

1. Admission/eligibility criteria
2. Services available to hospital/home
3. Quality initiatives to evaluate the service
4. Guidelines for staff to maximise quality of care
5. Protocols/guidelines for elderly abuse
6. Regular reviews of residents

Under each of these areas, hospitals/homes were asked to indicate what they had done in each area, what barriers they had encountered and further suggestions in the area.

6.8.2 Qualitative

- Meetings were set up with appropriate personnel from the community units and welfare homes to investigate areas that are specific to these services
- Focus group and in-depth interviews were conducted with over 30 residents from long stay hospitals/homes, community units and welfare homes to ascertain how the residents felt about their service and to ask them to make any suggestions/recommendations to improve the service

6.9 ACCESS AND ELIGIBILITY TO NURSING AND EXTENDED CARE BEDS

6.9.1 Long stay hospital/homes

Most have specified admission criteria. These are usually basic requirements such as:

- Patients must be over 65
- Patients have to be assessed by a geriatrician

- Patients must reside within a particular community care area or be referred from a particular hospital

Other criteria stated by some of the providers:
- Receipt of all information from the acute hospital/community prior to admission
- Patient and their family must visit the place prior to admission

Community units
All have specified admission criteria. These were generally along the same lines as above.

Welfare homes
Welfare homes have specified admission criteria, which all homes adhere to.

6.9.2 Barriers to adhering to criteria:
Long stay hospitals/homes and community units
- Pressure from public lobbying groups and politicians sometimes force admission criteria to be abandoned
- Delays in receiving information on the patient in advance of admission
- Hospitals referring patients that do not meet the admission criteria

Community units specifically
No liaison nurse in the community to co-ordinate referrals.

Welfare homes specifically
Arranging re-assessment and placement of residents when their health has deteriorated can take a long time. As a result most of the homes retain residents when they become more dependent.

6.9.3 RECOMMENDATIONS

Long stay hospitals/homes, community units and welfare homes
1. Inform/disseminate admission criteria to hospitals, community services and lobbyists to avoid inappropriate referrals
2. To keep services as local as possible for family and resident, only refer residents to services in that area where possible
3. Ensure all correct information comes with patient prior to admission

4. All residents and/or their families should be introduced to the service before admission or at least be given information about the place so that they can make an informed decision. Most of the residents interviewed stated that this did not happen but expressed that they would have liked to have seen the place or at least receive information about it, as it would have reduced their initial fears of entering care.

Welfare home specifically
1. Ensure a more comprehensive multi-disciplinary assessment of clients prior to admission.

6.10 SERVICES/FACILITIES AVAILABLE TO HOMES AND HOSPITALS

6.10.1 Long stay hospitals/homes and community units
The hospitals/homes were asked to list the services available to residents. The response varied greatly from provider to provider.

Most of the providers stated that they felt the services that were available were not appropriate/suitable in terms of not having access to particular services or not enough of another

It should be noted that some of the hospitals/homes and units have funding for posts but they are unable to fill them.

In general the services that seem to be lacking the most were:

- Speech and language therapy
- Nutritionist
- Social work
- Diversional therapy
- Aural
- Occupational therapy
- Physiotherapy

Welfare homes specifically

- All paramedical services are provided by the community services. There are long waiting times, i.e. up to six months, even where there is an acute need.
- In some cases chiropody, ophthalmic / aural services are poor and are availed of on a private basis.

6.10.2 RECOMMENDATION

1. All hospitals/homes should have equal access to necessary services such as allied health professionals.
2. Residents care to be reviewed periodically by a geriatrician to assess changing need
3. Develop and provide more diversional therapy in hospitals/homes

Welfare homes specifically

1. The homes sometimes cater for patients with medium dependency needs when they cannot find alternative placement for them. Therefore, there is a need for physiotherapy and occupational therapy on a sessional basis.
2. Provide a transport service so that residents can easily avail of services in the community

6.11 QUALITY INITIATIVES TO EVALUATE SERVICES

6.11.1 Long stay hospitals/homes
Most of the hospitals have had some type of quality initiative. They were generally some of the following:

- Audit/accreditation of service (computerised audit of patient care, clinical audits or accreditation as part of the overall hospitals accreditation)

- Quality initiative/improvement programme either with an external agency or as an internal project (Quality programme with Derek Browne Associates, quality improvement in continence, wound care etc.)

Community units
Half of the six units had some type of quality initiative. They were generally the same as above.

Welfare homes
There is an absence of quality initiatives in welfare homes. They rely on staff to identify good quality care and practice.

6.11.2 Barriers to developing quality initiatives

Long stay hospitals/homes, community units and welfare homes
All providers indicated the same barriers

- Financial resources
- Staff shortages
- Time
- Training and education

6.11 3 RECOMMENDATIONS

1. Each provider should have a recognised evaluation/accreditation of their service
2. Need to train and educate staff to best practice etc.

6.12 GUIDELINES FOR NURSING, MEDICAL AND PARAMEDICAL

6.12.1 Nursing guidelines

Long stay hospitals/homes, community units and welfare homes

All providers had guidelines for nursing care. The type of guidelines varied from one service to the next. Some of the guidelines stated were as follows:

- Policies and procedures for specific areas of care such as infection control, continence, drugs etc.
- Staff handbooks and manuals
- Ropen Logan-Tierny
- General policies and procedures for nursing care

Medical guidelines

Long stay hospitals/homes, community units and welfare homes

Very few of the providers have medical guidelines. Where details were given, they were along the lines of prescription procedures and protocols

Paramedical guidelines

Long stay hospitals/homes, community units and welfare homes

Very few of the providers have paramedical guidelines. Where details were given, they were along the lines of staff developing their own standards.

The barriers to having guidelines

- Training/education
- Funding (particularly for ratifying standards)
- Time
- Staff shortages

6.12.2 RECOMMENDATIONS

1. Recognised guidelines for medical and allied therapist developed in each service provider.
2. Guidelines should also be introduced to other staff members such as care staff, catering/dietary

6.13 PROTOCOLS FOR ELDER ABUSE

6.13.1 Long stay hospitals/homes

A lot of the providers have developed some protocols. These were generally along the lines of:

- Local policies and procedures
- General guidelines on abuse but not specifically on older people

Community units

Only one of the six units has developed protocols.

Welfare homes

None have developed protocols.

6.13.2 Barriers

- Lack of any existing guidelines
- Time involved in developing such guidelines bearing in mind staff shortages

6.13.3 RECOMMENDATIONS

1. Develop an overall Board policy, which can be adapted to each service. These should be developed in line with the Working Group on Elder Abuse. This Working Group was established in October 1999 by the Department of Health and Children to advise on the development of policies, procedures and guidelines in relation to elder abuse. The Group has prepared draft policies, procedures and guidelines and these have been introduced on a pilot phase in two community care areas. Recommendations will be submitted to the Department next year based on the evaluation of these pilots.
2. Need to educate and train staff around this area

6.14 CONDUCTING REGULAR REVIEWS OF PATIENT CARE

6.14.1 Long stay hospitals/homes, community units and welfare homes

All services conduct regular reviews of patient care

This occurs in the following ways:

- Care plan reviewed/evaluated on weekly/monthly basis
- Staff meetings to review patients
- Ward rounds/reviews
- Patient and/or family satisfaction survey

Barriers to conducting reviews

- Time
- Staff
- Financial resources (for satisfaction surveys)

6.14.2 RECOMMENDATIONS

1. Ensure regular multi-disciplinary reviews of residents
2. Have regular client satisfaction surveys
3. Have regular relative/carer satisfaction survey in the absence of a resident being able to articulate their views
4. Establish a multi-disciplinary visiting team for peer review

6.15 OTHER RECOMMENDATIONS

Long stay hospitals/homes, community units and welfare homes

1. The need for paramedical services and more of it where it is already provided has been highlighted. It is also suggested that consultant geriatrician's review/re-assess residents periodically to assess changing need.

2. A group established to set guidelines on staffing levels and skills mix in relation to number and dependency of patients

3. Formalise/increase links with community services

4. A residents committee including family and friends set up to get feedback from service users. The residents particularly expressed this wish as they welcomed the opportunity to discuss their service and have an input into the planning of service.

5. Ensure environment is homely, spacious and safe

   Bedrooms:

   There is a need for more single and double rooms. Most older people are in wards with up to three or five other residents. This is not conducive to privacy. It was noted during the interviews with residents that many enjoyed the company of other residents in their ward and would be lonely in a room on their own; however, the choice should be there for residents.
   Also single rooms are important for medical reasons when a patient is very ill, has an infectious disease or is dying.

   Dining and day rooms

   These rooms need to be more spacious to cater for all residents. In many of the hospitals/homes and in particular the community units, these rooms could not accommodate all residents.

   Smoking area

   There is a need for a designated smoking area for clients separate to the day room as not all residents smoke

   Garden/outdoor facilities

   Residents should have the opportunity to have access to a safe outdoor environment. This was something that was stated as being very important to the residents.

6. Have a visitors room separate to the day room where families can visit residents in privacy instead of using bedrooms

7. More variety is needed in the food residents eat. Many of them felt that they didn't have enough variety in their daily meals and would welcome a change in this area.

8. There is a need to provide more recreation for residents. Residents enjoy day outings and social events, but expressed that they would welcome more activities.

9. Increase rehabilitation for patients with rehabilitation capability

10. Information and awareness for residents of their rights especially pocket money allocation etc.

6.15.1 Welfare homes specifically

Staffing

- Some of the recommendations set out in the 1998 10 Year Action Plan in relation to staffing have not all been implemented. While some staff improvements have been implemented in some homes, this is not consistent across all five homes.
- There are concerns with unqualified staff working night duty alone as this shift presents a time of greatest risk.

Physical Facilities

- Additional accommodation required for recreational activities.
- *All homes lack minimal facilities and services, e.g. toilets, showers, sluice room / access to same.*
- An oratory is required in some homes.
- Basic maintenance support can be slow.

Other issues

- Homes have no clerical assistance to deal with general administrative duties. Presently the manager of the home conducts this line of work.
- Although all five homes are similar, there are variations in operational policies, which affect standards and quality of services provided. There is a need to establish collaboration between welfare home managers to discuss:

- Operational policies
- Review of on-going staff training
- On-going training for managers to keep up-to-date on current best practice
- Managers also stated grading structures in homes should be reviewed.

- Change the name of welfare home to 'residential home'. Residents particularly want the name changed.

6.15.2 Community units specifically

- Three of the units are currently providing services for less people than originally set out due to a lack of space, structural damage and staff shortages.
- In general, the units are too small structurally. For example:
  - There is only one clinical room for providing all paramedical and recreational activities
  - There is very little storage space for equipment
  - There is not enough storage space for residents
  - The rooms in general are too small for manoeuvring appliances making the delivery of care difficult. It is suggested that the planning of units should involve all multidisciplinary personal who have experience in caring for older persons in consultation with the architectural and technical people.
- There is no piped oxygen or suction available in the units. At present portable cylinders operate this, which takes up storage space.
- No oratory
- More toilet facilities needed

SECTION 7

USER AND CARERS

A users and carers sub group set about examining the key recommendations from the 10-year Action Plan, and the commitment to involving service users and carers in all aspects of their care.
The sub group held a number of meetings since the end of April last. These involved the examination of the current planning process for services for older people in the eastern region and the collation and review of literature both national and international on user and carer centered care. Carers and users were co-opted to the sub group and their opinions and considerations proved to be very valuable and enlightening.

The following is a list of 9 key recommendations taken from the '10 year Action plan'

- Creation of support group for carers in South Dublin.
- Creation of small care support groups in East Wicklow and Kildare / West Wicklow.
- Carer support groups to be met and liased with on annual basis either at community care area or board level as appropriate.
- The drafting of a Charter of Rights for Older People.
- The extension of the pilot advocacy project to other hospitals and residential homes.
- The setting up of a patient/carer service provider in all hospitals and residential homes to take on board the views of the patients and carers.
- Introduction of questionnaire type mechanisms to the community.
- Creation of full time posts to link to key voluntary organisations.
- Establish mechanisms for meetings between provider agencies and key organisations acting as advocates for older people.

7.1 Progress has been made on a number of the key recommendations in the following ways:

- Age Action organises and operates a number of support groups for carers in South Dublin, Kildare and Wicklow.

- Carer support groups held an annual meeting in 1999 and a further annual meeting is planned for later this year

- A Charter of Rights for Older People in "In-Patient Care" has been produced along with a video. The South Western Area Board will launch this charter and video later this year on behalf of the three area boards and the ERHA.

- The pilot advocacy project, which is located in St. Mary's Hospital Phoenix Park, has been extended. The organisation of this program is under the auspices of Age Action. However, developing pilot advocacy projects is restricted by the difficulty in recruiting volunteers.

- A questionnaire has been used to establish the views of older people. This questionnaire is based on case studies of older people and currently operates in two community care areas – Area 4 and Area 8.

- The post of Development Officer to link up with voluntary organisations and carer organisations dealing with older people will shortly be advertised in the N.A.H.B. This is a pilot project and the Development Officer will initially be engaged on a temporary basis for 6 months.

- Area health boards and voluntary agencies are establishing mechanisms to work together on projects to develop advocacy for older people. This includes annual meetings, joint submissions on development proposals and joint service planning.

7.2 USER INVOLVEMENT

The involvement of service users in all aspects of their care was reviewed. There is a growing appreciation among service providers that establishing a good quality of life for older people requires the involvement of the older person in the planning of the services that are important to them and which support their choices.

After a very full and useful discussion it was agreed that user and carer involvement in the planning and development of services should be firmly rooted in:

a) The need to embrace a positive image of ageing. This image recognises that older people are generally active, healthy and socially involved.

b) Facilitating ageing in place. It is the universal wish of older people to live at home and in their community.

c) Supporting self-sufficiency. From this perspective, services should promote and support independence, respect choice and place older people at the centre of the planning process.

d) The development of local resource centres. These centres will be points of information and service provision and a locus for the personal empowerment of older people.

7.3 CARER INVOLVEMENT

Procedures or mechanisms by which the participation of carers in the planning process could be achieved were discussed. During the discussions it became clear that the basic information on services available, how to access these services or even access this advice/assistance, often at times of crisis, was unavailable to the carer. As a result the carer's perception is that the services are inadequate for their needs and the carer is forced to rely on their own resources. Therefore carer interaction with these services is minimal and often negative. New and innovative approaches are needed to ensure the carer's input into the planning process.

Carers perform a critical role and their support of family members is very important to the community.

One key objective for the future should be the development of support services for carers. There are three types of support the carers need:

- Information and advice
- Practical help
- Appreciation and social companionship.

The needs of carers cannot be compartmentalised or departmentalised and the need of carers are multifaceted. Carers can find their role stressful and health promotion is essential to help carers maintain their own health. Local carer groups and other voluntary organisations provide support, which is vital. These groups give carers the opportunity to meet other carers and exchange ideas. Carers can become very isolated while caring and these networks are very supportive and can help integrate carers socially.

Carers are very happy with the focus mornings as a social outlet. It gives carers an opportunity to meet others carers and exchange ideas.

Carers could benefit from:

- An independent system of needs assessment introduced with a statutory right to services arising from the assessment.
- Access to independent advice and advocacy.
- User-friendly resource centres for carers at a local level.
- Seamless, co-ordinated total systems of care aimed at facilitating an appropriate range of services in response to carers' continuing health and social care needs.

7.4 RECOMMENDATIONS

1. The establishment of a working group to ensure the involvement of users and carers in the planning process. It has become clear that a new dialogue between users, carers and services providers needs to be initiated. The future planning process for services and resources for older people must involve representatives of the three main participant groups: users, carers and statutory and voluntary providers.

2. The working group should also examine payments to users and carers for their participation in any planning process.

3. The appointment of an experienced project leader - to facilitate the new dialogue between users, carers and service planners and providers - is essential. Dialogue should lead to the development of inter-agency partnerships and multi sectoral service provision. The objective should be to involve older people in the planning of services, as active participants and not solely at a consultative level.

4. Older people should work with the Authority to help establish and influence regional planning and strategy. At the local level, older people should organise local forums in each community care area to identify local needs. These needs should be brought to the attention of the senior management in the area health boards. Local forums should be established with an initial budget of £10,000 for each area health board.

5. The involvement of users should lead to the development of new partnerships at local and regional level.

6. A number of issues need to be considered at both regional and local level. These include attitudes to ageing, facilitating ageing in place - home and community, promotion of independence and choice, local resource centres for information service provision and a locus for the personal empowerment of older people.

7. The review group recommend that the involvement of users and carers, in what they refer to as the new *Dialogue,* should begin as soon as possible with the aim of being fully operational by the autumn of 2002. The ERHA should develop a policy on involvement that recognises that users should participate in the planning process at an early stage.

Appendix I

Analysis of DCU questionnaire

Introduction

The ERHA is undertaking a review of the implementation of the 10 year Action Plan for Services for Older People, examining both the status of the implementation of the plan and also considering areas which might have changed since the development of the plan in 1999. As a part of this review, a small study of the operation of the District Care Units was undertaken, in order to see how this service has progressed since its inception in 1990 and how it has developed in each Community Care Area in response to the different needs of the area.

One element of this study was a survey of DCU clients on the in the second half of July. This short report provides a description of the findings of the survey.

Method

A series of focus groups were carried out with staff of the DCU (these are described in the report on the focus groups) at which a short questionnaire was developed for each client of the DCU, using comments and suggestions from the focus group participants. The goal was to develop a series of questions, which would provide useful information about the types of clients on the DCU but was at the same time simple to fill out using information readily available to team members (A copy of the questionnaire is attached). It was also essential to restrict the questionnaire to one page per client. It was hoped that the questionnaires could be filled out at the weekly/fortnightly DCU meetings as each client was discussed.

Questionnaires were returned for 161 clients on the DCU in the last 2 weeks of July (except for Area 2, which were for clients in the first 2 weeks of August). Returns were received from 7 community care areas (Areas 2,3,4,6,7,8,10) and for 11 DCUs in these areas (it should be noted that in some areas a number of different DCUs operate effectively as one team with joint meetings, while other operate separately). Because of the varied coverage of the questionnaire some of the analysis should be treated with caution (for example in relation to the referring hospitals). Nonetheless the data collected provides a useful picture of the activities of the DCU in the Eastern Region. Further data returns would enhance this.

Findings

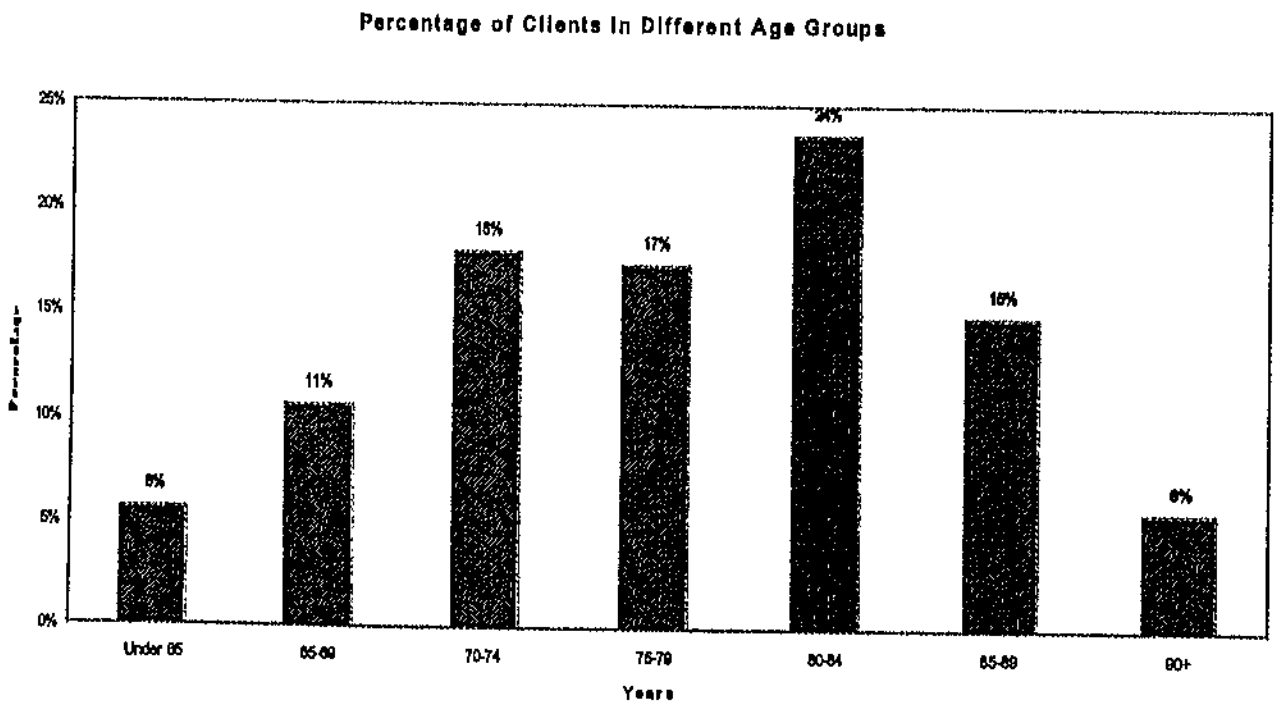
In this section the findings of the survey are summarised to give a picture of the type of clients who use the DCU service. The results are given for all of the DCU teams together but where there are differences among CCAs or DCUs these are highlighted.

Numbers on the DCU

The number of clients on the DCU varied considerably by area, both Areas 8 (North Dublin) and 10 (Co. Wicklow) had 33 clients (in Wicklow there were 24 clients on the DCU based in Bray and 9 on the DCU for South Wicklow). In Area 8 the clients were on the Coolock DCU (12) the North County DCU (10) and the Chronic Care Unit based in Coolock (11). In the other Areas there were fewer clients: Area 2 returned questionnaires for 25 clients, Area 3 for 11; Area 4 had 19 clients; Area 6 had 20 and Area 7 had 20. Staff shortages (discussed further in the report on the focus groups) have made it very difficult to operate all DCU teams fully, and in some areas the teams have been amalgamated, or the decision had been made to reduce the number of teams in order to allow more staff for the general service. This accounts for some of the variation in numbers on the DCU in the different areas.

Age of DCU clients

The average age of clients the survey was almost 78 years, while the youngest was 58 and the oldest 95 years old (there was no data available for 7 clients). Those between the ages of 80 and 84 were the biggest group comprising some 24% of the sample, while clients in their 80s accounted for 39% of all DCU clients while those in their 70's accounted for only 35%. The age distribution of the clients is shown below.



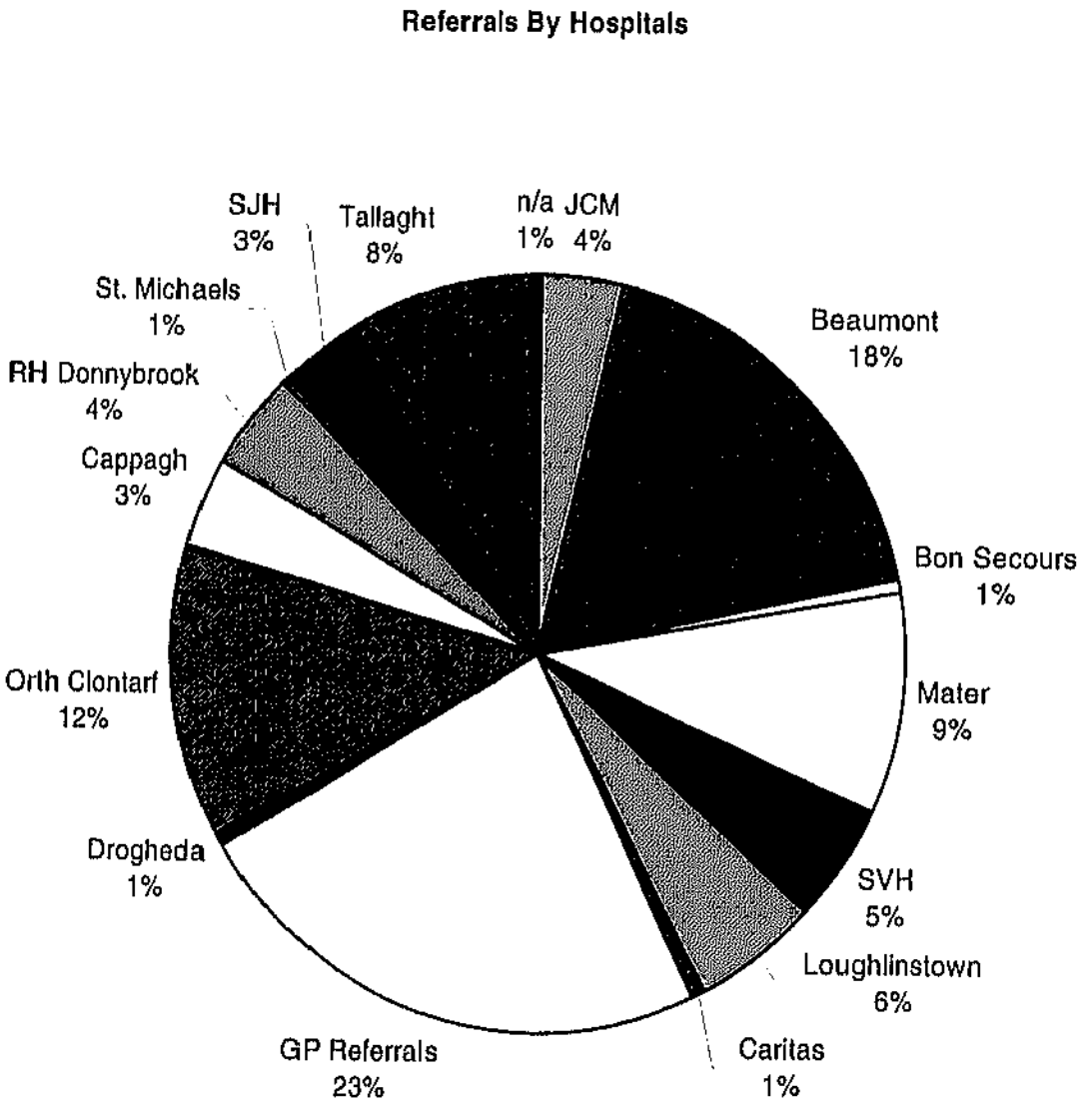
Of the 9 clients under the age of 65, five were in Area 6, where the DCU has a policy of regularly accepting clients under to ages of 65 (see focus group findings for further discussion).

Table of Clients in Survey by Age

Under 65	9	6%
65-69	17	11%
70-74	29	18%
75-79	28	17%
80-84	38	24%
85-89	24	15%
90+	9	6%
N/a	7	4%
	161	100%

Referral sources (and hospital)

Most (76%) of the referrals to the DCU are from hospitals (step down referrals) with the rest (38 referrals) coming from GPs. Interestingly, however, Wicklow (Area 10) accounted for 20 of the GP referrals, which was 61% of their total referrals, indicating the emphasis on 'step up' referrals in Area 10. In most other areas GP referrals only account for a small proportion of clients, while referrals from different hospitals account for most of the DCU clients.



The number of referrals from hospitals to the DCU often depend on the level of knowledge of the DCU within the hospital, with the geriatricians and other consultants looking after older patients. Those who are familiar with the service are more likely to make referrals. This is considered in the discussion of the focus group findings. It should be noted here, however, that as 7 Community Care Areas only returned data some hospitals would be under represented because their catchment includes Community Care Areas, which have not returned any data. Nonetheless the referrals are given by hospital in the chart below. Beaumont and the Orthopaedic Hospital in Clontarf are the main hospital referrers in this survey.

Hospital	Number referred	Percentage referred
Beaumont	29	18%
Clontarf	20	12%
Tallaght	13	8%
Loughlinstown	9	6%
Mater	15	9%
RH Donnybrook	7	4%
St Vincent's	8	5%
Cappagh	6	3%
St James's	5	3%
JCM	6	4%
Caritas	1	1%
Drogheda	1	1%
St Michael's	1	1%
Bon Secours	1	1%
GP Referrals	38	23%
Not available	1	1%
	161	100%

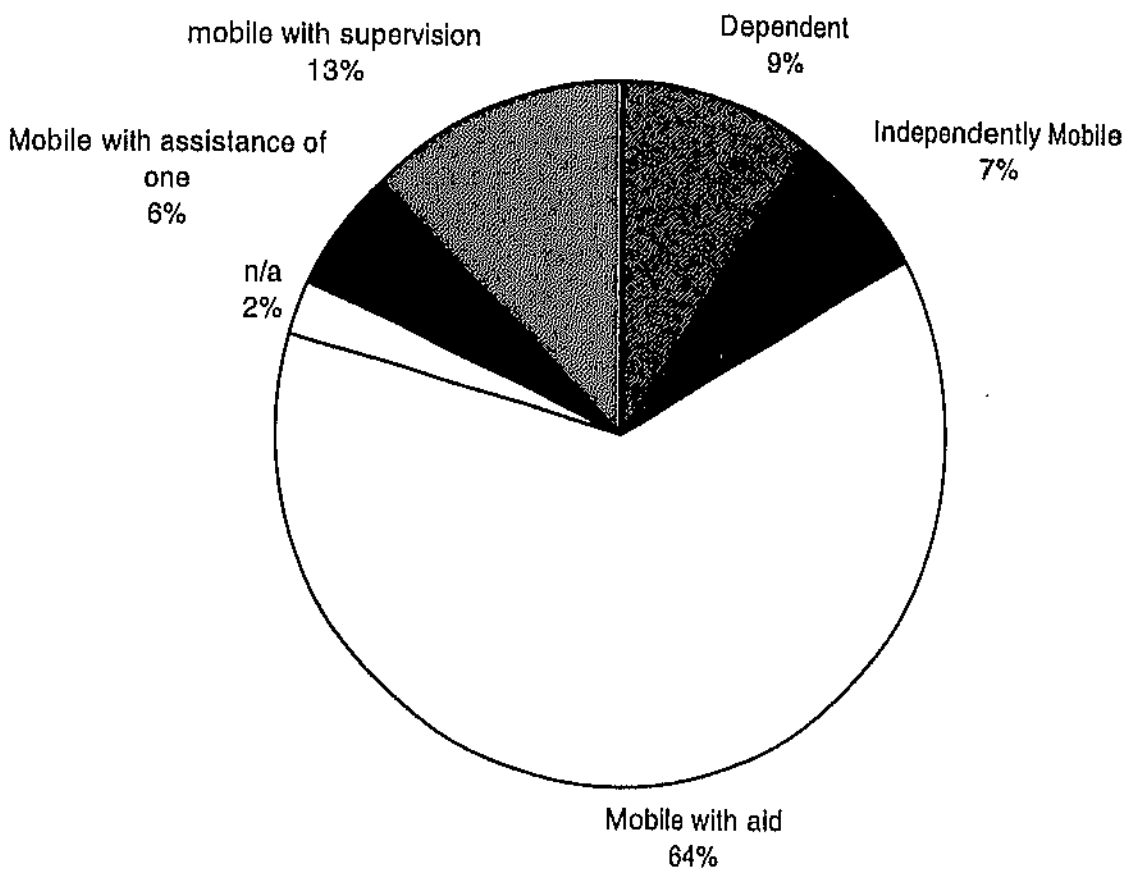
As would be expected Beaumont mostly referred to the DCU in CCA 8, which is part of their catchment, the Orthopaedic Hospital in Clontarf, however referred more evenly to the DCUs throughout the region, reflecting its larger catchment as a specialist hospital.

Diagnosis and Mobility

Clients referred to the DCU had a variety of diagnoses, but orthopaedic referrals (including fractures, amputations etc) were the most common, comprising almost 40% of all referrals for whom a diagnosis was returned. Conditions relating to immobility (including arthritis, Parkinson's disease and other causes of decreased mobility) were also significant as were CVA (strokes), which also accounted for 16%. It should be noted that although the diagnosed conditions were split into 4 groups for the purposes of analysis, many of the clients (53) were noted as having more than one condition. Hence the DCU is often not dealing with one clear-cut medical condition but providing multi disciplinary support for those with a complex group of diagnoses including those with psychiatric conditions, as well as on occasion, providing social support. In Area 8 a psychologist has begun to provide a service to DCU Clients on a trial basis, although none of the clients in the questionnaire were in receipt of the service. The requirement for different team members to provide additional DCU services is discussed further below as well as in the focus group analysis.

The mobility of clients on the DCU was also considered, as mobility provides a good indicator of how dependent a client is, and how much care they need.

DCU Client Mobilty



Most of the clients were mobile with an aid (64%) and they constituted the most significant group. A small number were independently mobile (they had varying diagnoses so it wouldn't be possible to suggest that they constituted a particular group of clients). Most of these were receiving short-term rehabilitation from the DCU, they consisted of a higher proportion of the GP referrals than patients in other mobility categories, perhaps reflecting the "step up" nature of their DCU admission, intended to prevent hospital admissions.

Some 9% of clients were in the dependent category, having in effect no mobility and so requiring a high level of care. Despite the high level of care necessary for these clients only half were regarded as receiving chronic care rather than short rehabilitation input from the DCU. Six of the fifteen dependent clients had had strokes, and the rest had rather varied diagnoses. Area 8 had most of the dependent clients (7) and most of these were receiving chronic care rather than short rehabilitative care.

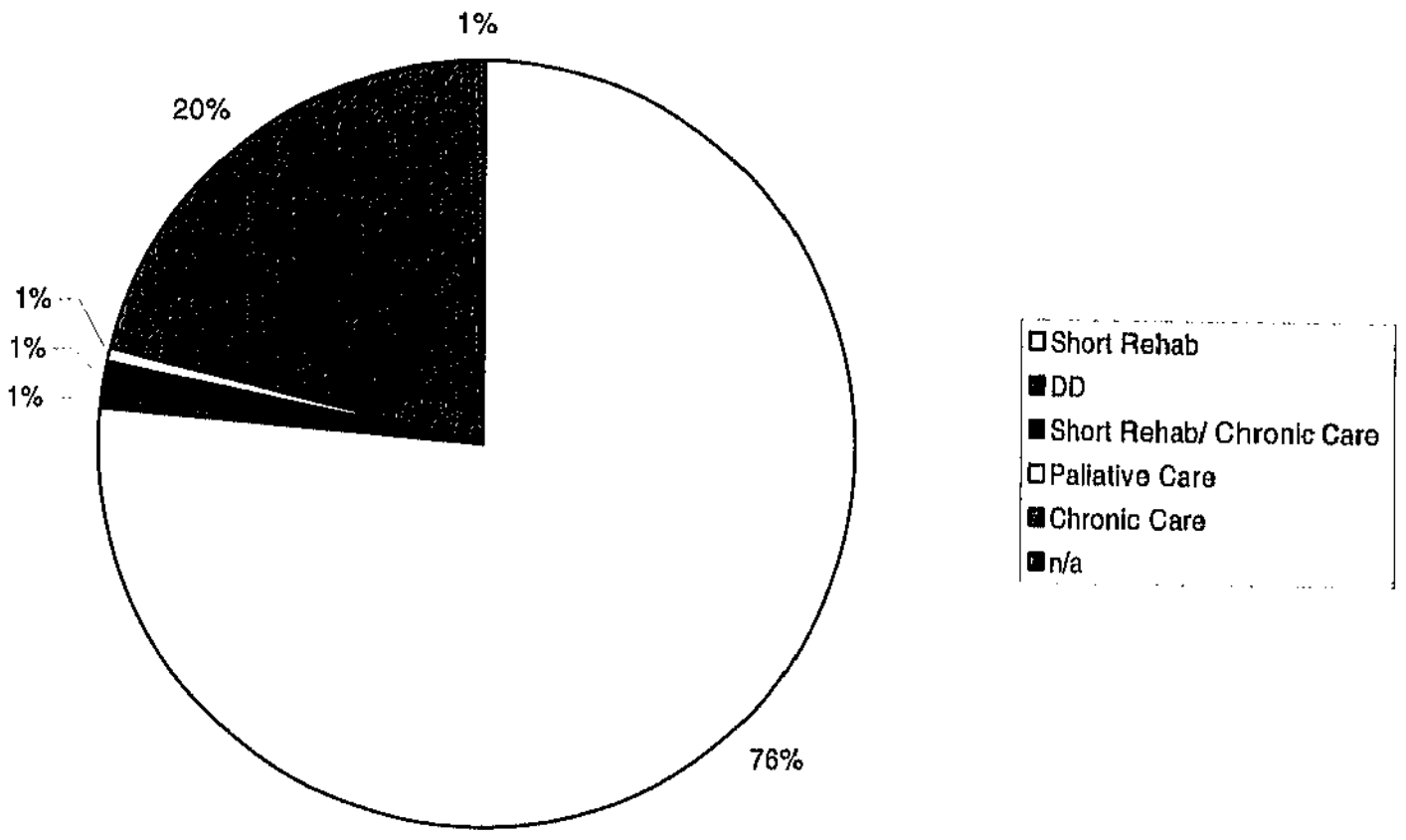
Mobility of DCU clients

Independently mobile	12	7%
Mobile with aid	101	63%
Mobile with supervision	20	13%
Mobile with assistance of one	9	6%
Dependent	15	9%
Data not available	4	2%
	161	100%

Type of DCU Service

The DCU was originally set up to provide short-term rehabilitative care to clients in their own homes, with the aim of discharging them from the service within 12 weeks. As the service has developed over time there have been some moves to provide an extended care, or chronic care service to clients who are not able to live at home with out additional support of the kind provided by the DCU. The main DCU team provides some of this chronic care, otherwise a special service is provided by a designated chronic care team (as in Area 8). The different forms of care are discussed in more detail in the focus group report.

Types of Care provided by the DCU



Most of the clients on the DCU were receiving Short Term Rehabilitation (76%) with almost a quarter receiving longer-term chronic care. Although, it had been mentioned at the focus groups that occasionally some DCUs provided palliative care, only one client was receiving this type of care at the time of the survey. However, although the majority of the clients were regarded as receiving short-term rehabilitative care, a number of them had been admitted to the DCU over four months ago. Nonetheless, none of those receiving Short-term rehabilitative care were admitted prior to 21.03.01 and so had not been on the DCU longer than 18 weeks, which while longer than the target of a 12-week admission would remain an appropriate time period for rehabilitative care.

Interestingly most of the clients (59%, 20 clients) admitted for chronic care had also been admitted within the last 4 months, with a further 7 admitted within the last year. A small minority (6 clients, 18%) had been admitted to chronic care over a year ago with two of these admitted in 1995. There provide an indication that DCU type support may successfully maintain older people in their homes in the longer term, although this would have to be investigated further.

DCU service type

Short rehab	123	76%
Chronic Care	34	21%
Short Rehab. /Chronic Care	2	1%
Palliative Care	1	1%
N/a	1	1%
	161	100%

Input

Most of the 161 clients for whom information is available, received the services of the OT (157) and Physiotherapist (156). This would be expected in the context of the multidisciplinary team approach, in particular because of the limited availability of these disciplines in the general service. Most of the clients (138) were also receiving RGN services, while for 74 clients the PHN was involved in their care as part of the DCU. This reflects the differing roles of RGN and PHNs in different community care areas, which is discussed in the focus group report.

Home Care Attendants, whose posts were originally to form an integral part of the DCU provided service to 53 clients (33%) reflecting both the current shortage of Home Care Attendants and the fact that the Home Care Attendants, from the early days of the DCU were based in Health Centres rather than being integrated into the DCU in most areas. This is discussed further in the focus group report. Some 55 clients have home help services. The home help is not part of the DCU, but some clients would have had home help before admission to the DCU and would have retained this service. Other clients would have required home help after admission and where this was available would receive it. Shortages of home helps mean that many clients have to wait or may not receive home help services. This is discussed further in the DCU report but it is recognised that home help is not a part of the DCU and DCU clients do not have preferential access to the service.

Some of the DCU have a small Speech and Language therapist input. Seven of the clients in the survey were receiving speech and language therapy as part of the DCU, a number of others were receiving SLT as outpatients at the hospital from which they had been discharged. The prevalence of clients with strokes on the DCU means that SLT is an important input, although the shortage of Speech and Language therapists at community level restricts the availability of the service for older people.

Clients were also receiving other services such as day care, psychiatric services or GP services which were not part of their DCU service.

Destination

Of the 161 patients discharge decisions had been made of 93 patients (58%) and most of these 85 were to be discharged to the General Services, usually to the care of the PHN. Other destinations included respite (5 clients) and a few required long term care (1 client) or admission to an acute hospital (2 clients).

APPENDIX 11

Best Practice models for Stroke cases and needs assessment for stroke Units in ERHA

Dr Catherine Hayes

Specialist in Public Health Medicine

22 October 2001

Introduction

Stroke is an illness with a huge personal and societal impact. It is the most common cause of acquired physical disability, and is the cause of the second most common form of dementia, vascular dementia. .It is second only to dementia as the most expensive illness in health and social care costs, and these costs exceed those of either cancer or ischaemic heart disease[1]. Most strokes occur in the over 65s. This paper examines the evidence for effective rehabilitation for stroke and attempts to estimate the bed requirements for stroke units in the ERHA region.

Demography

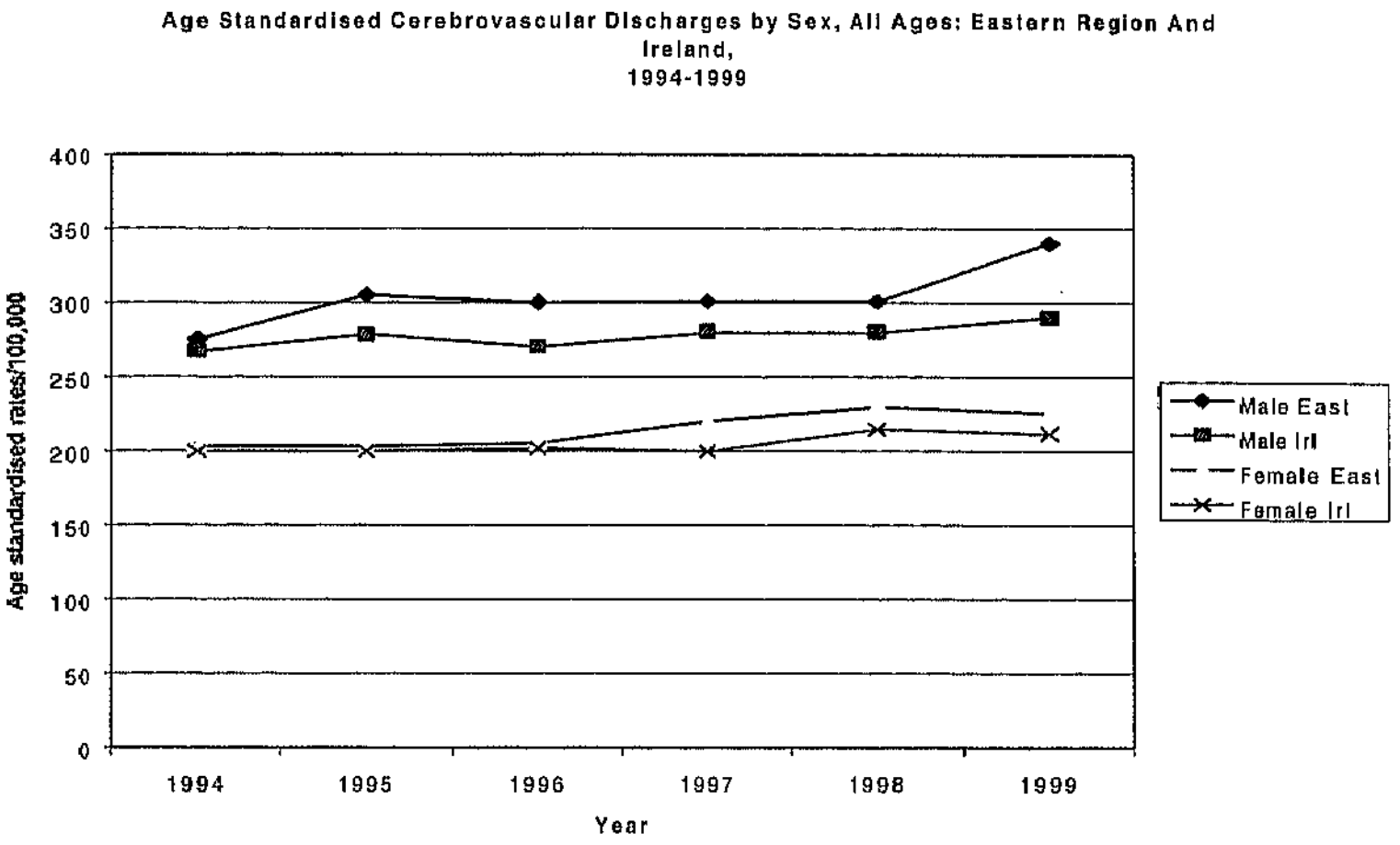
Population trends 1996-2011, Eastern Region and Ireland including a net migration inflow of ~ 10,000 per year 1996-2011 into the Eastern Region

Year	Eastern Region Agegroup					Ireland Agegroup				
	65-74	75+	Total 65+	Total pop	% Total	65-74	75+	Total 65+	Total pop	% Total
1996	74,908	50,363	125,271	1,295,939	9.7	239,351	174,531	413,882	3,626,087	11.4
2001	79,149	54,243	133,392	1,412,468	9.4	240,936	186,761	427,697	3,833,711	11.2
2006	87,327	56,863	144,190	1,508,848	9.6	256,103	196,251	452,354	4,031,435	11.2
2011	99,962	60,991	160,953	1,586,015	10.1	296,381	207,440	503,821	4,201,181	12.0

*** Sources: National data-PHIS v4Beta, 1996-2011 projections - M1F2 assumptions. Eastern Region 1996-2011 projections: Health Information Unit, Department of Public Health, ERHA: natural increase plus the effect of a net inflow of ~10,000 into the area per annum 1996-2111.**

From the table it can be seen that the Eastern Region has a smaller population in the 65-74 and 75+ age group than Ireland as a whole age group than Ireland as a whole. The distribution of the elderly 65+across the three area health boards is as follows:

NAHB	9.7%
SWHB	8.6%
ECHB	11.6%



Incidence

In international terms, the incidence seems to have remained steady however, the projected increase in the elderly population in Ireland is likely to lead to an increased prevalence of stroke in the future.

Morbidity

There were 1854 cases where stroke was recorded as the principal diagnosis (using ICD codes 430-434 and 436) admitted to hospitals in the ERHA region in 1999, see table.

No of discharges with Stroke as Principal Diagnosis in (patients aged 65+) by Acute Hospital within Eastern Region (HIPE data 1999)

Hospitals	Males	Females	Total
Beaumont	200	168	368
JCM	33	38	71
Mater	128	151	279
St James's	191	197	388
St Vincent's	153	190	343
Tallaght	61	73	134
Loughlinstown	31	53	84
Naas	50	53	103
St Michael's	33	49	82
Other	1	1	2
Total	**881**	**973**	**1854**

In addition there were 875 cases in those aged <65 years in the ERHA region, yielding 2729 cases for all ages.

A district with a population of 250,000 would expect to have 500 first-ever and 100 recurrent stroke cases per year (in total about 0.25% of the population) [2].. About 20% of stroke victims die within the first four weeks, with a further 10% dying within a year. The in-hospital mortality is 21% in general hospitals in the Eastern Health Board region.

The typical district of 250,000 is likely to require about 30 beds to the care of stroke victims who have recently had a stroke[2]..

The typical district will have around 1500 stroke survivors living in the community of which half 750 will have a significant level of disability.

From international studies it is estimated that there are 30,000 people with residual disability from stroke: of these

- 48% have a hemiparesis
- 22% cannot walk
- 24-53% need help with activities of daily living
- 12-18% aphasic
- 5% have a residual swallow disorder
- 32% are clinically depressed
- 33% have cognitive impairment

Bed requirements in the ERHA region based on an estimated requirement of 30 beds per 250,000

Year	ERHA total population	Est. no. of beds
1996	1,295,939	155
2001	1,412,468	170
2006	1,508,848	180
2011	1,586,015	190

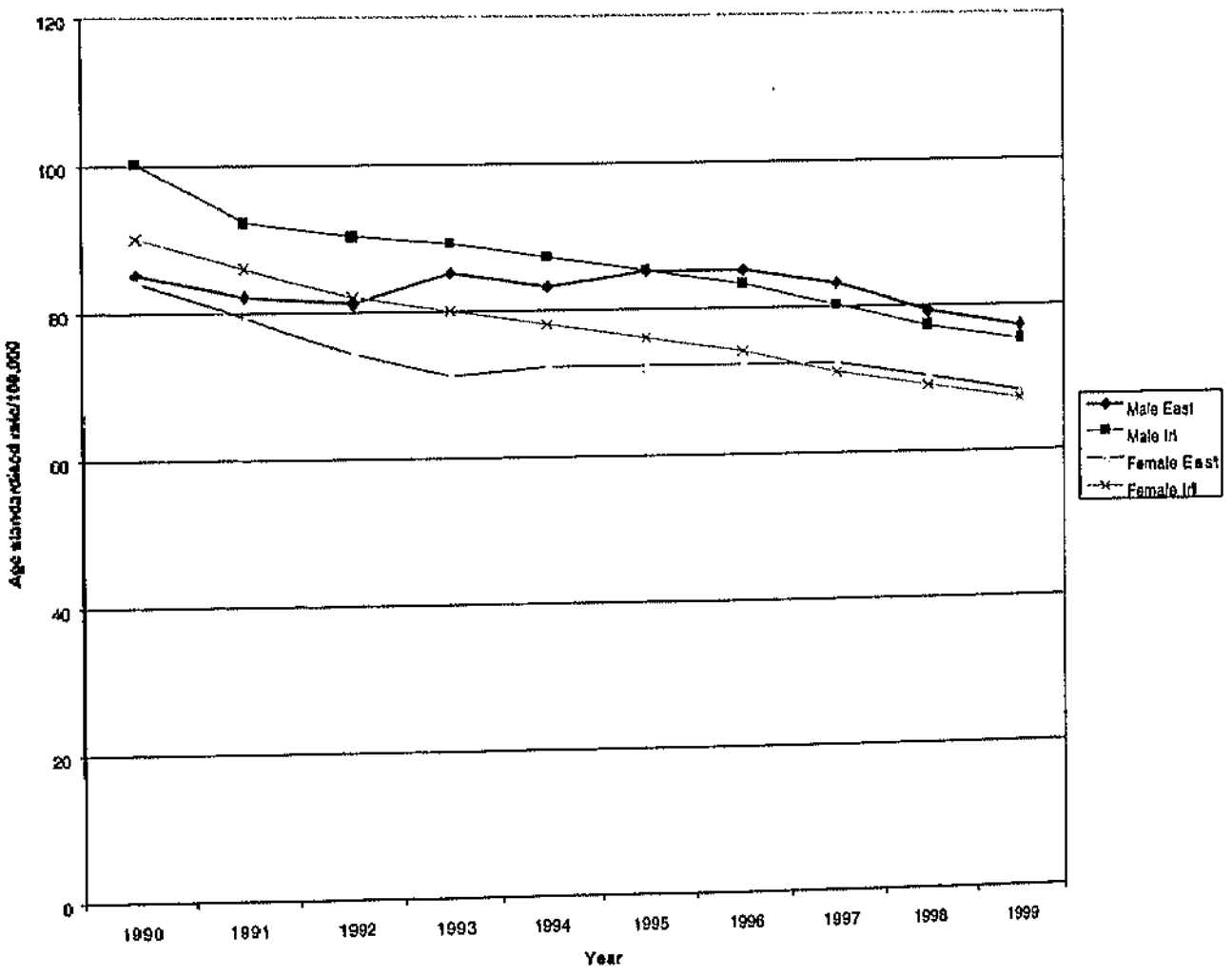
Bed requirements will be higher in the East Coast region relative to the other two boards.

Mortality

Stroke is the principal cause of death in 8.7% of all deaths in Ireland (1997)[3]. It accounts for 6.8% of deaths in Irish men and 7.6% in Irish women aged 65-74[3].

Mortality from stroke has been falling for some decades. At all ages the decrease in death rates in Ireland between 1970-1972 and 1991-1993 was 47% for men and 52% for women. In the 65-74 year age group the age specific death rates from stroke decreased from 1978-1980 to 1995-1997 by 46% in Irish men and 56% in Irish women[3]. There are no statistically significant differences between health board regions in stroke death rates in men. In women death rates from stroke are significantly higher in the Midland and South Eastern Health Boards and lower in the ERHA[3].

Age standardised Cerebrovascular Mortality by Sex, all ages, Eastrern Region and Ireland, 1990-1999



Stroke Council Guidelines

An interdisciplinary initiative from the Council on Stroke of the Irish Heart Foundation has resulted in the production of guidelines for the development of stroke services in this country.

Among the aims of the report are to:

1. Outline current best practice in stroke prevention, treatment and rehabilitation .
2. Provide a consensus-derived and realistic basis for the development of healthcare policy so that the principles of the Health Strategy can be fully implemented for people with stroke .

Focussed prevention and treatment strategies for stroke can reduce the burden of death and disability associated with stroke. To this end, this report recommends the following measures

1) **Prevention and health promotion**: to develop active programmes for primary, secondary and tertiary prevention for stroke. The primary prevention could most usefully be undertaken in conjunction with the Cardiovascular Initiative. Secondary and tertiary prevention should be based in Stroke Services (below).
2) **Acute treatment and rehabilitation**: that in every general hospital admitting patients with acute stroke, people with stroke should be admitted to a Stroke Service under the care of a dedicated specialist(s) in stroke care, associated interdisciplinary team, appropriate diagnostic technology (eg, CT/MRI) and a clearly defined continuum of care. Access to tertiary services (ie, carotid endarterectomy) should also be available. Rehabilitation strategies should start from admission and should be continued during the hospital stay.
3) **Community rehabilitation**: Out-patient rehabilitation should be made available for all patients of all ages in each Health Board area, on the basis of 250-300 patients discharged to the community/year per 250,000 population. These should encompass the full interdisciplinary team with either a domiciliary focus or adequate transportation if provided as out-patient care. Services should be available at any age and the model of the stroke services at Baggot St Hospital,

Dublin should be considered. The activities of the Volunteer Stroke Scheme should be developed and supported.

4) **Stroke Register.** A register of people with acute stroke should be set up as a priority, much on the lines of the cardiac surgery, coronary care and cancer registries.

The particular emphasis in this report is on organisation of services for Acute treatment and rehabilitation and community rehabilitation.

Prevention

Risk factors can be grouped into three main groups: those that are non-modifiable, those that are modifiable and apply to whole populations and those that occur in smaller sub-populations and which require a targeted or opportunistic health promotion approach. Such an approach is described in detail in the Stroke Council document.

Secondary prevention

A strategy of secondary prevention should be undertaken in all those who present to healthcare providers with stroke, of transient ischaemic attacks (TIA), vascular dementia or gait dyspraxia. A multiple risk factor intervention is indicated. Appendix A outlines the National Clinical Guidelines on secondary prevention.

In relation to the organisation of stroke services the management of transient ischaemic attacks is important. 12% of patients with develop a stroke in the first year, and 5% annually thereafter. Treating 1,000 patients with a history of cerebrovascular disease (stroke/TIA) will prevent 37 cardiovascular events at 3 years (death, non-fatal stroke or myocardial infarction).

The Stroke Council recommends that the specialist leading the Stroke Service in each hospital should provide a rapid-access clinic for TIAs. The clinic needs access to appropriate imaging (CT/MRI, dopplers) and a rapid access to a vascular surgery service. Out of a population with TIAs and minor strokes it is likely that 11-12% will

come under serious consideration for carotid endarterectomy which is indicated for suitable patients with symptomatic carotid stenosis of 70-99%.

Acute treatment and rehabilitation in hospital

The acute care of patients with stroke aims to control and prevent medical and neurological complications as well as reverse the neurological effects of the stroke itself. The processes of acute care and early rehabilitation are not easily separated. The National Clinical Guidelines for Stroke produced by the Royal College of Physicians UK[4] recommend the following with regard to the organisation of stroke care.

Every organisation involved in the care of stroke patients over the first 6 months should ensure that stroke patients are the responsibility of and are seen by services specialising in stroke and rehabilitation (A)

The stroke service should comprise:

i. a geographically identified unit acting as a base, and as part of the inpatient service (A)
ii. a co-ordinated multidisciplinary team (A)
iii. staff with specialist expertise in stroke and rehabilitation (A)
iv. educational programmes for staff, patients and carers (A)
v. agreed protocols for common problems (A)

The most important advance in stroke care is the realisation that organisation of stroke care into stroke units saves lives, reduces disability and institutionalisation. Evidence for the effectiveness of stroke units is shown in the table.

Table **Organisation of stroke care; specialised services**

Source	Design and sample	Intervention(s)	Conclusions
Stroke Unit Trialists' Collaboration, 1998	n=19RCTs, n=2060 patients	Stroke unit care or general Medical ward care	Stroke unit care reduces mortality and morbidity with no increase in length of stay
Dekker et al, 1998	n= 7 trials, n=1133 patients	Day hospital outpatient rehabilitation or routine care/domiciliary care/nil	No firm conclusions can be drawn
Kalra, 1994	RCT* ;n=141 stroke patients	Stroke unit or general medical ward	Stroke unit patients recovered faster, and more, and had shorter length of stay despite less total therapy tine
Laursen et al, 1995	RCT*; n=65 acute stroke patients	Stroke unit or general ward	Stroke unit discharged fewer to nursing home
Logan et al, 1997	RCT*; n=111; stroke patients after discharge	Enhanced domiciliary OT: or normal social services OT service	Enhanced service reduced carer distress, and improved patient function
Indredavik et al, 1997	RCT*; n=220; 5 year follow-up on acute patients	Specialist stroke unit or general medical ward	Stroke unit benefits sustained; less disability, more at home, fewer deaths
Ronning & Guldvog, 1998a	RCT*; n=550; acute stroke patients admitted	Specialist stroke unit or general medical ward	Stroke ward was more likely to intervene medically, and reduced stroke recurrence
Indredavik et al, 1998	RCT*; n=87; 5 year follow-up on acute patients	Specialist stroke unit or general medical ward	Stroke unit associated with more social activities and less emotional distress

***RCT= Randomized Controlled Trial**

Extracted from National Clinical Guidelines on Stroke, RCPI UK 2000

The National Clinical Guidelines for Stroke UK [4] are summarised in the Appendix.

What is a stroke unit? [1]

A stroke unit is a service where the acute and rehabilitation care of the patient with stroke is under the direct care of a specialist with training and expertise in stroke management, in conjunction with a dedicated interdisciplinary team.
Although this does not of necessity imply a distinct geographical location for the service, it is preferable to group as much of the service as possible into one area, so as to facilitate a philosophy of care, specialist nursing care and efficient and directed working of the interdisciplinary team.

There is sufficient evidence to support the setting up of well organised services for acute stroke patients. The evidence indicates that these services should provide comprehensive care centred on an integrated multidisciplinary team who have a specialist interest in stroke rehabilitation. The way in which this is achieved is likely

to reflect local circumstances. Stroke unit care does not apparently increase the time spent in hospital

The Stroke Unit Trialists' Collaboration[4] paper on a systematic review of randomised trials has shown that organised stroke unit care resulted in long term reductions in death, dependency and the need for institutional care. Stroke units reduce the risk of death or living in an institution at a median of 12 months after a stroke. Mortality is reduced by 28% at 17 weeks and 25% at 1 year.. At a median of one year after a stroke the following results were obtained :-

Type of care

	Dead	Dead or in institution	Dead or dependent
Organised stroke care	20.9%	40.1%	59.8%
Control	25.4%	47.2%	66.4%

Numbers of patients needed to treat in a stroke unit setting to gain one of the following benefits:

For 1 extra patient to survive:	22 patients treated in a stroke unit
For 1 extra patient to return home	14 patients treated in a stroke unit
For 1 extra patient to regain physical independence:	16 patients treated in a stroke unit

The chances of a patient dying were reduced by 18%, of dying or requiring institutional care by 25%, of dying or remaining physically dependent by 29%.

The stroke unit approach places the patient under the direct care of a team lead by a physician with specialist expertise in stroke. Acute treatment and rehabilitation should ideally take place as part of a continuum. In the Irish setting, stroke specialisation takes place among geriatricians, rehabilitationists and neurologists. The precise contribution of each specialty will relate to local resources and strategic interests.

Published research on stroke units includes the following as core members of the stroke rehabilitation team:

Specialist physician
Nursing (specialized where possible)
Physiotherapist
Occupational Therapist
Social Worker
Speech and Language Therapist
Clinical Nutritionist
General practitioner

Access to clinical psychology/neuropsychology, psychiatry, podiatry, orthotic and pastoral care services are also important but unquantified. Access to vascular surgery will be indicated for a minority of patients.

The report of the Stroke Council of the IHF recommends stroke units the following staffing levels per 10 dedicated beds based on authoritative review:

	BMJ	**Irish Estimate**
Designated Specialist Physician	0.5-1	0.5
NCHD cover	Not stated	1.0
Nursing	7-12	11
Physiotherapist	1-2	2
Occupational Therapist	0.9-1.3	1.3
Social Worker	0.4-0.7	1.0*
Speech and Language Therapist	0.2-0.6	1.0*
Clinical Nutritionist	Not stated	1.0
Psychologist	Not stated	1.0

*The higher figure is compensatory for the almost complete lack of these services in the community in Ireland compared to the United Kingdom.

Selection criteria

There is no evidence to support particular selection criteria for more active rehabilitation or admission to a stroke unit. If anything, those with more severe stroke have been shown to have the most to gain from it[5]. (Stroke Units Trialists' Collaboration 1998).

Unanswered questions

One paper has suggested that some caution is required as variations in case mix may account for 24% of the variance between some stroke rehabilitation outcomes (Davenport, 1996). It is not also clear whether standard multi-disciplinary care in a geriatric medical setting will not be equally effective (Stone 1999).

Pharmacological interventions

(see Appendix, National Clinical Guidelines, Acute Treatment)

Two acute pharmaceutical treatments with proven but modest effect are

i) Aspirin: Early use of aspirin after an ischaemic stroke confirmed by CT scan reduces the risk of death and dependency and improves the chance of complete recovery[5]. Other trials show continuation of low-dose aspirin long-term post ischaemic stroke gives long term protection.

ii) Intravenous thrombolysis, which may be introduced in Ireland in the near future. The National Clinical Guidelines for Stroke UK recommend the following:

> Thrombolytic treatment with tissue plasminogen acativator (tPA) should be given only in a specialist centre, within 3 hours of stroke onset (when haemorrhage has been definitely excluded) (A)

Differences between the trials mean that the 'best' type of thrombolytic to use remains unknown

The introduction of this therapy will have implications for the delivery of stroke care. There is likely to be an increase in the number and urgency of referrals. Apart from improving response time, it requires rapid access to CT/MR, as well as the development of skills in reading the often subtle signs of established infarction. Possibilities include intensive training of senior clinical personnel, or the use of tele-

radiology. There are also ethical difficulties about explaining to compromised patients and carers the trade-off between the benefits against the ten-fold increase in symptomatic ICH. Finally, the patient will require intensive monitoring after thrombolysis.

Rehabilitation

Stroke rehabilitation is an active process beginning during acute hospitalization, progressing for those with residual impairments to a systematic program of rehabilitation services, and continuing after the individual returns to the community.

Because the clinical manifestations of stroke are multifaceted and complex, stroke rehabilitation is best implemented through the coordinated efforts of a team of rehabilitation professionals. The Stroke Council document recommends that in-patient rehabilitation of stroke in Ireland should take place either on the general hospital site or in adequately equipped and staffed rehabilitation hospitals.

A well-conceived rehabilitation management plan is the basis for all rehabilitation. The first step is to match the patient with the appropriate rehabilitation services and setting.

Scientific Basis for Stroke Rehabilitation

Rehabilitation is effective. At present, however, we cannot easily differentiate between the influence of specific interventions and the natural recovery process. The effective delivery of post-stroke rehabilitation requires development of an integrated care system that spans acute care and rehabilitation, outpatient rehabilitation services, home care, and community support services.

Issues within the Irish healthcare system include:

Lack of a coordinated approach

Lack of full interdisciplinary teams

Rural/urban differences

Age issues

Lack of community resources, lack of transportation to Outpatient care

Recommendations for acute treatment and rehabilitation in hospital

The Stroke Council document makes a number of recommendations re the following:

- the care of all patients with stroke should be under the care of an interdisciplinary team lead by a physician with specialist training in stroke, in the setting of a stroke unit, with a clearly defined continuum of care
- all patients with stroke should have access to timely CT/MR scanning, as well as modalities such carotid duplex scanning. Senior personnel need to be trained in the reading of CT scans in acute stroke
- procedures for thrombolysis in Irish hospitals need to be developed in conjunction with primary care if thrombolysis is licenced for the treatment of acute ischaemic stroke.

Rehabilitation in the community

The National Clincial guidelines for Stroke in the UK recommend the following:

i. Specialist stroke services can be delivered to patients, after the acute phase, equally effectively in hospital or in the community, provided that the patient can transfer from bed to chair before going home (A)

ii. Specialist day hospital rehabilitation or specialist domiciliary rehabilitation can be offered to outpatients with equal effect (A)

iii. Each district conducts a needs assessment exercise to determine the level of care so that all stroke patients in the area have access to the same standard of care (C)

iv. Patients not admitted to hospital should be seen by a specialist rehabilitation team (A)

Stroke-specific community rehabilitation is of limited availability present. The Stroke Council recommends the following in relation to community rehabilitation:

- Full out-patient rehabilitation should be made available for all patients of all ages in each Health Board area, on the basis of 250-300 patients discharged to the community/year per 250,000 population
- Transportation should be made available for Out-patient care
- Community services should be developed to encompass the full interdisciplinary team and appropriately supported to enable team work
- Other strategies should be developed for rural areas where distances are greater: and domiciliary services may be more appropriate
- The activities of the Volunteer Stroke Scheme should be developed and supported
- On-going therapy needs of those in long-term care must be fully supported

References

1. Towards excellence in stroke care in Ireland. Stroke Council of Ireland Irish Heart Foundation. Draft 2 2001.

2. Getting Research into Practice (GRIP) Stroke Rehabilation. Effective Healthcare Bulletin April 1994.

3. Department of Health and Children 1999. Building Healthier Hearts. The Report of the Cardiovascular Health Strategy Group. Dublin: The Stationery Office

4. Stroke Unit Trialists' Collaboration. Collaborative systematic review of randomized trials of organised inpatient (stroke unit care after stroke. BMJ 1997; 314:1151-1159.

5. Clincial Evidence Issue 5. June 2001 BMJ publishing group.

Appendix A

National Clinical Guidelines for Stroke, Royal College of Physicians UK, Concise Guide

Level of Evidence	Type of Evidence	Grade of Recommendation
Ia	Meta-analysis of randomized controlled trials (RCTs)	A
Ib	At least one RCT	A
IIa	At least one well designed controlled study but without randomization	B
IIb	At least one well designed quasi-experimental study	B
III	At least one well designed, non-experimental descriptive study (eg comparative studies, correlation studies, case studies)	B
IV	Expert committee reports, opinions and /or experiece of respected authorities,	C

Organisation of Stroke Care

a) Every organisation involved in the care of stroke patients over the first 6 months should ensure that stroke patients are the responsibility of and are seen by services specialising in stroke and rehabilitation (A)

The stroke service should comprise:

i. a geographically identified unit acting as a base, and as part of the inpatient service (A)

ii. a co-ordinated multidisciplinary team (A)

iii. staff with specialist expertise in stroke and rehabilitation (A)

iv. educational programmes for staff, patients and carers (A)

v. agreed protocols for common problems (A)

b) Specialist stroke services can be delivered to patients, after the acute phase, equally effectively in hospital or in the community, provided that the patient can transfer from bed to chair before going home (A)

c) Specialist day hospital rehabilitation or specialist domiciliary rehabilitation can be offered to outpatients with equal effect (A)

d) Patients not admitted to hospital should be seen by a specialist rehabilitation team (A)

Carers and families

a) Families should be given information on the nature of stroke and its manifestations and on relevant local and national services (A), and patients and carers should be involved in decisions (C)

b) Stroke services must be alert to the likely stress on carers (B).

c) Family support workers should be involved to help reduce carer distress (A).

d) Patients and their carers should have their individual psychosocial and support needs reviewed on a regular basis (C)

Diagnosis

a) Stroke is primarily a clinical diagnosis. Confirmation, using imaging, will be needed if there are unusual clinical features.

b) Brain imaging is required as a matter of urgency if: (B)

- There is a clinical deterioration in the patient's condition
- Subarachnoid haemorrhage is suspected
- Hydrocephalus secondary to intracereberal haemorrhage is suspected
- Hydrocephalus secondary to intracerebral haemorrhage is suspected
- Trauma is suspected
- The patient is on anticoagulant treatment, or has a known bleeding tendency.

c) Brain imaging should be undertaken in all patients within 48 hours unless there are good clinical reasons for not doing so (C)

d) The diagnosis should always be reviewed by a neurologist or physician with special interest in stroke (B)

Acute treatment

a Aspirin (300mg) should be given as soon as possible after the onset of stroke symptoms (if a diagnosis of haemorrhage is considered unlikely) (A).

b No other drug treatment aimed at treatment of the stroke should be given unless as part of a randomised controlled trial (A)

c Neurosurgical opinion should be sought for cases of hydrocephalus (B)

d Thrombolytic treatment with tissue plasminogen acativator (tPA) should be given only in a specialist centre, within 3 hours of stroke onset (when haemorrhage has been definitely excluded) (A)

e There should be local policies for the early management of hypertension, hyperglycaemia, hydration and pyrexia (C).

f Where stroke has caused weak or paralysed legs, full-length compression stockings should be applied (unless contra-indicated) to prevent venous thrombosis (A)

Secondary prevention

a All patients should have their blood pressure checked, and hypertension persisting for over one month should be treated. The British Hypertension Society guidelines for optimal blood pressure treatment targets are: systolic blood pressure <140 mmHg; diastolic blood pressure <85 mmHg; the minimum accepted level of control recommended is <150/<90 mmHg (A).

b All patients, not on anticoagulation, should be taking aspirin (50-300mg) daily (A), or a combination of low-dose aspirin and dipyridamole modified release (MR). Where patients are aspirin intolerant an alternative antiplatelet agent (clopidogrel 75mg daily or dipyridamole MR 200 mg twice daily) should be used (A)

c In the presence of a trial fibrillation (A), mitral valve disease, prosthetic heart valves, or within 3 months of myocardial infarction (C), anticoagulation should be considered for all patients who have ischaemic stroke.

d Anticoagulation after transient ischaemic attacks or minor strokes is contraindicated unless cardiac embolism is suspected (A).

e Any patient with a carotid artery area stroke, and minor or absent residual disability should be considered for carotid endarterectomy (A)

f All patients should be assessed and treated for other vascular risk factors and advised about life-style factors (B).

g Therapy with a statin should be considered for all patients with a past history of myocardial infarction and a cholesterol >5.0 mmol/l following stroke (A)

Rehabilitation

Core principles

a Any of the current exercise therapies should be practiced within a neurological framework to improve patient function (A)

b All members of the healthcare team should work together with the patient and family, using an agreed therapeutic approach (B).

c Clinicians should use validated assessment measures to assist clinical decision-making on therapeutic interventions, and monitor patients' progress during rehabilitation (C)

Multidisciplinary general assessment:

A A multidisciplinary assessment using a formal procedure or protocol should be undertaken and documented in the notes within 5 working days of admission (A). The protocol should include assessment of:

i. Consciousness level, using a validated clinical method, on admission (C);

ii. Swallowing, using a validated, clinical method, to be undertaken within 24 hours by appropriately trained personnel (C); see Guideline 8.2.a;

iii. The risk of developing pressure sores, undertaken on admission (C);

iv. Nutritional status, using a validated method, to be undertaken within 48 hours by appropriately trained personnel (B);

v. Cognitive impairment, using a validated clinical method, within 48 hours of regaining consciousness (C);

vi. The patient's needs in relation to moving and handling, within 48 hours of admission(C).

b) All patients should be referred to a specialist rehabilitation team as soon as possible, preferably within 7 days of admission (C)

Management

a Protocols should be adhered to for:

- Management of urinary and faecal incontinence and constipation (B)
- Nutritional support and enteral feeding
- Prevention and management of shoulder pain
- Discharge planning

b Goal setting should involve the patient (B), and family if appropriate (C)

c Patients and specific communication difficulties should be assessed by a speech and language therapist for their suitability for intensive therapy (B)

d Patients should be screened for emotionalism, depression and anxiety within the first month of stroke, and their mood kept under review (C). when diagnosed, an intidepressant should be considered (A)

e A physiotherapist with expertise in neuro-disability should co-ordinate therapy to improve movement performance of patients with stroke (C).

f All patients with difficulties in activities of daily living should be assessed by an occupational therapist with specialist knowledge in neurological disability (A)

g Carers should receive all necessary equipment and training in moving and handling, in order to position and transfer the patient safely in the home environment (B).

Services for Older People