National Council On Ageing And Older People

COMMUNITY CARE SERVICES
Ageing in Ireland Fact File No. 6

The health strategy document *Shaping a Healthier Future*[1] outlines a clear commitment to maintaining at least 90% of persons aged 75 years or more in their own homes. To achieve this, a comprehensive system of home and community care supports is essential.

The key community care support services for older people and their carers as identified in *The Years Ahead* report[2] (the main Irish policy document on services for older people, published in 1988) are domiciliary nursing, home helps, day care centres and meals services with occupational therapy, physiotherapy, chiropody, speech therapy and social work services additional as appropriate. There is evidence, however, that access to these services is limited and variable within and among regional health boards[3]. In addition, the projected increases in the older population will have obvious and serious implications for the provision of community health and social services.

The following information is derived from a review[4] of the implementations of the recommendations of *The Years Ahead* report carried out by the Council in 1997, unless otherwise stated.

Nursing Services

- Alongside a good medical service, *The Years Ahead* report identified a comprehensive nursing service as being vital to caring for older people at home. Community nurses perform a number of vital functions, including health screening, anticipatory care, liaison with other community care professionals, health education, management and administration of medical appliances and aids, and home nursing.

- In 1995 there were 1,410 full-time public health nurses in Ireland, roughly one for every 2,500 persons of all ages (Table 1).

Table 1. Number of Public Health Nurse posts in 1995

Health board	1987	WHOLE TIME EQUIVALENT (WTE) 1995		WTE 1995 Excluding Superintendent PHN		WTE 1995 Excluding Superintendent PHN and Senior PHN		Population
		N	Ratio	N	Ratio	N	Ratio	
EHB	365	434.73	1:2976	425.73	1: 3039	404.73	1: 3197	1,293,964
MHB	78	105.47	1: 1946	103.47	1: 1984	101.47	1: 2023	205,252
MWHB	103	125.42	1: 2527	123.42	1: 2567	109.42	1: 2896	316,875
NEHB	105	129.73	1: 2356	126.73	1: 2412	117.73	1: 2597	305,703
NWHB	97	106.33	1: 1976	104.33	1: 2014	101.33	1: 2074	210,112
SHB	129	180	1: 3034	176.00	1: 3103	161.03	1: 3391	546,209
SEHB	130	157.49	1: 2482	154.49	1: 2531	146.49	1: 2669	391,046
WHB	147	171.21	1: 2055	168.21	1: 2092	159.21	1: 2210	351,874
Total	1154	1410.38		1382.38		1301.41		3,621,035
Ratio	1:3065	1: 2567		1: 2619		1: 2782		

Source: Department of Health, 1995 Census of Public Health Nurses

- The number of posts increased by more than 250 between 1987 and 1995. The current ratio is superior to the target of 1:2,616 mentioned in *The Years Ahead* report.

- Nurse to older person ratios vary significantly across the health board regions. The best ratio occurs in the Midland Health Board region (1:1,946) and the worst occurs in the Southern region (1:3,034). Feedback from public health nurses reveals widespread dissatisfaction with the current number of posts.

- As well as public health nurses, all health boards have established panels of general nurses who provide nursing care to older people at home on a part-time basis. These nurses are seen as providing particularly beneficial services to chronically or terminally ill older people living at home. They also allow the public health nurses to concentrate on other duties.

- Excluding superintendent and senior public health nurses who carry managerial roles, it has been found that four health boards are below the recommended ratio level of public health nurses to patients.[4]

- There is still a need for more nurses to carry out liaison responsibilities and a need for more nurses dedicated to the care of older people.[4]

- A study of older people's use of and need for community health services (the HeSSOP study, 2001) found that the public health nursing service was the most frequently used of the home-based services.[5] The study found that 15% of older people reported using the public health nurse service and many of this group (14%) wanted to use more of this service.

- While less than 1% of the sample of older people reported using the personal care attendant service, 17% of these people would also have liked to use this service more frequently.

- Just 3% and 2% of older people respectively reported that while they did not use the public health nursing service and personal care attendant service, they would have liked to.[5]

- Despite many of the people in the 2001 study having difficulty with the tasks of daily living, approximately one-third had no informal help whatsoever. The most common reason given as to why people did not avail of the public health nurse service was lack of information.

Home Help Services

- Home helps provide a range of services to older people. These may be divided into personal care (eg bathing), home care (eg cleaning), tasks outside the home (eg shopping), companionship and monitoring.

- The most important factors in determining the need for a home help are: the degree of dependence; level of mobility; living conditions; availability of an informal carer, and degree of isolation.

- In 1998, there were approximately 12,000 (mostly part-time) home helps and 20,000 recipients of the service.[7]

- In is often assumed in assessing a person's need for home help services that they should neither substitute nor supplement existing informal arrangements where care is already provided by relatives or neighbours. The 2000 community study found that requests for home help services appear to be turned down if there seems to be someone else fulfilling the role of a 'home help'.[5]

- In the same study, of the 5% of older people who used home help services, 14% of this group reported that they would like to use this service again. A further 3% of older people who did not receive the home help service would have liked to.

- The Joint Committee on Women's Rights (1996) estimated that, based on current patterns, population growth and care provision, around 100,000 older people will require home care by the year 2011, an increase of 30%.

- *The Review of the Implementation of the Recommendations of the Years Ahead* study revealed widespread concern about the level of provision of the service.[4]

- The 1994 study found there were six models governing the delivery of the home help service across the country. Table 2 below outlines these models and indicates the particular models used by each health board.

Table 2. Models of delivery of home help service

	Model of delivery	Health board
1	Overall responsibility with Superintendent PHN	North Eastern and some areas of South Eastern and Southern
2	Overall responsibility with Superintendent PHN and Superintendent Community Welfare Officer	Areas of Eastern and South Eastern
3	Home Help Organiser employed by health board	Western and Midland and areas of Mid-Western, North Western, Southern and South Eastern
4	Overall responsibility with Superintendent PHN but with input from Home Help Organiser	Parts of North Western
5	Voluntary organisations have responsibility	Most of Eastern and areas of Mid-Western
6	Overall responsibility with Superintendent PHN but Home Help employed by voluntary organisation	Areas of North Western and part of Southern

Source: Lundström and McKeown (1994)

- The home help service is usually delivered directly by the health board, but in the Eastern health board and in some areas of the Mid-Western and North Western health boards there is a large voluntary input.

- A 1994 report showed that the commonest complaint among home help clients in the study was that they required longer hours of care.[6]

Day Centres

- It is estimated that under the National Development Plan, between 1998 and 2000 over 1,000 day-places per week will have been provided in ten new day care centres (twenty places per centre multiplied by five days per week).

- The HeSSOP study of older people in the community included day time services in its survey of health and service use by older people. Day hospitals and day care units were viewed as the more 'medical' services, while day centres and day clubs were seen as places with a 'social' emphasis. Some 15% of older people reported using the more medical daytime services while 2% of people had attended the more socially orientated services.[5]

- The study found that 4% of the older people who did not use day centres or clubs would have liked to have availed of these services. Barriers to service use identified by older people included being unaware of the service or lack of adequate transportation.[5]

- The main purposes of day centres are: to provide a service such as a midday meal, a bath and a variety of paramedical services; to promote social contact and prevent loneliness; to relieve caring relatives, particularly those who have to go to work, and to provide social stimulation in a safe environment for older people with mild forms of dementia.

- The number of day care places for older people is difficult to estimate, as many are provided by the voluntary sector. The 1997 review of implementations of recommendations of *The Years Ahead* report found that at least 4,000 places were provided nationally (Table 3).

Table 3. Provision of day care places for older people 1996

Health board	Places provided	Centres provided
Eastern	200 board places	Approx. 1,600 voluntary places in 68 centres
Midland	248 (approx.)	17
Mid-Western	280 (approx.)	14
North Eastern	315–420 (approx.)	21

North Western	410	13
Southern	250 (approx.)	17
South Eastern	10–25 in each centre	43
Western	153 (approx.)	12

Source: Interviews with Programme Managers of Community Care and CSEs

- The current number of day care places is widely accepted as being inadequate and most health boards have plans to extend this sector. The level of provision is also uneven across the country with the western and southern regions having particularly low numbers of places.

Meals Services

- In the HeSSOP study only 1% of older people reported using meals-on-wheels. Around 17% of those who did use meals-on-wheels would have liked to have received more of the service, while a further 1% of people who did not use the service would have liked to. Lack of information regarding the service and stigma prevented people from availing of this service. Factors that appeared to be associated with a need for meals-on-wheels were depression and lack of family help rather than immobility.[5]

- Almost all meals services to older people are provided by voluntary organisations. Despite the perception, meals services are not simply a form of economic support for poorer older people. Older people have a higher risk of malnutrition than younger people and meals services have an important role to play in maintaining nutritional health.

- The most commonly reported nutritional deficiencies in older people are of iron, protein, vitamin C, folic acid, calcium, vitamin D, zinc, water and fibre. Poor nutrition in old age can negatively influence the health, longevity and quality of life of older people.

- Commonly cited major risk factors for malnutrition in older people are social isolation, recent bereavement, poor dentition, reduced mobility, psychiatric morbidity and multiple medication usage.

Other Services

- A number of other professions are also involved in the care of older people living in the community. In general, these services are provided in community health centres or hospitals, despite evidence that many older people require these services at home.

- In the HeSSOP study, 3% of older people in the community had used physiotherapy during the past year. Despite the low level of usage, there was a high satisfaction rate with the service (97%). Eight per cent of people who used the service would have liked to have received more physiotherapy while 5% of older people who had not received physiotherapy in the past year would have liked to have received this service.

- Chiropody was one of the health and social services used most by older people in the community (16% of respondents). On average, older people who availed of this service used it about three times a year and seemed to be quite satisfied with the service (96%). However, the provision of this service is not keeping pace with demand. Some 14% of the respondents already using this service would have liked to have received more of this therapy while 12% of older people who did not use this service would have liked to.

- Occupational therapists are involved in the care of older people by advising on how they might adapt their homes to cope with increasing disability. Where necessary, occupational therapists are also involved in the allocation of medical appliances and aids.

- In the HeSSOP survey of older people in the community, less than 1% of older people used occupational therapy. While only one person out of a total number of seven who had used the service during the year would have liked to have used more of the service, 1% or 12 people who had not previously used the service reported that they would have liked to.

- Lack of information was reported as the biggest barrier in older people's use of these therapeutic services. Nine per cent of older people in the community survey reported that they did not know a service was available while a further 2% had never heard of the service in question, and 14% rated obtaining information as difficult or very difficult. GPs were preferred by the majority of the respondents (79%) as informants. A large portion of older people felt that better health information was important for improving their health.[5]

According to a 2001 report,[8] prepared for the Department of Health and Children, an additional 1,300 chartered physiotherapists and 875 occupational therapists will be needed if adequate services are to be provided in the years ahead. To help alleviate the expected shortages of therapists, the report recommends that a fundamental review of the training system should be undertaken; that appropriate two-year courses should be made available to enable assistant therapy grades to be expanded significantly; that the Department of Health and Children should review the career structures within the three professions, and that, in the short term, a concerted drive should be undertaken to recruit from overseas.

Reference Material

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