Ireland

Care Work with Older People

Whitehall College of Further Education
Tara Winthrop Private Clinic

Education and Culture
Leonardo da Vinci
FIN-00-B-P-PP-126556

"This project has been carried out with the support of the European Community. The content of this project does not necessarily reflect the position of the European Community or the National Agency, nor does it involve any responsibility on the part." The expansion of the transnational module and development of the work placement supervising. The ETM-pilot project 2000-2003 FIN-00-B-P-PP-126556

Content

"Dear Student

Welcome to Ireland! We are pleased you are doing your work placement here and hope it is a productive and pleasant time.

The purpose of this handbook is to give you an overall view of the development of Health and Social Services for older people in Ireland. It maps the history of Health and Social Services from the 20th century right up to the present day and also includes future plans. On a practical level it outlines the social services and networks into which older people can link. It describes the role of the care worker within the Irish healthcare system, and the level of care which our older community can expect.

There is a lot of information contained in this handbook. It is best used as a reference and guide. Please read the content list and use the relevant material you need at any particular time. There is a glossary of terms and words used in Ireland in the area of care of older persons.

We trust you will find it a helpful resource in understanding the Irish system.

Outline of Chapters:

In the following chapters we will go into some detail of how the Health & Social Services in the Care of Older People, apply in Ireland.

Chapter 2 deals with Social Welfare Policy in Ireland. The Social Welfare system covers all of the internationally recognised forms of social protection.

Chapter 3 outlines the development of Policy and Services for Older people. It identifies the various Policy Documents and endeavours to show how the contents of those Documents and Reports are being implemented.

Chapter 4 - This chapter on Services for older people in Ireland, traces the history of what was available from early 20th century to the present time.
Chapter 5 - Incorporates a mix of both social insurance and social assistance programmes, which offers financial support to older people. The chapter shows the most up-to-date information on income support, pensions, medical support both public, private and voluntary .

Chapter 6 - Introduces concepts in the Care of Older People, Professional Ethics involved, Codes of Practice and one of the models of care used in the nursing care of older people.

Chapter 7 - This section will give the student an idea of the assessment procedures used when compiling a care plan for the older person in care. Here we include a case study of each situation the Care Assistant may find him/herself in when caring for an older person (a) in the home (b) in the community and (c) in residential care.

Chapter 8 - Gives students a broad outline on employment in the care of older people. This chapter is based on the employment situation in Ireland at the present time. It also outlines the duties of a Care Assistant, from recruitment to employment.

Chapter 9 - deals with Education and training in the work place.

*Please note
Older people in Ireland prefer to be referred to as Senior Citizens or Older People rather than the Elderly. This must be acknowledged and respected.

1. United Nations, European Union and Social Policy:

1.1. United Nations' Second World Assembly on Ageing 2002: Building a society for all ages.

An ageing population is a challenge to all societies. Global guidelines and principles are drawn to secure and enable older people's integration as full citizens in different societies. As an example of such global aims, the following United Nations' document presents United Nations' principles that are re-phrased on a European Union level.

Building on previous meetings of the United Nations Plenary Assembly in 1982 during which they formed an action plan and United Nations Plenary Assembly in 1991 when this action plan was passed a further meeting was convened in 2002.

To address challenges associated with the momentous demographic shift taking place in the older population, the United Nations' General Assembly decided to convene the Second World Assembly on Ageing from 8th to 12th April, 2002 in Madrid, Spain. An international action plan in this regard was passed on 12th April, 2002. Article 1 of this plan is expressed as follows:

We, the representatives of the governments, meeting at the second world assembly in Madrid, to address the fact of ageing, have decided to pass an international action plan to take into account the possibilities and challenges associated with older people in the 21st century.

We commit to ensure at all levels, including National and International, that this action plan is built on three solid foundations:

- Older people and their development
- Promotion of health and well being in advanced years
- Guarantee of a beneficial and supporting environment.

The Principles of the United Nations for the care of the older person such as:

- Independence
- Participation
- Care
- Self fulfilment and
- Dignity

Are now set in stone, with targets, measures, demands listed in 117 points on the charter. Special mention was given in the International network (point 109) to the words exchange - consultation - support. The United Nations Commission for Social Development will be responsible for implementing and following up those Principles to ensure that action plans are carried out at National and International level.

Further information on the United Nations guidelines and principles may be had from:
http://www.un.org/esa/socdev/ageing/waa/index.html
http://www.un.org/ageing/dpi2230.html

1.2. United Nations Principles for Older Persons

(adopted by the UN General Assembly December 16, 1991 - Resolution 46/91)

◆ The following excerpt highlights in a more detailed way, aims which the United Nations has set for policy makers and legislative bodies in different societies.

"To add life to the years that have been added to life"

The United Nations' Principles aim is to ensure that priority attention will be given to the welfare of older people. The United Nations' Principles address the independence, participation, care, self-fulfilment and dignity of older persons.

The General Assembly appreciates the contribution that older people make to their societies and encourages national Governments to incorporate the following Principles into their national programmes, whenever possible:

Independence

1. Older persons should have access to adequate food, water, shelter, clothing and health care through the provision of income, family and community support and self-help.
2. Older persons should have the opportunity to work or to have access to other income-generating opportunities.
3. Older persons should be able to participate in determining when and at what pace, withdrawal from the labour force takes place.
4. Older persons should have access to appropriate educational and training programmes.
5. Older persons should be able to live in environments that are safe and adaptable to personal preferences and changing capacities.
6. Older persons should be able to reside at home for as long as possible.

Participation

7. Older persons should remain integrated in society, participate actively in the formulation and implementation of policies that directly affect their well-being and share their knowledge and skills with younger generations.
8. Older persons should be able to seek and develop opportunities for service to the community and to serve as volunteers in positions appropriate to their interests and capabilities.
9. Older persons should be able to form movements or associations of older persons.

Care

10. Older persons should benefit from family and community care and protection in accordance with each society's system of cultural values.
11. Older persons should have access to health care to help them to maintain or regain the optimum level of physical, mental and emotional well-being and to prevent or delay the onset of illness.

12. Older persons should have access to social and legal services to enhance their autonomy, protection and care.
13. Older persons should be able to utilise appropriate levels of institutional care providing protection, rehabilitation and social and mental stimulation in a humane and secure environment.
14. Older persons should be able to enjoy human rights and fundamental freedoms when residing in any shelter, care or treatment facility, including full respect for their dignity, beliefs, needs and privacy and for the right to make decisions about their care and the quality of their lives.

Self-fulfilment

15. Older persons should be able to pursue opportunities for the full development of their potential.
16. Older persons should have access to the educational, cultural, spiritual and recreational resources of society.

Dignity

17. Older persons should be able to live in dignity and security and be free of exploitation and physical or mental abuse.
18. Older persons should be treated fairly regardless of age, gender, racial or ethnic background, disability or other status, and be valued independently of their economic contribution.

Further information is available at:

http://www.aoa.gov/international/Principles/princple.html
www.un.org/socdev/iyoppop.htm

1.3. European Union and Social Policy

◆ The European Community Treaty enacted in Maastricht in 1992 emphasises connections between economic growth, employment and welfare. Social policy and social protection are seen as factors promoting economic growth.

The EU-level social policy decision making is restricted in drawing up general guidelines and principles that can be found in different Council's Recommendations and Charters agreed by Member States.

From an ordinary citizen's viewpoint the question lies more with the national social policy legislation: social policy is a core responsibility of the Member States. The EU has laid down only minimum standards and minimum rights.

The European Social Charter represents a consensus over basic economic, social and cultural rights. The rights guaranteed by the European Social Charter are as follows:

The right to education
The right to employment,
The right to health,
The right to housing,
The right to non-discrimination and
The right to social protection.

The European Social Charter defines the rights of EU-citizens on a general level. The implementation of these rights is

executed by Member States. Under the Charter, states must guarantee the right to social protection i.e.

The right to the protection of health,
The right to social security
The right to social assistance and
Social services.

It lists the special measures, which must be taken for the older person. The revised Charter guarantees the right to protection against poverty and social exclusion. The European Social Charter defines the rights of EU citizens on a general level. The implementation of these rights is executed by Member States.

1.4 Social Protection of Older People - Social Charter

◆ The following additional protocol to the European Social Charter specifies older people's rights to social protection. As all Member States have ratified the Charter, it binds Member States and they are expected to adapt their social policy programmes and measures to meet the aims of the Charter. The additional protocol lays the guidelines for the social protection of older people on a European Union level, in the following way:

Article 4 - Right of older persons to social protection.

With a view to ensuring the effective exercise of the right of older persons to social protection, the Member States undertake to adopt or encourage, either directly or in co-operation with public or private organisations, appropriate measures designed in particular:

1. **Enable older persons to remain full members of society for as long as possible, by means of:**
   (a) adequate resources enabling them to lead a decent life and play an active part in public, social and cultural life;
   (b) provision of information about services and facilities available for older people and their opportunities to make use of them;
2. **To enable older people to choose their life-style freely and to lead independent lives in their familiar surroundings for as long as they wish and are able, by means of:**
   (a) provision of housing suited to their needs and their state of health or of adequate support for adapting their housing;
   (b) the health care and the services necessitated by their state.

3. **To guarantee older people living in institutions appropriate support, while respecting their privacy, and participation in decisions concerning living conditions in the institution.**

Source: European Social Charter, Additional Protocol to the European Charter ETS No. 128.

The Member States are to develop their national social policy legislation accord-

ing to these EU-level guidelines of the European Social Charter. The national policy on ageing of a Member State should be based on the above Article 4 - Right of Older Persons to Social Protection.

Ireland like most of Europe, has reaped the benefits of the last thirty years of increased Government investment and resources in the Health and Social Welfare of it's population. Prosperity, good nutrition and effective health and social care policies have contributed to the increased life expectancy of Irish men and women.

This is in stark contrast to Ireland in the first half of the 20th century, as evidenced in statistics available. It is very clear how lack of education, poverty, emigration and general low nutritional quality, contributed to a low birth survival rate, late marriages and poor life expectancy.

Of course this problem was not exclusively an Irish one, similar conditions could be found in other under-developed countries.

The Irish System is not simple with regard to Social Care. The boundary between social care and medical treatment is not always easy to define precisely. Social Care in the context of which we are writing, will mean all services other than medical care. Social Care, for the most part, takes place in the cared-for person's home or, failing that, in a residential setting which is a substitute for home for those who have become too dependent to live in the community.

Medical care will mean General Medical Services available to the older person in Ireland and is covered more comprehensively in chapter 5.

In Ireland the development of services for older people, similar to the development of general social service provision, has been piecemeal.

Traditionally, the care of older people has been provided for by the extended family, in particular female members.

In Ireland Care of Older People continues to be provided by extended family. However, increasing participation of women in the workforce has meant that care of older people is increasingly provided outside the home/family. This involves either State (Public Funding) or Private provision or a combination of both.

The 1960's Ireland experienced a "baby boom" due to increased prosperity, which resulted from our Government's single-minded dedication to modernise and industrialize the country. However births have declined since the 1970's and this has shifted Ireland's demographics considerably.

Similar to our European partners, we now have a greater population of older people and the trend is set to continue for the next thirty years, (see section dealing with statistics on demography). The Irish Government recognizes this and has been trying to put in place various Social Care policies and formulate strategies to meet the needs of an increasingly large population of older people, and what that means in terms of their health and social care.

2. Welfare Policy in Ireland

2.1. Introduction:

The beginning of a new Millennium makes us aware of improvements in many areas of our daily environment. Life expectancy has increased, and so this is a good time to assess our care provision for the older people in our population.

Social Care incorporates a mix of both social insurance and social assistance programmes. It provides financial support to certain people in situations such as old age, illness, unemployment and widowhood.

Other features of the Social Welfare System include supports for older people in respect of optical, dental and community care. There are other secondary benefits such as free travel and financial support towards the cost of fuel, television licences and telephone rental charges.

The bulk of social care is still provided here in Ireland by family members. It is therefore difficult to incorporate in policy analysis.

(National Council on Ageing and Older People. - Health and Social Care Implications of Population Ageing in Ireland 1991-2011)

2.2. Factors which influence Policy:

Health and social care policies in Ireland are influenced by a number of factors some of which are outlined here.

- The Population structure as per information available from the Central Statistics Office,
- Competing sectors of the economy,
- Strength of lobbying groups within the country,
- The burden of disease, e.g. cardio-vascular, cancers, accidents,
- Mixed Economy of Welfare, Public, Private and Voluntary.

Over the years there have been a number of reports, which have contributed to health and welfare policies for the older person the most notable of which are:

- Care of the Aged Report (1968)
- Planning for the Future (1984)
- The Years Ahead (1988)
- Shaping a Healthier Future (1994)
- Health Promotion Strategy (1995)
- Year Action Plan for Services for Older Persons (1999-2008) Eastern Health Board (Bord Slainte an Oirthir)
- The National Health Promotion Strategy (2000 - 2005)
- Quality and Fairness - a System for You (2001)

2.3. Departments responsible for funding for Care of Older People.

Social Welfare policy in Ireland is administered by the Department of Social, Community and Family Affairs. The function of the Department is to formulate appropriate social protection policies, and administer and manage the delivery of statutory and non-statutory social, community and family schemes and services.

Funding for the Department of Social, Community and Family Affairs Policies comes from the Pay Related Social Insurance Scheme. This Scheme obtains mandatory contributions from both employers and employees. The contributions are a percentage of salary. The percentage is reviewed annually at Budget and may vary according to the Minister's requirements. Any deficit in expenditure is met through the Exchequer.

Spending on Social Welfare accounts for approximately one-quarter of current Government expenditure (about 9.87% of GNP) and benefits more than 1.3 million people (Ireland in Brief - Dept. of Foreign Affairs)

2.4. Key issues for the future care of older people:

- The need for a vision of ageing
- The need for an holistic approach to needs in older life
- The need for adoption of a consumer orientation
- The need for research and evaluation of the services provided.

Physical health is only one element of the well being of senior citizens and, in a modern vision of ageing, social, emotional, intellectual, spiritual care and mental health needs must also be taken into account.

The Irish Government has begun to treat the senior citizen as a consumer and to realise the value of involving this group of our population in decisions which affect them.

The report of the Inter-Departmental Committee on Care of the Aged (1968) provided the impetus and philosophy for public policy for the older person. In contrast to the haphazard and institutionally biased nature of care that went before, The Care of the Aged Report (as it became known), recommended that the basic objective of policy should be, to enable older people to live in their own homes for as long as possible.

For this objective to be met, significant improvements in Community Care would have to be undertaken. Specifically, the Report recommended improvements in the areas of:

- Home Nursing,
- Home Help
- Paramedical Care
- A more flexible General Practitioner Service.

The emphasis of the Committee on an integrated approach to care led to further suggestions concerning income maintenance and the housing needs of older people. It also called for a re-organisation of existing institutional care and the introduction of a new form of welfare home provision (National Council for the Elderly - The Impact of Social and Economic Policies on Older People in Ireland.)

However, although enormous progress has been made throughout the years since the Report was published to improve the Social needs of the older person, a good deal of what was contained in the Report remains aspirational, particularly in respect to domiciliary care.

'Home is best' policy would be the ideal in a perfect world, unfortunately social care budgets do not stretch to the ultimate care solution and the providers of care must work within the confines of their designated budgets.

2.5. Health and Social Care Policies:

Ireland, like most of Europe has reaped the benefits of the last thirty years of increased Government investment and resources in the Health and Social Welfare of the population. In particular,

- peace in our time,
- prosperity, due to policies on Industrialization and Information Technology investment in the country,
- good nutrition,
- effective Health and Social Care policies,

have all contributed to the increased life expectancy of Irish men and women.

Voluntary bodies such as the Alzheimer's Society, St. Vincent de Paul Society, Friends of the Elderly and various Church bodies, provide a wide range of social services for the older person in the community and greatly enhance the State's input in this important area of care.

In recent years the impact resulting from Public/Private partnerships in the care of older people has been most evident in the areas of nursing care and housing. Private funding together with voluntary aid has helped to highlight the needs of older people.

The Programme for Prosperity and Fairness which involved the Social Partners, i.e. The Irish Government, The Trade Unions and Private Enterprise recognised that older people wish to play an active and full role in Irish Society.

It was strongly recommended that we should make full use of the creativity, lifetime experience, skills and ideas of older people for the future development of this country and of local communities.

With that in mind, the Programme for Prosperity and Fairness recognised that all older people should have an adequate income, which would enable them to live in dignity and to share the benefit of economic growth.

For more information on this programme contact Irish Congress of Trade Unions website **www.ictu.ie**

3. Older People in Ireland and Irish Policy on Ageing

3.1. Development of Policy and Services for Older People:

Recent publications on services for older people in Ireland frequently stress the importance of improved co-ordination in the delivery of those services. The reports have identified key areas where improvements can be made;

- Linking the statutory, voluntary and informal systems of care together,
- and involving older people themselves.
- Sharing of expertise by health and social service professionals in the community with a view to reducing the vulnerability of older people at particular risk,
- And liaison between acute hospitals and community care staff, particularly prior to discharging older patients home. (National Council on Ageing and Older People)

In 1981, the Minister for Health established the National Council for the Aged in response to intense lobbying by senior citizen groups. This group set out to advise the Minister on all aspects of the care and welfare of older people.

In 1990 the name of this group changed to the National Council for the Elderly, and in 1997 it became known as the National Council on Ageing and Older People. The Council has published a number of Reports, each containing recommendations which are taken very seriously by the Government and they have been to the forefront in stimulating important legislation, publishing entitlements for the elderly and highlighting problems of abuse and neglect of the older person.

Recent publications of this body are:

- Health & Social Services for Older People, 2001
- An Action Plan for Dementia, 1999
- Abuse, Neglect and Mistreatment of Older People, 1998
- The Future of the Home Help Service, 1998
- Adding Years to Life - Life to Years, 1998
- A Review of the Implementation of the Recommendations of the Years Ahead, 1997.
- Mental Disorders in Older Irish People 1996.

The Report - "Planning for the Future" (1984) recommended sweeping changes in the way Psychiatric Services were to be

planned and delivered in the future, with emphasis on a community approach. It's key recommendations in relation to the elderly were:

- Encouraging older people to remain in their own homes as long as it is practical and possible.
- The appointments of Consultant Psychiatrists in Old Age.
- Older, long-stay psychiatric patients should remain the responsibility of the Psychiatric Services.
- Geriatric specialist units to be set up in major hospitals.

The Years Ahead Policy Document (1988) outlined the improvements necessary in:

- Income Maintenance,
- Housing and
- Health services.

It also chronicled the main improvements vital, in institutional and hospital care of the older person. In addition, it echoed much of what was recommended in the Care of the Aged Report, (1968) and more recently the Planning for the Future Report.

The Years Ahead Policy Document (1988) recommended, as a matter of urgency, that Psychiatrists with responsibility for older people be appointed in Dublin and Cork, to provide a service in their catchment areas, to develop a model service, and to promote high standards in the care of older people, with mental health needs.

The first such Service in Ireland, The North Dublin Psychiatry of Old Age was set up in 1989 with the appointment of the first Consultant Psychiatrist in Old Age, Dr. Margo Wrigley. The Service is based on the principle of Domiciliary Assessment and there are now a total of nineteen, Psychiatry of Old Age Services in Ireland.

The Years Ahead Policy Document (1988) was the first major National Policy Document to focus on the need to develop services for older people. The National Council on Ageing and Older People in a review of the implementation and recommendations of The Years Ahead Report (1997) recommended that the Department of Health should develop a new health strategy for health and social care services for older people.

In response to these developments in health and social care for older people, many health boards developed new strategies aimed specifically at improving service provision for older people. The Health Boards have recognized that:

- There is an urgent need to co-ordinate and integrate services to make them more accessible and to have a person centred focus.
- The creation of service co-ordination posts such as Co-ordinators of Services for Older People has opened the way for development of Care Packages as an approach to care for older people.

"Quality & Fairness - A Health System for You" -(2001) outlines necessary social policy and service provision to meet older peoples needs. Central to this is the development of the following:

- Home support services
- Day and respite services
- Community nursing units.

In keeping with the movement towards home/community based care this report also favours:

- Increased investment in home improvement schemes and
- The provision of sheltered accommodation.

It seeks to review the financial and social needs of Carers and to promote greater equity in subsidizing persons availing of Nursing Home accommodation.

3.2. Services for Older People:

In Ireland services for older people are provided by a mixed economy of welfare involving:

- The State
- Private Enterprise
- Voluntary Bodies

Because the care available was not sufficient, private nursing homes emerged in the 1960's alongside the development of the Health and Social Policies for the elderly, to inject much needed private funds into the care of older people.

Nursing Homes were an entirely new concept in the care of the older person and were quite novel at the time. Up to that time Nursing Homes provided birthing facilities for mothers who wished to enjoy private care. Trends changed and more mothers were availing of hospital care. Necessity being the mother of invention, an enterprise opportunity presented itself and a niche market was created.

Because Nursing Homes were privately owned and operated, fees were charged to their residents for nursing care and maintenance. This meant that only the middle income retiree could afford the service. As the 20th century drew to a close however, Private Nursing Homes were responsible for the care of approximately fifty per cent of the older population in the Republic of Ireland.

Nursing Homes managed by Voluntary Church Bodies and Religious Orders have contributed enormously to the health and welfare of the older person in Ireland over the years. The service they have given and are still giving is significant. Voluntary Bodies and Religious Orders look after the nursing needs of approximately 10% of the elderly population.

Very recently public services are developing to meet the needs of older people. The Department of Health together with the Health Boards are aware of the value given to the State in the provision of much needed

beds for older people by private nursing homes. Legislation governing the operation of Nursing Homes has been up-dated and financial aid to the residents has been indexed in line with current fee structures. Intermixing of public funding to private facilities is now an established solution to what had been a worrying logistical problem for the Irish Government.

A number of voluntary bodies like the St. Vincent de Paul Society, The Alzheimer's Society, Friends of the Elderly and Carers' Association, provide invaluable community service to the older person, augmenting the services provided by the State and Private Enterprise. Together with the National Council on Ageing and Older People, The Older People's Parliament and other interested parties, these voluntary bodies present a very strong and active lobby group for the older person in Ireland.

In summary, one of the most important pieces of legislation governing Nursing Homes during the 1960's was the Health (Homes for Incapacitated Persons) Act, 1964. This was followed in the last decade of the 20th Century by the Health (Nursing Homes) Act, 1990. A Code of Practice, for Nursing Homes was also published in conjunction with this act.

The Years Ahead - A Policy for the Elderly (1988) was an important policy in the development of services for older people.

Against a background of increasing numbers of older people and other demographic trends, which indicate that there will be more older people living in the community, it is prudent to put policies in place which will be effective in the delivery of care.

In Ireland the Oireachtas is the legislative arm of Government. Below outlined you will see the chain of command, which filters down to the bodies responsible for the delivery of care:

The Oireachtas is the Legislative Body
(The House of Parliament)

↓

The Department of Health & Children and
The Department of Social Community
and Family Affairs
(The Government Departments in charge of
Health & Social Care)

↓

The Regional Health Authorities who liaise with
The Community Care Areas (Local offices)

↓

The Community Care Area Boards, work in close contact with the Private and Voluntary Sectors of the Community to deliver care.

Students can access further information from the following websites:

Dept of Health:	**www.doh.ie**
Dept of Social, Community & Family Affairs:	**www.welfare.ie**
Information for Key Life Events:	**www.comhairle.ie**

4. Services for Older People in Ireland

This chapter on Services for Older People in Ireland traces historical provision from:

- The early 20th Century (4.1) (how it was in the past)
- What is available at present (4.2) (how it is now) and
- Aspirations for the future (4.3) (how it may be in the future)

4.1. Care of Older Persons - How it was:

4.1.1. The early part of 20th Century

In the early part of the 20th Century, social welfare was not a concept that governing bodies recognised. The country had been occupied by British rule for centuries and the only welfare laws that were enacted during that period provided very little support for the indigenous community. The Poor Relief Act of 1834 provided for the setting up of "soup kitchens".

Institutions such as "poor/work houses" and "asylums for the insane" were the only examples of organised housing for the elderly and indigent. Religious orders and Voluntary bodies also tried to provide assistance but the vast majority of elderly citizens were cared for in their own homes mostly, it has to be said, by a female relative.

Rural areas fared a lot better than urban areas because of the family support system and the fact that the country had, an agriculture based economy. At least, the majority of the rural population would be in a position to provide fuel for themselves and their neighbours - this was because Ireland had vast areas of peat bog, which produced fuel (peat or turf) in abundance. Poverty was rampant, and one by one the young people emigrated to Great Britain or America in order to make a living and in the process send a little money home.

The emergence of the Irish Free State in 1922 brought tremendous change and upheaval. A civil war followed hundreds of years of British Rule and the suffering of the masses continued until stabilization occurred. New Government structures had to be set up and a total re-organisation in the way Ireland was governed had to be undertaken.

1947 saw the establishment of the Department of Social Welfare in the Republic of Ireland and by 1952 it had become a fully functional department. It was responsible for the administration of schemes of social insurance and social assistance within the state system of social security.

By 1974 compulsory social insurance was introduced and in 1979 the Pay Related Social Insurance Scheme came into being.

This set the scene for the development of a social welfare system in the Republic of Ireland which, by the end of the 20th century, was equal to the standards which pertained in more developed European countries.

In summation, prior to 1947 services for older people, or indeed the ordinary individual, were not defined strictly by any regulatory body. Care of the sick and indigent, was undertaken by various Voluntary bodies, inter-denominational Church Authorities and by the Family. Irish people, young and old worked from the cradle to the grave without benefit of state aid and just hoped that their health and strength would endure, until the eternally optimistic, "better times" arrived.

4.1.2. General Care of Older People at Home.

The Family were the primary carers for the over 65 age group. The social culture was such, that there was a moral obligation on the part of a son or daughter to stay at home and look after their parents in old age. The absence of real alternatives meant that families in poverty and struggling to care for their own family members, were also attending to the needs of older parents.

This practice presented a number of problems:

- Overcrowding,
- Isolation of Older People
- Isolation of Carers and
- Poor Nutrition resulting in the early onset of dementia and related illnesses in the elderly parent.

It also contributed to mental disorders for the carers in certain isolated areas in the country where poor communication and loneliness were big issues. It undoubtedly was a major factor in late marriages or non-marriage for a high proportion of those sons and daughters who cared for dependent older people.

4.1.3. General Care of Older People in Residential Care

During the first half of the 20th century and indeed slightly beyond, older, "mentally infirm" people were sometimes admitted to mental hospitals or as they were then termed "lunatic asylums".

The problems of early dementia and conditions induced by poor nutrition, poverty and loneliness were not recognized. Consequently, older people suffering from various dementias were, more often than not, certified insane by the General Practitioner and admitted to the nearest mental hospital/asylum.

Families could not cope with the problems of old age, as they were already burdened by poverty and the population

decimated by emigration, especially in the rural areas. Older unmarried persons along with widows and widowers had to go into the State Hospital/Home due to this unfortunate situation.

This Hospital/Home was called the "County Home" or the "Ward Union". It is only fair to point out that while those places were not the ultimate in comfort and luxury, they were staffed by very caring people who did what they could, despite being grossly under resourced.

Irish people are by nature, very independent and the fact that they had to accept what they felt was "charity", coupled with the loss of their independence, was totally devastating for the majority of people, who had no alternative care.

The negative memory evoked by the County Home still survives in the memory of present day older people. This continues to contribute to reservations about entering State care.

The advantages of the County Home were

- A Safe Place
- Three meals a day
- Nursing Care.

The disadvantages of the County Home:

- Historic stigma of once being a "lunatic asylum"
- Routines of the homes undermined personal independence
- Once admitted, most clients remained in the County Home until death.

4.1.4. **1947 Onwards and Policy Change:**

The Department of Health was established in 1947 under the Ministers and Secretaries (Amendment) Act, 1946. Prior to 1947 the Public Health Services were the responsibility of the Department of Local Government. Public Health continued to be administered by Local Authorities until 1970. The Health Act 1970 which, established eight Health Boards and abolished the Hospital's Commission, increased the Department of Health's involvement in the execution of a health policy.

The Government published a White Paper in 1951, which recommended that County Homes (the responsibility of the Local Authorities) should be reserved for the sole care of the aged and chronic sick.

This White Paper also highlighted the following facts:

- There was an absence of support for old people at home.
- Few Local Authorities had accepted responsibility for meeting the special housing needs of older people.
- Home helps, meals on wheels and day centres were services offered by a small number of pioneering voluntary organisations.
- Older people who were poor and could no longer maintain themselves, sought admission to the County Homes.

A programme of extension to, and reconstruction and upgrading of, County Homes, followed the White Paper. This resulted in 2,196 new or replacement beds for the elderly population, at an estimated cost of Ir. Punts 3.3 million.

The emphasis on curative and regulatory aspects of the health services and on the need to develop the acute hospitals sector in particular, remained one of the defining characteristics of health policy in the decade following the passing of the Act.

The history of services for the elderly in the twenty years between 1968 and 1988 is largely concerned with the implementation of the recommendations of the Care of the Aged Report (1968)

An inter-departmental committee appointed by the Minister for Health in 1965 prepared the report. The committee was asked to examine the general problem of the care of the aged and to recommend improvements in services. Its terms of reference included income maintenance, housing, health and welfare services for the elderly.

The Care of the Aged Committee approached its task with what was at the time a radical belief -

> "That it is better, and probably much cheaper, to help the aged to live in the community than to provide for them in hospitals or other institutions".

It was the Committee's view that -

> "Public and family care should be regarded as complimentary - not as alternatives - and that the public authority should endeavour to help the family, not take over from it.

The Care of the Aged Report put forward alternative objectives for services for the Elderly:

- To enable the older person who can do so, to continue to live in their own homes.
- To enable the older person who cannot live in their own homes, to live in other similar accommodation.
- To provide substitutes for normal homes, for those who cannot be dealt with as at 1 or 2 above.
- To provide hospital services for those who cannot be deal with at 1,2, or 3 above.

Consequently housing, financial assistance, health and welfare services should be closely integrated to provide a comprehensive service for the Older Person.

The Care of the Aged Report (Dept. of Health 1968) recommended that four main types of accommodation should be provided for the elderly.

- General Hospital,
- Geriatric Assessment Units
- Long-Stay Hospital Units
- Welfare Homes

Since this Report, "work houses/county homes" were re-named Geriatric Hospitals and in many cases were rebuilt, refurbished and modernized.

Community units evolved for the elderly, consisting of extended care beds, respite beds, convalescent and day care facilities.

4.1.5. **More Recent Developments:**

◆ There was an economic "mini-boom" in the early 1960s and '70s in Ireland, which allowed for some financial assistance towards the care of the elderly and a serious attempt was made to upgrade care facilities. It also was an opportunity to look at the grim reality of the elderly mentally infirm being cared for in mental institutions. At this time, Private Nursing Homes began to appear as an alternative to those institutions.

The Private Nursing Home was a new development in Ireland and was originally only available to the older person who, because of means testing, was not eligible for care in the public sector. As private nursing homes became established as an alternative to public nursing care units, older people in general, began to exercise their right to equality and fairness, in the care which they received, whether this was to be public or private.

It soon became apparent that Private Nursing Homes needed to be regularized and assimilated into the extended care area. To ensure proper standards, protocols were put in place in the enactment of an important Government Act. This Act was called The Health (Homes for Incapacitated Persons) Act, 1964 and it paved the way, for the statutory regulation of standards of care of the older person in nursing homes.

The 1964 Act covered a broad range of care homes provision where people were being maintained for profit, viz. old age, physical infirmity, injury, defect or disease, or mental infirmity or mental handicap and also guest homes, maternity homes and mental homes. The Act did not and does not cover public community care nursing units.

This was a very important piece of legislation because it laid down strict guidelines for the operation and maintenance of such homes and institutions. It prescribed certain standards of care and maintenance, food and medicines, which should be adhered to. It specifically established the qualifications of a person deemed suitable to own/manage a Nursing Home. It provided for penalties, including a prison sentence for people in breach of their duty of care.

Because Nursing Homes, towards the end of the 1980's were catering for an increasing number of older people, Nursing Home Owners felt that they would become a more focused and integrated part of the Health Services if they had a professional representative body. So it was that the Irish Registered Nursing Homes Association was established and in collaboration with the Department of Health produced a Code of Practice for Nursing Homes.

In the following years the Department of Health updated the legislation governing Nursing Homes and the "Health (Nursing Homes) Act, 1990 came into being. The Health (Nursing Homes) Act, 1990 and the Nursing Home Regulations which, came into effect on the 1stSeptember, 1993 represent a strengthening of the legislation on standards and care for residents of nursing homes, both public and private.

The Private Nursing Homes sector in the Republic of Ireland is responsible at the present time for the care of 53% of the elderly population. The Health Boards have a number of long stay geriatric hospitals and community nursing units. There are also a number of voluntary hospitals and care homes maintained by religious orders, specialising in care of the disenfranchised and disabled elderly.

As the 20th century drew to a close, a fairly comprehensive service had emerged in the care of older people with Nursing Homes, Community Care Units and Acute Hospitals working together for the good of their patients.

4.2. Present Day Provision for Older People.

4.2.1. **The latter part of the 20th century to today:**

◆ The latter part of the 20th Century shows a significant increase in the population base, particularly in the 65+ age group. As the new millennium dawned there was a concerted effort on behalf of the Government, The Health Boards and Social Partners to increase service bases to the older population.

In 1986 there were 384,355 people aged 65 or older, representing 10.86% of the total population in Ireland. Proportionately, this is not high by European standards and reflects, in part, continued high levels of fertility in the population, which tended to balance out improvements in life expectancy.

It is still the case, however that life expectancy in Ireland is among the lowest in Western Europe. The most recent projections by the Central Statistics Office predict that there may be 437,400 people aged 65 or more by 2011 or 12.62% of population, with a further possible increase to 553,100 (16%) by 2021.

At this point in time, older people can choose the service which best suits their needs, as follows:

Home Community Care
or Residential Care

4.2.2. **Older People at Home:**

In order to minimize costs to the Exchequer in the care of the older person and in keeping with the recommendations in The Years Ahead Report the Health Boards are endeavouring to maintain a "home is best" policy.

This system, when it works as intended, is obviously the answer for people who are reasonably mobile and who are reasonably mentally competent. The Health Boards try to co-ordinate all the services which older people are entitled to, when they return to their own homes, following a stay in an acute hospital.

A multi-disciplinary team, which consists of a doctor, public health nurse, care-giver, occupational therapist, physiotherapist and chiropody services are available in the community to older people. Meals on wheels are also available. This system depends very much on, the older person being mentally competent and physically able to care for himself/herself.

If the older person is suffering from dementia and no longer able to live at home, disabled or requiring ongoing nursing care, the Health Boards may contract beds in private nursing homes or organise beds in one of the local community care units. Please note that as and from 1st September, 2003 contract beds in Private Nursing Homes are being abolished by the Health Boards and instead an 'enhanced' subvention is being offered to older people.

To enable older people to remain in their own homes for as long as possible, a range of services is available to them:

- An assessment of need, is conducted by the Health Board's District Community Care unit.
- A Carer is appointed if required, usually for 1 hour per day, progressing if necessary to 4 hours per day.
- Meals on wheels are organised.
- The services of community nurse, physiotherapist, chiropodist and occupational therapist are assigned.

If an older person wishes to remain in her/his own community, but not in their own home they may be offered sheltered housing, a long-stay public unit or a nursing home in their area.

4.2.3. **Older People cared for in the Community:**

Sheltered housing will apply when the older person involved does not have a domiciliary residence or through circumstances beyond control, have lost their own home. Again an assessment of need is conducted and according to the outcome the older person will be offered the best available option for them.

If the best available option is full time nursing care, the older person may be offered a public long-stay unit nearest to her/his own community area. This is important so that the older person will not lose touch with their family and friends. However, the older person has

a choice here - she/he may decide to request private nursing home care, or voluntary nursing home care instead of the public long stay unit.

4.2.4. Older People cared for in a Residential Setting:

◆ In the event of any of the above choices not being suitable to the nursing, medical or social needs of the older person the long stay geriatric hospital may be the only placement in this case.

The older person may be suffering from a chronic illness, stroke or terminal illness; therefore the assessment of need would be hospitalisation.

The Health Boards at community level endeavour to place older people in the unit of choice and if a community long-stay unit is not available the Health Board will purchase a bed in a private nursing home.

An important service to the elderly in the community is Medicine for the Elderly who provide Day Hospital Services at the major teaching hospitals or day care in the local Community Care Unit. There are a number of pilot schemes currently underway by Consultant Geriatricians in the Departments of Medicine for the Elderly at the Dublin Academic Teaching Hospitals.

The Day Centres take care of the older person's need for social inter-action and is a very valuable service in keeping the older person community based for as long as possible.

The service is constantly evolving and one cannot judge at this early stage if it will be a cost effective and efficient method of keeping people community based. More research is urgently required to examine the wider provision with the hope of a more functional, practical and visionary policy emerging in the near future.

In practice, however, there are older people who cannot function at home independently, while others want to stay at home for as long as possible.

Their choices must be respected and organisations and staff must strive to accommodate their needs in every practical way. Assessments must be ongoing and informed decisions made in order to provide the most suitable and happy placement, always remembering the dignity of the individual and the root meaning of the word "to nurse is to nourish".

4.2.5. **Summary:**

To summarize, there are four different types of homes/hospitals caring for the older person, all of which provide nursing care and maintenance. The units provide a variety of services for the older person as follows:

- Health Board Geriatric Hospitals - Provide long term nursing care for the chronically ill older person. They also provide a Day care service where the older person can have medical and clinical assessments carried out on the day.
- Health Board Welfare Homes - Provide care and supervision for those in need of such an environment.
- Voluntary Hospitals/Homes - Offer Nursing care, Day care, Respite, Long-Stay, assessment and some Social care.
- Private Nursing Homes - Certain bigger units, which are modern and up to date offer, in addition to 24 hour Nursing Care and Maintenance, Long-Stay, Respite Care, Day care and Social care, to the older person.

4.2.6. **Older People in Ireland today:**

In 1961 the population of the state was at its lowest level. Dublin on the East Coast, accounted for just over a quarter of the total population, while the share of the mid-east region was 6.7 per cent. This percentage had risen to 29.2% in the Dublin area by 1996 while the mid-east region represented 9.6% of the total population. During the same thirty-five year period all other regions lost population share.

Projections show that a further increase in the population by 2031 will show Dublin having 32.6% share of the population, while all other regions are projected to show decreases in their population share.

Figures from the Central Statistics Office reveal that the number of older persons aged 65 years and over will increase in every region between 1996 and 2031 with the most marked increases being in the mid-east (plus 211.4%) and Dublin (plus 140.5%).

The very old population, those aged 80 years and over is projected to double by the year 2031. The graph overleaf illustrates the projected elderly population by age and sex, 1986-2011 ('000's) nationwide.

	1986		1996		2001		2011	
Age Group	Male	Female	Males	Female	Male	Female	Male	Female
65-74	112.0	128.5	106.2	126.5	105.3	122.0	124.1	142.4
75-84	48.8	69.6	52.5	79.5	52.0	81.6	52.3	79.3
85+	8.0	17.4	9.3	20.8	10.4	23.9	11.2	28.1
All elderly	168.7	215.6	167.9	226.8	167.7	227.5	187.6	249.8
Total Population	1769.7	1771.0	1748.8	1754.6	1739.0	1746.2	1727.3	1738.4
% of elderly	9.5	12.2	9.6	12.9	9.6	13.0	10.9	14.4

*Assumptions: Medium (M2) and slowly declining fertility (F1)

Source: Central Statistics Office, 1988 Population and Labour Force Projections 1991-2021

Central Statistics Office Website: www.cso.ie

Throughout this century the fastest growth in the population has been in the oldest subgroups of the population over 65 years. The total number of people aged 65 or over rose by 51 per cent between 1926 and 1986; however among those aged 75 to 79 the increase was 64 per cent, while among the 80 plus group it was 62 per cent. This trend is expected to continue in the future. Between 1986 and 2011, the elderly population as a whole is expected to increase by 14 per cent. In the same period the 85 plus age group will increase by 55 per cent, with the number of older women exceeding that of older men.

Studies of older populations reveal that the levels of mental health problems increase with age. Approximately 5% of those over 65 years suffer from severe dementia. Mental health problems are one of the most important causes of disability in old age (Dewey et. al. 1995). They can range from minor anxiety to a disabling dementia, but depression is considered to be the most common mental disorder in the elderly affecting from 13-23% (Lawlor, B. et al 1994)

Alcohol abuse is a considerable public health problem here in Ireland. While in general, the rate of heavy drinking decreases, and the rate of abstinence increases, with age (Adams et. al. 1990), alcohol abuse remains an important problem in later life.

The projected average life expectancy age is expected to increase by 7.5 years, over the coming years.

4.3. Care of Older People - How it May Be

The beginning of a new Millennium brings many changes. New resolutions and aspirations, not alone for ourselves but endeavouring to seek the highest standards from our legislative bodies to bring about changes in how we perceive the service we receive from Government.

If we are to build on the achievements of "The Years Ahead" to find the best way forward, the main dimensions that have to be addressed are:

- The development of a more positive view of older people and old age,
- The broadening of the view of older life to encompass more than health needs and
- The development of the view of responsiveness to needs, which encompass more than just norms of service provision. (The Years Ahead Report- A Review of the Implementation of it's Recommendations)

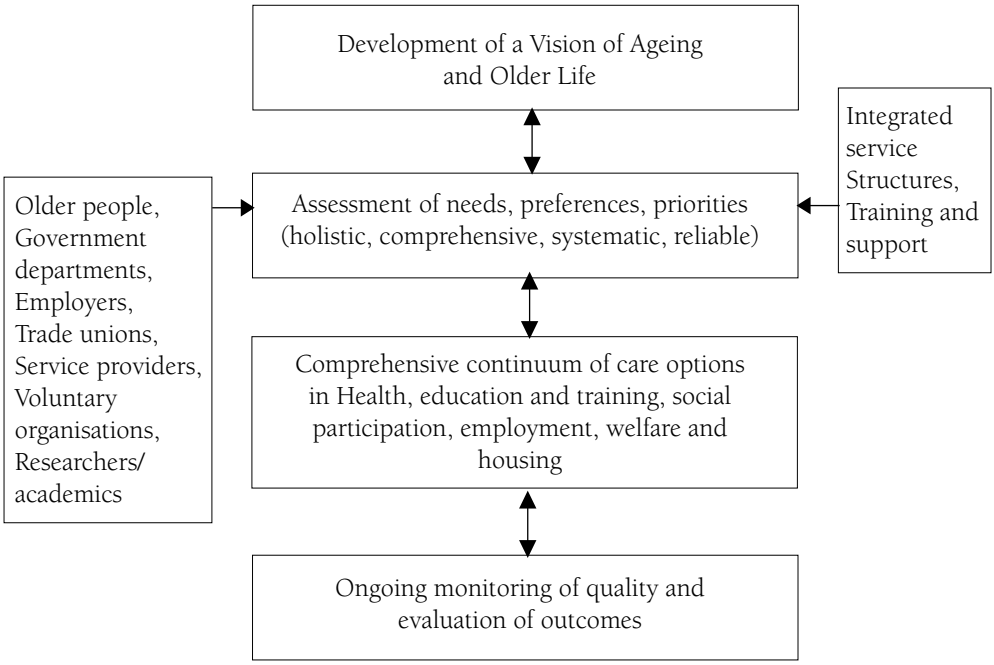
The proposed future strategy for older people is grounded in and informed by a positive vision of ageing and older life. A major aspect of this strategy is the focus on older people as recipients of care.

A vision of ageing must, in addition to independence, also include the dimensions of social interaction; active participation and contribution; lifelong learning; self-development and self-fulfilment.

A positive vision of ageing would not only ensure quality of life in old age but would also ensure that the potential of older people is released and their knowledge and resources are used for the benefit of all age groups.

In this way older people engage in reciprocal and mutually beneficial relationships with people in other age groups rather than being seen solely as 'receivers of care' from others who are more resourceful and able. A variety of perspectives must be brought to bear on the development of a vision of ageing and older life. Most importantly, the perspective of older people themselves must be taken into account.

A possible framework for a future strategy for older people is outlined in the following:



(The Years Ahead- A Review of it's Implementations and Recommendations)

The proposed strategy moves on from "The Years Ahead" by emphasising that health care is not the only significant need area that has to be addressed in older life. Due recognition is given to other significant needs including:

- Social participation and contribution
- Education and training
- Employment
- Social welfare and income security
- Housing and family relationships.

In the strategy, holistic, comprehensive and reliable assessment of need provides the framework to guide the options and services that must be provided in the different need areas. In the assessment of need, as with the development of a vision of ageing, the proposed strategy assigns a critical role to older people themselves.

In the case of older people requiring health care, the strategy incorporates the provision of a continuum of care options ranging from anticipatory care to long-stay institutional care. Building on the knowledge acquired from The Years Ahead but providing a clear development on it, the proposed strategy incorporates rigorous procedures for monitoring the quality of all services provided and evaluating the outcomes achieved.

Implementation of a strategy based on a wide-ranging vision of older life, requires the input of many different agencies. As you will have seen from previous chapters, the main agencies involved in the health and welfare of older people were:

- The Department of Health
  - National Level
- The Health Boards
  - Regional Level
- Voluntary Organisations,
- Family members and neighbours
  - Local Level

The proposed strategy requires partnership among a much wider range of agencies than has been provided previously. It requires a national partnership between Government, National Voluntary Organisations and other non-traditional agencies including Business, Employers, Trade Unions and Researchers and Academics.
Only in this way can the policy implications of a positive vision of ageing be taken into account in the areas of health, social welfare, training and education and employment.

At regional and local levels partnership is required between, for example, Health Boards, Local Authorities, Education Authorities, Social Welfare Agencies and Voluntary Organisations. At every level, older people themselves must be given a place as an equal partner.

The proposed strategy respects the heterogeneity within the population of older people, while acknowledging that there are certain groups whose frailty or vulnerability requires particular attention.

The major challenge for strategy in the future is an increased quality of life for all groups within the older population and the full social integration of older people as members with continuing needs, not only for physical health, but also for fulfilment, contribution, choice and dignity.

(The Years Ahead - A Review of the Implementation of it's Recommendations)

National Council on Ageing and Older People's website:
www. ncaop.ie

5. Support Systems for Older People

The main concern of this handbook is to outline the Health and Social Care Services for older people. However, it is beneficial for the student to also understand how income, housing and personal social services are integrated into a more co-ordinated social service for older people in Ireland.

5.1. Administration of Policy:

Social Welfare policy in Ireland, is administered by the Department of Social, Community and Family Affairs. The function of the department is to formulate appropriate social protection policies, and administer and manage the delivery of statutory and non-statutory social, community and family schemes and services. The funding for the department's policies, comes from the Pay Related Social Insurance Scheme. This scheme obtains mandatory contributions from both employers and employees. Any deficit in expenditure is met through the Exchequer.

5.2. Financial Supports - Income Maintenance.

For most people retirement usually means a considerable reduction in income. Among the elderly, however, there is likely to be a wide variation in relation to pension provision. Some rely solely on the Old Age Contributory Pension, some on Public Service Pension and others on a combination of Occupational and Old age Contributory Pension.

Social Welfare Contributory and non-Contributory pensions have risen significantly in real terms since 1966. You will find the most up-to-date rates of pensions available for the over 65's outlined below. Pensions can be augmented, as already pointed out by other welfare schemes particular to the individual's needs and financial standing.

In respect of non-contributory schemes each person is assessed on an individual basis, by what is termed a "means test". Means tests are complex. In the Department of Social, Community and Family affairs means test, income from virtually all sources is taken into account. If one has money in the bank, the Department doesn't look at the interest one actually receives but instead it assesses the capital involved in accordance with set rules.

It would be very difficult for an individual to assess his or her own means accurately, so one is encouraged to apply to the relevant departments and help is always given or one is pointed in the direction most appropriate to the need.

There are three pensions specifically for those aged 65 and over. The introduction

of pro-rata and mixed insurance pensions in recent years introduced different ways of qualifying for a pension. People who otherwise would not have qualified for a pension may now be able to get a partial pension.

Entitlement to social insurance benefits is conditional on the claimants having a certain number of contributions, paid or credited in a specific period of time. The contribution conditions vary according to the different insurance schemes. The following are the Contributory and Non-Contributory schemes which older citizens are entitled to:

1) Contributory Schemes
Social Insurance schemes comprise Old Age Contributory Pension, Retirement Pension, Widow/Widower's Contributory Pension, Orphan's Contributory Allowance, Deserted Wife's Benefit, Invalidity Pension, Disability Benefit, Unemployment Benefit, Pay related benefit, Maternity Allowance, Treatment Benefit and Death Grants.

2) Non-Contributory Schemes
Social Assistance schemes are financed entirely by the Exchequer. One of the basic requirements to qualify for payment under the social assistance schemes is that the claimant must satisfy a means test.

3) Social Assistance schemes
Comprise; Old Age Non-Contributory Pension, Widow/Widower's Non-Contributory Pension, Orphan's Non-Contributory, Deserted Wife's Allowance, Prisoner's Wife's Allowance, Lone Parent Allowance, Unemployment Assistance, Pre-Retirement Allowance, Supplementary Welfare Allowance, Family Income Supplement, Carer's Allowance and Rent Allowance.

The Contributory Retirement Pension:

In order to receive this pension, one must be aged 65 and one must have enough social insurance contributions.

- One must have started paying insurance before age 55
- One must have at least 156 paid contributions (i.e. 3 years Pay Related Social Insurance paid) from 6th April 2002 one will need 260 weeks (i.e. 5 years) PRSI, paid and from 6th April 2012 one will need 520 weeks (i.e. 10 years) Pay Related Social Insurance paid.
- One must have a yearly average of at least 24 contributions paid or credited from April 1953 or the year one first paid insurance (whichever is later) to the end of the tax year prior to reaching age 65. An average of 24 entitles one to the minimum pension; one needs an average of 48 contributions to get the maximum.

There have been many changes in recent years in the rules for Contributory Old Age Pension (COAP). Pre 1953 contributions may now be used for a partial pension. Because of the various ways one

may qualify for a partial/reduced pension there is no simple way of explaining the PRSI requirements. The only way to find out if one might be entitled to a pension is to apply, but generally the main criteria would be:

- One must have first paid insurance before age 55.
- One must have 156 (i.e. 3 years) full rate (Class A, E, H, or S) contributions.
- One must have a yearly average of ten paid or credited contributions between 1953 or the year in which one first entered insurance and the end of the tax year before one reaches 66. An average of ten will give minimum rate of pension - an average of 48 will get maximum pension.

In the case of the Non-Contributory Pension entitlements - One must be aged 66 and satisfy a means test. One may have means (as assessed by the Department of Social, Community and family Affairs) of up to 8 € per week or 15.50 € if married, and get a full pension.

The chart below will give the most up to date information with regard to those pension payments in respect of the over 65's.

	Personal Rate Aged under 80	Personal Rate Over 80	Qualified Adult Allowance
Retirement Pension/Old Age (Contributory)Pension	134. 60 €	141. 00 €	101. 00 €
Old Age (Non-Contributory) Pension	121. 00 €	128. 00 €	84. 50 €
Widow's/Widower's Contributory Pension	129. 50 €	136. 00 €	Not quoted

*Remark: Above is the average pension entitlements, at time of writing.
Further information may be found at the Department of Social, Community and Family Affairs website:
www.welfare.ie

5.3. Housing:

In the area of housing, the majority of older people are owners of their own dwellings. Since the 1970's various provisions have been made by the state to improve the housing conditions of, or provide special housing for the older person. Local Authorities, e.g. County Councils or Corporations, nowadays specify that all housing currently under construction must have 20% allocated to what is termed "social housing".

This term can cover and does cover Nursing Homes, Elderly housing, Traveller housing and Low Income Group housing. Prior to 1999 housing stock, purpose built and dedicated to older people were located in neighbourhoods which could provide the facilities and services they required. Funds were also provided to voluntary organizations providing accommodation for the older person.

A small number of sheltered housing schemes in the city and urban areas have also been developed over the years. Usually they contain independent living units with communal facilities attached such as large dining and recreation rooms catering for Day care and have laundry and other amenities in situ.

County Councils and Corporations are bodies similar to Municipal Authorities, in the European context, set up to manage the affairs of the county boroughs or city wards. There is a County or City Manager who implements the decisions made by the elected representatives of the Council/Corporation.

Those bodies receive funding from Central Government, Motor Taxation and by levying rates on Commercial Property. This income is used to fund housing, sanitary (i.e. sewerage plants and rubbish removal) requirements and road maintenance. Space does not allow for all the work Local Authorities are responsible for but the above services would be their main responsibility.

Further information may be accessed from their websites:
Fingal County Council (formerly Dublin County Council)
www.fingalcoco.ie
Dublin City Council .. ..
www.dublincity.ie

Home Improvements and Older People:

In 1982 the government established a special task force to deal with improving the housing conditions of older people. The Task Force was composed of representatives from Government departments, local authorities and voluntary organizations. They identified the most urgent needs and under a Government supported training scheme for unemployed persons, together with local contractors they set about improving the living conditions of older people in the community. Grants or Subsidies were approved by Central Government. Examples of the Grants available were:

- Essential Repairs Grant
- Disabled Person's Grant
- Draught Proofing and Insulation Grant
- Voluntary Housing Organisations Grant.

The latter category meant that approved voluntary organizations might qualify for grants, loans and subsidies for the provision of housing for particular groups, including older people.

A number of other Social Services were implemented, for example:

- Older people have free public transport from the age of 66
- Free Legal Aid is available to the over 65's for a nominal charge of 29.00 € and Free Legal Advice for a nominal fee of 5.00 €.
- All Citizens Information centres have freely available information for all citizens but particularly the elderly, on procedures to use when making a Will.
- Power of Attorney, Advance Directives (Living Wills) or to simply make a checklist of their possessions.
- For a fee of 7.62 € an elderly person can initiate a claim in the Small Claims Court. This procedure deals with claims in relation to any goods or services purchased in which the amount of the claim does not exceed 1,270.00 €.
- The Health Boards will provide wheelchairs and appliances to encourage the mobility of elderly clients and they may also pay for taxis to hospital for medical appointments, where appropriate.

5.4. Health Services:

Medical Cards:

- The 1970 Health Act entitled all adults and their dependents to apply for a Medical Card.

However this procedure was means tested and as already explained, means tests were not an exact science. Each person was assessed on income from all areas according to the Department of Social Welfare guidelines, but a simple guideline was that if one earned less than 127 € per week one was entitled to a Medical card.

Since July 2001 individuals aged 70+ are eligible for a medical card, regardless of income. Persons aged 65+ still come under the income guidelines as outlined in the table below.

Medical card income guidelines from 1/1/2001:

Single Person up to 66 years 126.97 €	Married couple up to 66 years 183.43 €
Single person aged between 66-69 years 138.40 €	Married couple aged 66-69 years 205.07 €
Single person aged between 70-79 years 274.26 €	Married couple aged 70-79 years 411.04 €
Single person aged 80+ 289.50 €	Married couple aged 80+ 432.35 €

Medical Card Holder Entitlements:

(i) General Practitioner service:

Medical card holders are entitled to the full range of General Practitioner services (Section 58 of 1970 Health Act), and to the same treatment as a private fee paying patient, e.g. you are entitled to home visits on the same basis as any other patient.

(ii) Drugs and medicines

With some exceptions, over 65s are entitled to prescribed drugs and medicines free of charge (Section 59 of Health Act, 1970). The doctor writes the prescription on a special form and most pharmacists participate in the scheme and will fill the prescription.

(iii) Hospitals

All medical card holders are entitled to in-patient services in a public ward (Section 52 of the Health Act, 1970) and out-patient services at a public hospital (Section 56, Health Act 1970) free of charge.

There is a charge of 3.00 € per day for in-patient services in a public ward for non-medical card holders. This is subject to a maximum of 330.00 € in any period of 12 consecutive months.

(iv) Free Travel to Health Services

Where public transport is impractical, health boards may provide transport in minibuses for Medical Card holders (e.g. to Outpatient Clinics). It may be possible to get assistance with the cost of public transport from the Community Welfare Officer.

(v) Dental, Optical and Aural services

Medical card holders have a legal right to these services, dental treatment, glasses, hearing aids (Section 67, Health Act 1970)

(vi) Medical and surgical appliances

Where a doctor certifies appliances, including wheelchairs, as necessary, they will be provided free of charge.

(vii) Nursing Home Subvention

From the 1/4/2001 the rates applying for Nursing Home subvention are as follows:

Medium dependency
114.28 € per week
High dependency
152.37 € per week
Maximum dependency
190.46 € per week

Tax relief is available on Nursing Home fees. The sons/daughters or family members can obtain tax relief on nursing home fees by executing a Deed of Covenant.

5.5. Extended and Respite care available for older people at home:

◆ Extended care is divided into two categories:

- Community based care, linked into the local Health Board Services
- Respite care, into public short-stay units or private short-stay units.

5.5.1. **Community based care, linked into the Local Health Board Service:**

◆ An important service, which emerged following the 1970 Health Act, was the Home Help Service, 1971. The main objective of the scheme was to assist and encourage persons who can remain in their own homes to do so by providing them with the necessary support. The tasks of the home help carer can vary depending on the circumstances of the person. The majority of home help carers are employed on a part-time basis and the elderly are the main beneficiaries under this scheme. The length of carer involvement is approximately two hours per day. The carer's remit would be to supervise the older person's activities of daily living and perhaps prepare a hot meal for him/her.

Usually the meals on wheels service will also apply to this person so that the carer would be used specifically for morning and evening activities, e.g. aiding dressing and undressing.

This project is serviced by Community Care Services, together with the appointed carer who can be a member of the older person's family. A doctor, public health nurse, occupational therapist and social worker get together to prepare a care plan for this person.

The Community Care Services are broad based and offer a very individual service to the older person. The services are based locally and are provided by the Health Boards who organise the provision of services either directly or through voluntary organisations. This valuable service is provided free of charge, or for a small fee depending on location and circumstances of the person involved. A list of services is provided overleaf:

Day Care Services:

Depending on the community area the older person resides in, he/she maybe able to link into their local:

- Community Centre, which in some areas can provide a fully equipped 'moving hospital' .
- Local Medicine for the Elderly Services.
- Private Nursing Homes provide day care service.
- Public and Voluntary Long-stay units provide day care service.

Community based services:

- Day Hospitals
- Public Health Nursing
- Health Boards must provide public nursing services for home nursing (Section 60, Health Act, 1970) for older persons resident in the community.
- Home help and meals-on-wheels services
- Health Boards may provide home help services (Section 61, Health Act, 1970) but, in practice, the extent of these services varies from one health board to another.
- Security measures for the older person
- Social Workers
- Chiropodists - Health Board will provide three treatments per annum free.
- Physiotherapists - The patient is entitled to free services of a community physiotherapist.
- Occupational Therapists - The patient is entitled to free services of a community occupational therapist.

Voluntary agencies such as the Society of St. Vincent de Paul, Friends of the Elderly, Carer's Association and the Alzheimer's Society of Ireland, all provide valuable community service for the elderly. Their main services would be similar to community care with regard to meals on wheels, physiotherapy, domiciliary visiting, home help service, but they also provide a laundry service, furniture, bedding, clothing, repair and decoration

of dwellings, day trips and holidays, social centres and clubs. Many of the services are provided in co-operation with statutory agencies. Varying degrees of financial support from public funds is made available to voluntary bodies.

Older people living alone are the most vulnerable. In 1980 the Society of St. Vincent de Paul, published a report entitled "Old and Alone in Ireland". The report was based on a survey of older people living alone and it concentrated on the extent and nature of their contact with other people and their housing conditions. The report highlighted the lack of mobility among many older citizens and the lack of visitors from either statutory or voluntary agencies, resulting in problems of loneliness.

Many of the older people lack certain amenities such as hot water. The report highlighted the need for co-operation between statutory and voluntary bodies in order to ensure adequate and flexible provision of services.

Hospital Day Services

As mentioned in earlier paragraphs, the Day Hospital Services for the older citizen are a very important part of the health and social care of older people. This service has been available to the older person for some twenty years or more, but unfortunately it has had to be confined to areas where hospitals are accessible, i.e. within five miles radius, as transporting the older person can be a daunting logistical exercise.
As our economy improved and the much talked about 'Celtic Tiger' was in a position to inject greater funds into the health services, the care of older people has taken on a new dimension. Most of the large city hospitals would now have a Consultant Geriatrician specifically employed to spearhead a more integrated healthcare service for the elderly. Likewise, attached to many of the General Hospitals are, Psychiatry of Old Age Departments, who work closely with the Departments of Medicine for the Elderly.

This service provides the Community Care team with a valuable insight into the social, medical and clinical profile of the older person. While they are attending the Day Hospital an older person can have access to the many services which will help to make their days more comfortable, for example, early detection of illness, chiropody service, physiotherapy, occupational therapy and rehabilitation if necessary.

5.5.2. **Respite Care for the Older Person living in the Community:**

◆ If an older person requires a few weeks nursing care following a spell in hospital, the Social Worker dealing with her/his care in the hospital will place the older person in a Private, Voluntary or Public nursing home for a period of two weeks or longer as the case may be.

The term 'respite care' is used when an older person, living in the community requires a short break if for example her/his carer is going on vacation. The Community Care services will request respite care in either a Private, Voluntary or Public nursing home, for that person.

5.6. Entry into Residential Care:

Long-Stay Nursing Homes (S.I. 225 1996)

◆ All older people who are in receipt of a medical card (over 70's) are entitled to Nursing Home Care be it public or private, when the need arises.

People are categorized by their level of dependency, by the Health Care Team. If the person has been admitted to a General Hospital for medical reasons, the Health care Team involved in assessing that person for Nursing Home Care, will be the Consultant Geriatrician, Nursing Staff and Social Worker.

If the person is no longer able to stay at home for social reasons or for reasons of infirmity, either physical or mental, the Community Healthcare Team will be involved in organizing suitable accommodation and care for her/him. The assessment procedure would then be undertaken by the Directors of Public Health Nursing, Medicine for the Elderly or Psychiatry of Old Age units.

At the present time this is the way assessments in respect of dependency levels are carried out. The assessment has a bearing on the level of financial help the older person receives towards his nursing home care. The physical health, mental health and financial status of the person involved are taken into consideration when the subvention is being allocated in a private nursing home.

In the case of the Public Nursing Homes the level of subvention per patient is not a consideration, in this respect - the Public Nursing Homes have been built, staffed and administered by the State body involved, so the normal commercial budget does not appear to apply - therefore, one cannot say with certainty how much greater the cost of care is to the exchequer in respect of the Public Nursing Homes versus Private Nursing Homes Subvention levels.

The Public Nursing Homes are not means tested but they will request the patient to pay part of their pension toward the cost of care. The patient/resident will hand up their pension book and a portion (one fifth) of the weekly income will be returned to the patient/resident. This portion is usually referred to as "comfort money" and amounts to approximately 26.00 € per week.

From 1st of September, 2003 older people who wish to avail of Private Nursing Home care will be means tested. This means that to qualify for a subvention older people cannot have assets of more than 7,618.43 €. The Older person's home will be considered as means and any other property including stocks, shares, securities, money on hand, in trust, lodged, deposited or invested; interests in a company business of any kind including a farm; interest in land; life assurance or endowment policies;

valuables held as investments; current value of equipment of a business or machinery (excluding a car)

Levels of dependency will also be considered when the Health Boards are offering a financial contribution towards the cost of nursing care and maintenance. Current rates are:

Medium Dependency	114. 50 € per week
High Dependency	152. 50 € per week
Maximum Dependency	190. 50 € per week

An 'enhanced' subvention can be approved for any amount between the maximum regular subvention rate of 190.50 € and the maximum 'enhanced' subvention rate of 680 €. (including the older person's own income)

Families who subsidise their elderly relative in a Private Nursing Home can avail of tax relief, by executing a Deed of Covenant or simply having the administrator of the Nursing Home confirm the fees paid, to the Revenue Commissioners. This does not apply to Public Nursing Home care.

5.7. Assessment and entry into Residential Care:

- Residential Care of older people is provided by Public, Private and Voluntary Nursing Homes.

Whether an older person is entering into Residential Care, be it from an acute hospital or from the community, the medical team looking after that older person, carries out an assessment of dependency.

Dependency levels are assessed as being, medium, high or maximum. Dependency refers to one's physical or mental dependency and is assessed by reference to one's need for help with activities such as:

- Dressing
- Eating
- Walking
- Washing and bathing.

- The assessment of dependency is carried out on behalf of the Health Board by the Multi -disciplinary team consisting of a doctor,
- Senior Public Health Nurse
- Occupational Therapist
- Physiotherapist and
- Social Worker

The following are the components used to determine dependency levels in the assessment procedures.

Components	Determiners
Personal Care	A. Bath/Self. B. Bath/Assistance. C. Bath Complete.
Feeding	A. No Assistance B. Partial Help C. Complete Help
Mobility	A. Up and About B. Bed Rest/Help C. Bed/Chair support
Nursing Intervention	A. 4 hourly or more B. 2-4 Hourly C. Hourly/Constant
Involuntary Drainage	C. Incontinent/Fistulas Vomiting/Colostomies etc.
Major Intervention	C. Theatre prep/Special Procedure
Specialising	C. One to One care, Dependency Level V

Dependency Scoring System:

Category 1	Four A scores only (minimal or self care)
Category 11	A+B, not more than one C score (average care)
Category 111	Two or three C Scores (above average care)
Category 1V	Four or more C Scores (maximum care)
Category V	Specialised constantly over 24 hours (one to one nursing)

One's social support is taken into account, in addition to one's medical condition, housing and family support.

The services in Public Nursing Homes, Day Hospitals or other Community Care centres are available at a nominal fee. Usually the older person pays four fifths of her/his pension in respect of nursing care and maintenance. The older person is allowed to keep one fifth of the pension for "comforts"

The term "comforts" means pocket money for special items that the older person requires such as toiletries, hairdressing, refreshments etc.

5.8. Private Nursing Homes:

5.8.1. **Regulations concerning care in Private Nursing Homes:**

◆ Nursing Home care is 24 hour supervised care for higher dependency category patients. The regulations require that a suitably qualified nurse, (this means a person on the live Register with An Bord Altranais which includes registered general nurse, psychiatric nurse, mental handicap nurse, paediatric nurse or midwife) is in charge of the nursing home 24 hours per day, 7 days a week. The Matron/Person in Charge of nursing homes is obliged to have a safe level of staffing to cope with the number of patients in the nursing home.

Private Nursing homes must be registered with the Health Boards and they must meet certain standards. The Health Board is obliged to keep a list of registered nursing homes and any member of the public is entitled to inspect this register.

Each nursing home must have a brochure setting out information about the home, including the name and address of the proprietor, the admissions policy, accommodation provided and special facilities and services. The Health Boards carry out inspections of Nursing Homes from time to time but not less than two inspections per annum. The reports of these inspections are available to the public under the Freedom of Information legislation.

In the eastern region of Ireland, Private Nursing Home Fees range from 634.87 to 1,000 € per week. Fees reflect the dependency levels of the particular patient. If one chooses to go into a private or voluntary nursing home, one must pay the costs involved. However, in certain circumstances, one may qualify for a Health Board subvention. To qualify for a subvention, one must be:

(a) Sufficiently dependant to require maintenance in a Nursing Home
and
(b) Unable to pay any, or part of the cost of maintenance in the home.

One's dependency is assessed and then there is a means test. There are three levels of dependency, medium, high and maximum as pointed out on previous

pages. Different conditions apply with regard to financial assessment procedures and dependency level assessments in Private Nursing Homes as in the Public Nursing Home.

5.8.2. **Code of Practice in Private Nursing Homes:**

There are detailed rules about physical standards and standards of care in Nursing Homes. There is also a non-statutory Code of Practice for Nursing Homes, which sets out the best standards of care to which nursing homes should operate. The rules governing Nursing Homes are enforceable by the Health Boards. The Code is voluntary.

Upon entry into a Private Nursing Home, a Contract of Care is agreed between the client, her/his family and the nursing home.

This Contract sets out the terms that will govern one's care and welfare and must include details of the services to be provided and the fees to be charged. The Code of Practice for nursing homes states that the Contract should cover:

- The services to be provided by the nursing home
- The level of fees, time and method of payment
- Whether the fees are in advance or arrears
- Extra services and appliances that are to be charged separately, (this cannot include essential services)
- A procedure for increasing fees when necessary
- Provision for review of one's stay in the nursing home
- The personal items which one may bring to the nursing home and those that the nursing home will provide
- Arrangements for the care of pets (where allowed)
- Terms under which one may vacate the accommodation temporarily (for example, for holidays or admission to hospital)
- The circumstances in which one can be asked to leave the nursing home
- Procedure on either side for ending the arrangement or giving notice of changes
- Statement of insurance cover
- Provision for the observance of religious beliefs
- Procedure on the death of a resident
- Arrangements for holidays

It is always advisable to visit the prospective Nursing Home before deciding to admit one's relative as standards can vary.

Most proprietors will be very anxious to accommodate the wishes of the client and this is important from the point of view of a happy placement.

Private Nursing Homes in Ireland have their own governing body. Further information and a membership list will be provided by contacting their offices:

Federation of Irish Nursing Homes Ltd:
finhl@eircom.net
Irish Nursing Homes Organisation Ltd:
inho@iol.ie

5.9. Public Long stay Units:

Places in Public Care are limited due to the fact that the building programme has not kept pace with the increase in the elderly population. During the past ten years the Health Boards have replaced some of their older buildings with new community based modern units and they are sited in the areas of greatest need.

The old stigma of the "work house" is slowly beginning to disappear nevertheless, many older people would prefer to avail of private nursing home care. The new modern units now being built by the Health Boards reassure the older person that the old style of public care has disappeared. The older people who avail of those new facilities have only good comments to make about them.

Like the private nursing homes, public long-stay units have similar criteria of assessment. Usually the community care team will have taken notice of older people who are in need of either respite or full time nursing care and in conjunction with the older person and their families, decisions will be made to take the older person into care.

The older person will also feel that they are not "charity" cases because they will give their pension book to the administrator of the Health Board involved to defray the cost of their fees. The older person will receive back one fifth of their weekly pension to be used for 'comforts' (i.e. hairdressing, toiletries etc.). In this way the older person feels that they have a little disposable income, which enables them to hold on to their dignity.

6. Concepts of Working in Care of Older People

6.1. Concepts of working in the care of older people:

◆ The care of older people has always been a specialised area of medical care. However, historically care of the older person has been a low priority. It is of course easy to see why this area is the "Cinderella" of the health services. People perceive that the emotional return one gets in the care of older people is not as rewarding as for example, care of children or rehabilitation of younger groups. It seems that older people are progressing nowhere except towards the grave. Perhaps that is why it is a difficult area in which to work and until recently not many consultants specialised in care of the elderly.

In general, many older people have poor perceptions of themselves - they feel a lack of self worth, become insular and depressed. They feel the loss of family, old friends and relatives who sometimes do not find them as interesting as they once were. They are not as vigorous physically or as alert mentally. Europeans, especially the Irish were never as interested in keeping themselves as fit and active as their North American peer group, but this aspect of life is beginning to change.

This chapter sets out to impress upon the student that it is important that we show tolerance and respect for our older people because we too, will be old some day. It is also only fitting to remember that our older generation were the people who set standards for us to follow, who worked hard in difficult times to raise their families and who left this earth a better place for their children and grandchildren to enjoy.

6.2. Professional Ethics:

◆ The owners or administrators of long-stay units, be they public or private, have a duty of care to their client, which supersedes all other duties - to care for their client as they would like to be cared for themselves. This is a very powerful phrase and it should be the guiding principle of care. "To care for others as you would like to be cared for"

It is important to acknowledge the older person's right to quality nursing care, creating an awareness and knowledge of the care older people need, considering their independence and well-being, their independent and dependent status and acknowledging their dignity and entitlement to the highest standards of nursing care and maintenance.

Doctors and Nurses are covered by their own codes of ethics. Hospitals and Long-stay Geriatric units have their own model of the Patients' Charter. Private Nursing Homes also have a charter of Rights for their clients.

Ethics, in the simplest form, means doing what is right - a code of moral principles. The code governs behaviour towards the client and his/her relatives.

When we admit an older person into our care we undertake to:

- Preserve their autonomy, allowing them free expression of opinion and freedom of choice.
- To protect our older people from any kind of elder abuse.
- To maintain a safe environment, which includes emotional safety needs.
- To acknowledge their right to risk, regardless of the level of disablement and promote the right of free choice and independence.
- Maintain social links, including links with surrounding persons, family, friends and community.
- To ensure privacy and respect the dignity of all residents.
- To respect religious beliefs and allow for the availability of pastoral care according to personal choice.

6.3. General Aims and Principles of Care

- An understanding of the patient or client is basic to nursing. She/he is viewed in the context of a human being and as a unique person with her/his particular character, experiences and responses.

For many years delivery of nursing care not only to the older person, was centred around hospital ward routine, for example recording temperature, blood pressure and pulses, the recording of which was both individual and central. It was found this method of working de-personalised care.

Nowadays the nursing process seeks to individualize the delivery of care, so that the client receives care to meet her/his particular needs and so that effective nursing interventions can be made to prevent, or minimize problems.

The Care Assistant is encouraged to be aware and to understand their work environment and the individuals in that environment. The Care Assistant always works under the guidance and supervision of the Staff Nurse, who is the team leader.

The Nursing Process is used for assessing, planning, implementing and evaluating patient care.

In Ireland the principles of care of older people, whether in the hospital setting or the nursing home setting is based on the activities of daily living model of care - The Roper, Logan, Tierney model.

6.4. Theoretical Orientation and Synopsis of Nursing Care Model.

◆ This model of care is used at Tara Winthrop Private Clinic. Watson and Royle (1987) state that although theorists differ in their focuses on nursing practice, they all agree that the application must be systematic, goal-directed and must consistently use the nursing process. The following is an example of a case study using the nursing process and the Roper, Logan, Tierney model of nursing. This model of nursing views the patient as a biological, psychological, social, cultural and spiritual being. It is the holistic approach that is used at Tara Winthrop Private Clinic to plan the care of a patient.

It is important to note that this case study is merely used to illustrate how a Care plan is devised and implemented. The name, address or geographical detail does not bear any resemblance to a real person, either living or dead.

Case Study of William:

To gain an in-depth knowledge of the patients, their previous lifestyle and environment the Director of Nursing or her Assistant at Tara Winthrop Private clinic will visit the patients and their families, prior to admission.

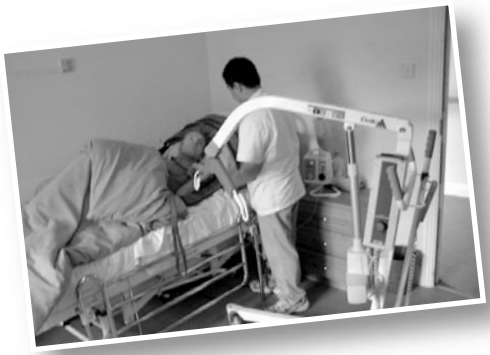
William is an eighty four year old retired, separated gentleman who lives alone and was referred to the clinic by his Community Mental Health Nurse. Until recently, William lived with his two sisters, one died in February and the other is in long-term care in a public long-stay Geriatric Hospital since March. He is retired from British Airways for the last twenty years.

William was diagnosed diabetic in March at Beaumont Hospital following an assessment at the day hospital there. He also has a past medical history of hypertension, diverticular disease, hip replacement and depression.

It was not until May that he was diagnosed by the Psychiatry of Old Age Team with vascular dementia with delusional ideas and commenced on olanzapine. His Mini Mental Score Examination at this time was 13 out of 30.

At this point William was considered "at risk" living alone and was referred to the clinic for long-term care and was admitted in July.

The Nursing Process



The nursing process is the systematic problem solving approach used in carrying out nursing activities with and for the patient. The model used, as previously stated is Roper, Logan and Tierney's (1985) nursing process and activities of daily living model of nursing.

In the model individuals are seen to engage in twelve activities of daily living, but due to circumstances in their life span they may no longer be able to carry out these activities, hence they require nursing help to do so. Pearson et al (1998) identifies the process in the following five steps:

- Assessment of patient (on admission)
- Identification of patient problems (Nursing Diagnosis)
- Planning of patient care
- Implementation
- Evaluation

Assessment of William's ADL'S

Maintaining a safe environment

William was unable to look after himself at home due to his short-term memory loss. The environment that he was living in had become hazardous because of this. William's poor eyesight had also become a problem in getting around this environment.

Communicating:

Speaks clearly but confused at times. William did say he was hard of hearing but did not wear a hearing aid. "His eyes have got very bad lately and his glasses are doing no good for him at all"

Eating and Drinking:

William says that he eats a good diet, when questioned if this is sugar free he laughs.
He cannot remember what type of meals he likes.

Breathing:

Normal. No chest problems.

Eliminating:

William finds it hard to go to the toilet at times, but generally he would have his bowels open once a day.

Personal hygiene and dressing:

Able to wash himself, but unable to get in the bath.

Controlling body temperature:

Temp normal.

Mobilization:

Walks with the aid of a walking stick. William says that he is steady on his feet.

Working and playing:

A Navigator in World War 2, William retired from British Airways, twenty five years ago. He enjoyed reading and TV, although not any more, as his eyes have failed him. He goes down to his local pub at night for a couple of pints.

Expressing sexuality:

He is separated from his wife for over twenty years.

Sleeping:

William does not sleep well. He says, "the mice that are crawling up his nose keep him awake most night's".

Dying:

Dying was not discussed with William at this point and he did not portray any morbid thoughts.

Identification of patient problems:

William denied having any problems, but he stated he was here because of the sugars in his blood. The nurse went on to identify the following actual and potential problems for William.

1. Difficulty in maintaining a safe environment due to poor vision and short-term memory loss.
2. Confusion and disorientation due to short-term memory loss and change of environment.
3. Anxiety regarding the whereabouts of his sisters and his home.
4. Difficulty in sleeping.
5. Difficulty in maintaining communication needs due to poor hearing and comprehension.
6. Difficulty in maintaining an adequate level of personal hygiene and dressing.
7. Difficulty in maintaining an adequate blood sugar level due to non-compliance with diabetic diet and medications.
8. Tendency to constipation.
9. Hypertension.

Care Plan - Aim of Care:

The care plan was designed by the Staff Nurse for William as he was unable to set realistic goals for himself and had no close relatives to assist:

1. To try to maintain a safe environment.
2. To reduce episodes of distress caused by confusion and disorientation.
3. To try to relieve anxiety and promote comfort of mind.
4. To promote a restful nights sleep
5. To maintain effective communication.
6. To maintain an acceptable level of hygiene and dressing.
7. To promote and maintain an adequate blood sugar level and to try to prevent complications of uncontrolled diabetes.
8. To promote a regular bowel regime and to try to prevent constipation.
9. To maintain normal Blood Pressure and to try to prevent complications of hypertension.

The overall aim of care was that William would settle at the clinic and would enjoy the remainder of his days with us at Tara Winthrop Private Clinic.

Implementation/Nursing actions:

It would not be possible to go into every nursing action that is required to implement all of William's plan of care, therefore I plan to discuss the main actions that were taken to achieve our main goal, which was for William to settle and be happy at Tara Winthrop Private Clinic.

On arrival to the clinic it was apparent that William had not been compliant with his medications, which were Amaryl, Tritace and Olanzapine. He gradually started on medication and the Olanzapine was changed to Respiradone 0.5mgs bd and Zimovane 7.5mgs to aid sleep which the Staff Nurse monitored closely.

Three days after his arrival to the clinic William escaped through an emergency exit to try to get home, he was taken back by the staff, but not without some resistance! Serenace stat was given and William was reassured that we would get Justin, his Community Mental Health Nurse to come and see him which settled him totally. William did not try to escape after this, which was probably due to him settling down to his new environment and also reaching a therapeutic level in his medications.

William's daily routine was structured, which allowed him feel safe and secure. Hutson et al (2001) identifies that residents need structure and without it are likely to become anxious, aggressive, resistant and combative.

William participates in the 'Sonas' programme, massage therapy, sculpting and arts and crafts classes. Sonas is a system that is devised for activating potential for communication in older people, using a multi-sensory approach. Arnst (1997)

reported that memory recall is improved among demented patients who hear familiar tunes.

William was reassured whenever he needed to be and was orientated on a repeated basis to his new room and immediate environment, which included sensory courtyard garden, oratory and hairdressers. A psychiatric review a month following admission, diagnosed dementia with delusions and no evidence of depression and a Mini Mental Score Examination was 13 out of 30.

Evaluation/conclusion:

The long-term goals identified are mostly achieved, but the care plan is continuous for William, as the problems identified remain a potential threat to him. William does ask about his sister occasionally, but is satisfied by an explanation that she is being looked after in hospital, he also continues to suffer from delusions, but is sleeping better. He continues to enjoy a pint or a whiskey at night and it would appear that we have achieved success in creating a happy home from home for William.

References

Arnst,C,.(1997) Songs that lead down memory lane : Business Week 3547 :75

Hutson, J., & Hewner, S., (2001) Activities 'Plus' Improve Alzheimer's Care:
Nursing Homes Long Term Care Management, 50: 6.

Pearson A., Vaughan B. & Fitzgerald, M. (1998), Nursing Model for Practice, 2nd Edition, Bristol, Butterworth Heinnman.

Roper N., Logan G. & Tierney D., (1985), The Elements of Nursing, a model of nursing based on a model of living, Edinburgh, Churchill Livingstone.

Watson,J., & Royle J. (1987) Watson's Medical-Surgical Nursing and Related Physiology

7. Responding to The Needs of the Client

7.1. Introduction

Here in the Republic of Ireland, in the past ten years especially, there have been a number of Consultant appointments in Medicine for the Elderly, with a special interest in Psychiatry of Old Age. Enormous strides have been made because of their dedication.

In this regard, there are a number of exciting projects and pilot schemes being launched. The teaching hospitals are working very much in co-operation with the nursing homes and community organisations to propel an integrated and comprehensive service for older people.

In earlier chapters we dealt with the different types of care facilities available for older people in Ireland, and have shown that the older person has a choice in this area of her/his care. We described the assessment procedures employed in delivering that care, the social assistance older people are entitled to and we outlined the mixed economy of welfare involved in the care of older people. We have outlined in the following pages three different cases as examples of how assessment procedures and their implementation, respond to the needs of the clients.

It is important to note that the following case studies are not actual case studies of real people - the author has merely devised the various scenarios to demonstrate how the system operates for teaching purposes. The names and addresses are fictional and do not bear any resemblance to real people either living or dead.

7.2. Assessment Procedures

In this section we will show three different case studies applying to:

- Assessment procedures for an older person living alone
- Assessing an older person in the community
- Assessment for long-stay public or private long-stay units.

Assessments are basically the same for all three categories. If the older person has been admitted to hospital the Consultant Geriatrician and her/his team will ensure that the patient is:

- Completely self-supporting if going back to living at home alone.
- Is capable of living in the community with supporting services, if going back to community care/ assisted living conditions.
- Going into extended care or long-stay nursing care units.

7.3. Implementing Care Plan

Care plans are prepared after fully consulting with the medical, nursing and care teams. The plans are also prepared in conjunction with the older person involved in the care.

A care plan will show:

- The name of the Client
- The client's present problems
- The aim of care
- Nursing action appropriate
- The signature and date of Staff Nurse preparing the care plan
- The date
- And the Review date.

In the previous chapter we outlined an actual care plan and how it was implemented practically. Here we will show a care plan prepared for an older person living alone, and how his case was handled.

In this first case study we will follow the life of Mr. Paddy McCormack, who is home based care.

Case study No. 1

Mr. Paddy McCormack, Old Mill Farm, North County Dublin. (Not his real name and address)

Paddy McCormack is an eighty seven year old single man. He lives in the lodge adjoining the grounds of the Old Mill Farm. The farm is quite substantial having approximately 450 acres of land attached. Paddy was a farm labourer all his life and used to hard work. He is therefore quite strong, independent and very proud.

Despite his age, Paddy is mentally alert, mobile with the aid of a Zimmer frame but unable to cook or clean for himself. Paddy has a reasonably good social life. His former employer takes him to the local public house on a Sunday evening for a couple of pints of Guinness and a lively music session, which he enjoys.

Every Tuesday evening a mini-bus calls for him and together with other senior citizens they go to Bingo at the Community Centre, which is approximately three miles away. Before he leaves for home, the Community Centre hostesses will arrange to give him a light supper of sandwiches and tea or cocoa. He has a television and a radio in his home and is able to keep up to date with the world happenings.

Paddy is well able to stay in his own home so the local community care services will now assess what his dependency levels are and implement a care plan for him. According to the "Patient Dependency Scoring System", Paddy is a low dependency older person. He will require the following care:

- Community Care Team and Services. Paddy will have his case assigned by the General Practitioner to the Director of Public Health Nursing.
- The Public Health Nurse will implement a plan of care and ensure that he is supplied with a Carer
- The Carer will help Paddy with his Activities of Daily Living, i.e. bathing, dressing, cooking and cleaning, etc.

The Director of Pubic Health Nursing and her/his team have requested the services of a physiotherapist to advise on the availability of treatment for Paddy's arthritis. She/he will also have spoken to the Occupational Therapist with a view to installing a shower as an aid to bathing and a Zimmer frame to help him walk with more security.

The Director of Public Health Nursing will ensure that Paddy sees the Doctor when he needs to and that his carer is implementing his care plan as instructed. Nurse will visit Paddy on a regular basis and will assess his ongoing requirements.

7.4. Care of an older person in the Community

Case Study No. 2

Community Care - Sheltered Housing.

Mr. & Mrs. Dick & Polly Joyce decided to avail of Home based community Care. Dick and Polly are 84 and 80 respectively. They lived in rented accommodation all their lives in the centre of Dublin. About five years ago their landlord decided to rebuild the apartment building where they had lived most of their lives and which was in dire need of renovation, but unfortunately Dick & Polly would have to move. As there was no possibility of returning to the modernised and now highly expensive apartment, they approached their local authority to request a community flat.

Dick & Polly were very fortunate to be offered a one-bedroom flat which had a small kitchen and dining area together with a good sized sitting room. Because Polly had Chronic Obstructive Airways Disease due to her lifetime of heavy smoking, the local authority offered them the ground floor apartment. This was satisfactory from the point of view that Polly could go out and sit in the garden, with very little effort.

As Polly was quite often short of breath and had to take frequent rest, Dick was well used to cooking for the two of them. Dick was an ex-army man and was still

very fit and active so that they were both able to maintain quite a high level of self - help. Dick was able to help Polly with dressing and would take her out to the garden for fresh air and in fact was very loath to relinquish the little tasks he performed for his wife. They had no children and not a lot of social support apart from that provided by their own devotion to each other.

The Area Community Care Services visited Dick & Polly. The Public Health Nurse agreed that some help was required to make life easier for them. The Nurse assessed their needs in conjunction with the General Practitioner, Physiotherapist, Chiropodist and Occupational Therapist. They devised a Care Plan for the couple and implemented the following services to help them.

a) A Carer for one hour per day to help Polly to bathe and vacuum the apartment.
b) A provision was made for oxygen deliveries in the event of need.
c) A wheelchair was requested for Polly in order to help with her mobility and independence.
d) The Public Health Nurse would call to them regularly and their ongoing requirements noted.

Mr. & Mrs. Joyce felt that their social needs were at a better level now, than they had previously experienced. They had neighbours, visits from the Public Health Nurse and her team and a Carer whose daily visits they looked forward to immensely.

7.5. Care of an Older Person in residential care

Case Study No. 3

This is the story of Tom and Betty Murray. Betty has had to be admitted to residential care because she has Parkinson's Disease. Her family felt that because of the progression of the disease, their father Tom was being overcome by the care involved, to the detriment of his own health.

Tom was extremely reluctant to avail of residential care, but he was encouraged to try the service for a few weeks in order to be completely sure this course of action suited both of them.

Mr & Mrs. Tom and Betty Murray,

Residents of a Private Nursing Home "Treetops" is a privately owned, family-run, long-term care facility. It was built on seven acres of land in Dublin, Republic of Ireland. The facility caters for 70 residents, a number of whom are elderly mentally infirm and physically heavily dependent.

Mr. & Mrs. Murray are in their eighties. Betty was admitted to the care facility a year ago suffering from advanced Parkinson's disease coupled with Dementia. Because Betty is still mobile, she was admitted to the frail elderly unit. Her husband Tom, despite his advanced years, is physically and mentally able to maintain himself at home.

On admission to the Nursing Home, the nursing care team compiled a Care Plan for Betty. Again this Care Plan is modelled on the Roper, Logan and Tierney Model of Nursing, based on the activities of daily living.

Tom is confident that the care envisaged for his wife will live up to his expectations. He also likes the fact that he can come and participate in the care of his wife and maintain the relationship that they have always had. They have been married for 60 years.

The Director of Nursing personally supervises all admissions to the Nursing Home. Betty with the invaluable help of her husband Tom has already gone through this process and at this point in time is very settled in her new environment.

Betty and Tom's extended family come and visit and due to the facility's flexible policy on visiting, they can stay as long as they wish.

There are scheduled daily activities, which Tom can escort his wife to and in which he can also participate. Physical exercise, Art therapy, Sculpture for beginners, flower arranging, games, "Sonas" holistic reminiscing therapy, hair and nail care. Tom especially enjoys bringing his wife to weekly religious services. Spirituality is central to the lives of older people.

He enjoys walking her around the long and spacious corridors observing the industry all around them and taking her to get her hair done on a weekly basis. There are outdoor courtyards where residents can get sun and fresh air and admire the shrubs and flowers through the seasons. Tom also enjoys a good relationship with the Nursing Home's management and approaches them with special requests for use of the oratory or dining areas to celebrate family milestones, such as birthdays, anniversaries etc.

The Care Plan prepared for Betty by the Nursing Director was again based on the Roper, Logan and Tierney model of care, which we have already discussed.

We illustrate below, in conjunction with Tom and Betty's story, the story of one of Betty's carers. Mary is a married lady who has looked after her own mother-in-law for 10 years prior to the mother-in-law's admission to a long-stay nursing unit.

Mary found she had quite a lot of time on her hands and decided she would look for work in a nursing home. It is appropriate that her story is told here.

A Day in the Life of a Care Assistant.

My name is Mary, I am employed at "Treetops" Private Nursing Home. I prefer to work 12 hour shifts and my roster is organized so that I can work three shifts one week and four the next. Sometimes I can be called on to do extra duties, particularly if someone has called in sick. I prefer days to nights and my day shifts can start at either 7 or 8 a.m.

Today I start at 8 a.m. I attend at the Nurses' station to see where I have been assigned. I will be working in the frail elderly unit and I have been assigned six patients to look after. Betty is one of my patients. The night staff hand over the report to the nurse on duty and highlight particular issues, which may have arisen overnight. Betty has had a restless night. Normally, she has cot-sides on her bed to prevent her falling out of bed. However, these are proving a hazard as she has managed to climb over them.

The night Staff decided to dispense with the cot-sides, as there was a high risk that she would injure herself and opted instead to put her mattress on the floor for the night, to avoid injury. I start my morning looking after Betty as she will need a refreshing shower and change of incontinence wear. I put out her day clothes on the bed and transfer her to the shower chair. All goes well and Betty is soon dressed and placed in her special chair for breakfast.

Betty needs help with eating, as she is not able to focus on this task due to her dementia. Sometimes Tom, her husband comes in quite early and he takes over the task of feeding her. While Tom does this, I quickly make the bed, tidy up the room and put all soiled clothes and linens into the laundry trolley. I continue to my next patient.

If my client is self-caring, I may supervise a little and help with selecting clothes or applying make-up for those who request it. My work is prioritized in so far as I encourage the more mobile of my charges to gather in the dining room for breakfast around 8:30a.m. I assist the dining room waitress with pouring tea and toasting bread. When I have organized the residents in the dining room, I bring trays to those of my group who need feeding, or who choose to have food in their rooms. Showers and bed-making are continued after breakfast. Residents, who wish to join in communal recreational activities, are encouraged to do so and in some instances escorted to these activities.

Care Assistants go on split breaks. The early shift goes at 10:30a.m. and the next shift at 11:00a.m. Today I am on the 11:00a.m. break. I go to the staff canteen where I can avail of hot tea and toast. My colleagues in the canteen consist of Filipinos, Polish, Spanish, Indian, Lithuanian and Bulgarian Nationals. It was very strange at first, as I had not worked for many years while I raised my children.

Now that I am back in the work place, many things have changed totally. This presents a challenge in terms of communication and building a sense of teamwork.

After the break, I rejoin my group at the Sonas reminiscing therapy session in the communal Day Room. Along with other carers, I join in the singing and supervise the movements of our clients.. Lunch for our residents is 12:30pm. Most residents gather in the dining rooms and are supervised where necessary. Residents who need assistance with eating are looked after and the staff nurse on duty takes care of enteral feeds. Tom looks after Betty and often brings in special treats for her.

The nurse on duty takes care of organizing the multidisciplinary team, who provide medical attention, physiotherapy, occupational therapy, chiropody, dietary, speech and language therapy. Appointments and transportation to and from the hospital, are arranged. Sometimes, I am asked to accompany patients to their appointments outside the facility.

After lunch, I help those who require toileting and changing of incontinence wear. Approximately, 2pm, I bring my residents to organized recreational activities. From 2-5pm, while our residents are kept busy, I perform a couple of tasks that have been assigned to me.

Today I am bringing fresh carafes of water to the resident's rooms, collecting clean clothes from the laundry and returning them to residents' bedrooms. I may be accompanied by one of our residents with dementia whom I engage to assist me. It helps to keep them focused on the positive aspects of their abilities and helps provide a stable routine within their environment. It also helps me to maintain a safe environment for them.

Care Assistants assist at recreational activities where some residents may need help integrating or using the materials provided, assisting the hairdresser when required, performing tasks requested by residents, playing games with residents such as chess, draughts, bingo and reading for some of them.

I am studying at present and will soon be graduating with an NVQ Level 2 training certificate. I am doing well so far and quite pleased with myself. Sometimes Nursing Management will ask me to pick a topic to research and give a talk to my colleagues on certain afternoons. I didn't think I would be able to do it, but it became a very exciting and confidence boosting exercise for me.

At 5pm tea is served and I start gathering my seniors again. The 5pm shift comes on to assist me. The dependency level can fluctuate from time to time as residents become more dependent and require more assistance. Usually the nurse on duty will request extra help for an hour or so from the maximum dependency wing, which has a much higher staff/patient ratio.

Residents begin to retire for the evening from 7pm depending on the age group. Betty goes to bed early so I organize her for bed. Tom will usually leave for the night at this point. I check back regularly to ensure that she is getting to sleep.

Sometimes, I may sit close by and fill out my Evaluation Sheets for the patients' Care Plans until she goes asleep. The night Care Assistant comes on duty at 8pm and begins by arranging tea, sandwiches, or biscuits for the residents. I prepare to leave and pass on all relevant information to the night staff.

The role of the Care Assistant is multi-tasked and varied. There is lots of scope for engaging fully with residents, helping to bring out the best in people, providing company and support during difficult times, and outlets for using particular talents and skills.

I get a lot of satisfaction out of what I do.

8. Employment in The Care of Older People

8.1. Introduction

Traditionally, the personnel involved in care of older people came from the married, 35-50 year old woman who because she was expected to stay in the home to look after her children, often had time on her hands when those children were of school going age.

They had virtually no training, but their kind and caring qualities and observational capacity were particularly valued. The quality of the care in nursing homes and long-stay institutions was certainly enhanced by the dedication of these women. It is only just and equitable that their contribution be recognized here.

Irish Nursing Homes were very fortunate to have had the benefit of a large number of Irish women who had trained as State Enrolled Nurses (SEN) in Great Britain, but who, for a variety of reasons returned to live in Ireland. The SEN had two years training in the hospital system in England where they worked in partnership with the State Registered Nurses (SRN's). They were skilled in many techniques, for example, observing patients, taking blood pressure, giving injections and dispensing medication.

As the Irish Heath-care System did not have a comparable category of practical nurse their qualifications were not recognized here. Up until the year 2000, an SEN worked as a Care Assistants, and therefore had a much narrower job description.

State Enrolled Nurses were excellent carers, however their pay and conditions did not compare with their colleagues in Great Britain. Due to extensive lobbying, mainly from the private sector, the Department of Health & Children decided to give a grant of 7,620 € to enable an SEN to convert to State Registered Status. Unfortunately, the SEN has to return to Great Britain to complete this course, which is validated by the University system and consists of one year module of study and practical experience at an approved Hospital.

In addition to above the education and training of Care Assistants is constantly evolving. New educational opportunities have emerged which harness and develop the work that Care Assistants perform and which gives them tangible recognition and validates their life skills.

Care Assistants are being trained in the practical skills of care under the supervision of a trained Nurse and they have the opportunity of Academic recognition. Many of the teaching hospitals have introduced courses for their own Care Assistants and the hospitals have benefited. Because of the shortage of trained nurses, care assistants are currently taking the places traditionally held by student nurses.

8.2. Job Opportunities:

The economic boom of the last 5 years in Ireland has contributed to a labour crisis in general, but more acutely in the healthcare sector. Not only has nursing been affected, but it has also been very difficult to attract care workers. The growth in the Information Technology sector has steered many young people away from the caring professions.

Many public and private enterprises have had to recruit abroad in countries such as The Philippines, South Africa, and Eastern & Central European countries. The whole face of healthcare in Ireland has become multinational and multi-cultural - a phenomenon unheard of in the short history of the Irish Republic. The indigenous Irish people have had to adjust in a short space of time to a new era in healthcare.

Employers have had to come to terms with providing for the needs of their multicultural workplaces. New policies and procedures have had to be compiled and issues of diversity addressed.

Training in the workplace is ongoing with a greater emphasis on up-skilling and educating personnel. Nursing Staff are encouraged to impart their clinical knowledge at a level that the Care Assistant can identify and put into practice, in the context of the holistic care of the older person.

In Ireland there are many opportunities for employment in the Healthcare Sector, particularly for Nurses and Care Assistants.

8.3. Job Description - Care Assistant:

The main role of the Care Assistant is to perform simple and basic care functions under the supervision of the registered nurse.

The following rules should help as a guide in understanding the role of the care assistant:

- You are an assistant to the nurse
- A staff nurse determines and supervises your work.
- You do not make decisions about what should be or should not be done for the patient, without consultation with a staff nurse.
- If you do not understand directions or instructions, you must ask a Staff Nurse before attending the patient.
- Do not perform any function or task that you have not been instructed to do or that you do not feel comfortable in performing without the supervision of a Staff Nurse.

The Staff Nurse on duty allocates the duty for the day. Usually one works in teams of two Care Assistants under the supervision

of the Staff Nurse. The Staff Nurse always dispenses the medication and observes all residents and the work carried out by the Care Assistants.

The Staff Nurse will also read and sign the daily reports on the Care Plans and advise the Medical Practitioner of any worries concerning the clients. The Medical Practitioner will prescribe all medication and will organise with the Nurse to have physiotherapy, dentistry, dietary problems or any other consultations which it is felt necessary to address, on behalf of the client.

The division of work is strictly defined and each discipline will have a clear and written policy of what their duties and responsibilities are.

The duties a Care Assistant cannot perform:

- Never give medications.
- Never insert tubes or objects into a patient's body openings or remove them.
- Never take oral or telephone instructions from doctors.
- Never perform procedures that require sterile technique.
- Never tell a patient or their family a diagnosis, medical or surgical treatment.
- Never diagnose or prescribe treatments or medications for patients.
- Never ignore a request to do something because it is outside your scope of practice as a Care Assistant, always refer such requests to the staff nurse.

The duties and responsibilities of Care Assistants:

The Care Assistant will work under the supervision and the direction of the Staff Nurse on each working shift. The Staff Nurse is responsible for the allocation of patients, the patient's Care Plan for the day, and informing the Care Assistant of their duties in respect of each individual patient for the shift. The Care Assistant is obliged to document all nursing interventions made by them in the patient evaluation sheet.

(a) Hygiene:

- Bath, shower, shave*, dress and undress patients.
- Assist with care of incontinent patients.
- Assist bed bound patients with toilet and washing needs.
- Assist in toileting of patients including the giving, removing and emptying of bedpans, urinals, commodes and the use of the bedpan washer.
- Supervise patients on commodes, in toilets and bathrooms and assist where necessary.
- Record and monitor bowel function and urinary incontinence as directed.

*Shave the face only in men. Women may require hair removed from the face, underarms and legs, seek advice from the nurse on duty on correct techniques.

(b) Nutrition

- Give help and support to patients during mealtimes.
- Feed patients as requested.
- Ensure individual patient's dietary needs are adhered to including special diets and supplementary drinks under the supervision of the staff nurse.
- Prepare and serve drinks outside normal catering hours when requested.
- Monitor and record patients' fluid and diet intake as instructed.

(c) Mobilization

- Lift and position patients when necessary.
- Assist patients with walking and limb exercises as directed.
- Ensure patients are positioned comfortably in their beds and chairs.
- Observe pressure areas and skin condition and report to staff nurse.

(d) Communication:

- Check that each call bell system is in working order and within the patient's reach on the commencement of each working shift.
- Report immediately any reports of pain or distress expressed by patients to the staff nurse.
- Answer call bells immediately and report requests to staff nurse if necessary.
- Report all incidents and accidents involving self, patients or visitors to the clinic to the staff nurse in charge at the time of the event.
- Receive visitors to the clinic with courtesy.
  Answer telephones and locate appropriate personnel when necessary.
- Assist patients to make telephone calls.

(e) Maintain a clean and safe work environment:

- Wash and disinfect trolleys, beds, wardrobes and lockers following discharge/transfer of patients as required.
- Dispose of soiled linen in the appropriate laundry baskets provided.
- Assist with the disposal of clinical waste and clean procedure trolleys daily.
- Make occupied and unoccupied beds.
- Attend to spillages immediately to reduce the risk of accidents.
- Ensure the sluice rooms, bathrooms, toilets and ancillary rooms are kept clean and tidy.
- Ensure that linen cupboards and store rooms are kept tidy and stocked.
- Empty all waste bins at the end of each working shift.
- Report broken items in need of repair to staff nurse.
- Clean and disinfect patient's basins, commodes, bedpans, feeding pumps, as instructed.

(f) Personal Hygiene:

- Suitable protective clothing must be worn while on duty in the form of a designated Care Assistant's uniform and low rubber heeled shoes/trainers.
- The Care Assistant must maintain a good standard of personal grooming and cleanliness. No nail polish. No rings with stones or protruding metal.
- Strict hand washing and disinfecting between handling of patients.
- Wear latex gloves when dealing with any body fluids as per universal precautions.
- The Care Assistant must be in a good state of physical health to perform adequately in his/her work.

Care Assistants should ensure that they have read and understand the foregoing. If there is any aspect of the role of the Care Assistant, which you do not understand, please seek clarification with Nursing Management.

Recruitment Process:

In relation to the foregoing chapters, perhaps it would be valuable for students to know, that there are a wide range of exciting opportunities here in the Republic of Ireland, for all categories of Health Care Personnel. It is the case, not just in Ireland but throughout the developed countries in the Western Hemisphere, that people who care for other people are in very short supply. Therefore, our Health Care system is severely understaffed in all the disciplines.

The professional status of the Care Assistant is recognised in their salary and conditions of employment. Care Assistants earn an average of 1500 € per month. They get double pay for Public Holidays and four weeks annual leave. Meals are provided while on duty and the staff rest room has food preparation facilities. Tax allowance is granted for the purchase and laundry of uniforms and the uniform consists of a pants and tunic style top. All Care Assistants undergo health and safety training in their place of employment.

The training includes lifting and handling techniques, observation of safety in the work place, fire drills and evacuation procedures. Most work places will have access to the services of a Medical Practitioner for their staff, who will advise them on their physical health and well being.

A typical advertisement for the position of Care Assistant would look like this:

CARE ASSISTANTS REQUIRED

The people we are seeking ideally should have their NVQ Level 2 completed, have an interest in caring for Older People and People with Disabilities, be of good character and have the ability to work as part of a team. Salary will be commensurate with experience but will not be less than 8.50 € per hour.
Apply to : Ms. Jenny Lynn, Personnel Director Tel. No. 8866213 during office hours

The selection process is carefully executed. The prospective candidate will be requested to attend for interview. The candidate will be requested to bring the following information to the interview:

1. A fully completed Curriculum Vitae
2. Any and all references from previous employers
3. A Police Clearance Certificate

N.B. The police clearance certificate will be required in respect of all candidates seeking employment in the Care Professions. The clients we cater for are very vulnerable and it is essential for both their protection and the protection of the employee to have all documents in order.

8.4. Salary and Conditions of Employment

When the selection process is completed the prospective employee will be informed and offered a contract of employment. Initially the contract of employment will be for a probationary period of between 3 and 6 months. Before actually taking up their position the employee must complete a mandatory training period during which they are introduced to the company ethos, lifting and handling techniques, the role of the care worker and client orientation.

Both the employer and employee sign the contract of employment. It outlines their conditions of employment, salary and the rules with regard to behaviour and ethics while in the employ of the company. A typical contract of employment will have the following information:

- The employers name and address
- The employees name and address
- The employment commencement date
- The probationary period
- Hours of work
- Remuneration
- Lay off and short time
- Uniforms and Personal Appearance
- Retirement
- Time Keeping
- Accident/Incident reporting
- Leave of Absence - Force Majeure leave
- Personal Property
- Dishonesty/Forgery

- Holidays
- Sickness and Absence, Notification thereof, and certification thereof.
- Disciplinary and Dismissal Procedures, which includes dismissal procedure for the purposes of Section 14 of the Unfair Dismissals Act (1977)
- Serious breaches of company rules, which may result in dismissal without notice or pay in lieu of notice.

Attention is also drawn to the Company's Safety Statement which outlines it's obligations under the Safety, Health and Welfare and Work Act 1989, the Safety, Health and welfare (General application) Regulations 1993, and the Maternity Protection Act, 1994.

In Ireland one can access the following legislation with regard to employment from the Social Community and Family Affairs website.

- Terms of Employment (Information) Acts, 1994 - 2001
- Unfair Dismissals Acts (1977 - 2001)
- The Protection of Employees (Part-time Work) Act, 2001
- Protection of Employees (Young Persons) Act, 1996
- Employment Equality Act, 1998
- Redundancy Payments Acts, 1967 - 2001
- Minimum Notice and Terms of Employment Acts 1973 - 2001
- Maternity Protection Act 1994
- The Organisation of Working Time Act 1997
- Parental Leave Act 1998 - Force Majeure Leave.

General Remarks:

Ireland, like a lot of countries in the Western Hemisphere, has experienced an increase in immigrants from outside the European Union. Many choose to work in care settings. Some stay for only a fixed term in the country, but quite a number will opt to stay permanently.

The changing face of Ireland's population in recent years means that planning for inclusion of diversity in care settings is vital, both to clients and workers.

8.4.1. **Application:**

- In general applications for the above positions will be from different sources. Applicants may have heard by word of mouth that a position is available, they may have seen an advertisement in the local or national newspapers, or they may be actively recruited from abroad.

In all cases the recruitment will be carried out and suitable applicants considered and evaluated based on their previous experience and work history. A candidate's educational and training background is important, but if a person has an ability and interest in caring for older people, they will receive on the job training.

9. Vocational Education / Training

9.1. Structure of Care Worker's Nursing Curriculum

Structured courses for Care Assistants in care of older people in Ireland are a somewhat new concept. Up until the last decade of the 20th century Care Assistants were really only employed in Nursing Homes or Voluntary Geriatric Homes.

The student nurse, in the hospital setting, traditionally did the work that care assistants are doing now. Because of curriculum changes for nurses in the 1990's, student nurses had to spend more time in college and therefore could not be relied on to fill this niche.

An alternative supply of labour for this very essential service had to be sought, policies and procedures put in place in respect of courses and educational facilities researched to accommodate this new professional qualification.

Some colleges were already facilitating Social Care Diploma Courses and as the jobs were considered to be of a vocational nature, a suitable and respected qualification that was already in practice in Great Britain, was chosen. This was known as NVQ or National Vocational Qualification.

Of course this was only one of a number of training courses for Care Assistants available - some of the teaching hospitals devised their own courses.

These courses are taken typically by-post leaving certificate students who are interested in social care, nursing or childcare. The NVQ, which was introduced in Ireland in recent years, is a nationally recognized qualification both here and in the United Kingdom. It credits Care Assistants with their work experience and can be used as a stepping stone to a career as a registered general nurse.

In the latter decade of the 20th century, the country experienced a chronic shortage of personnel, due to changes in the Nursing Curriculum and a shift in demographics. This shortage was evident in all work places, but was most critical in the caring professions.

During the past five years (from 1997 onwards) Directors of Nursing from the major teaching hospitals and the private nursing home sector have been recruiting overseas nurses and care assistants to help augment the very depleted nursing sector here in Ireland.

The Department of Health and Children became acutely aware that the healthcare service was in crisis. The Minister has endeavored to rectify the situation and is proceeding on a number of fronts:

- Training of SEN's to Registered Nurse Status
- 1,500 places now available for nurses at university level
- NVQ and NCVA courses underway for Care Assistants

9.2. The Present Situation

We were fortunate here in Ireland to have had excellent nursing assistants, who had SEN qualification. State Enrolled Nurses are similar to the Practical Nurse Category in Europe and United States. However, in Ireland no such category existed. Typically, SEN nurses had two years hospital experience in the United Kingdom and were familiar with the nursing process.

Following intense lobbying of the Department of Health and Children, mainly by the private sector, the Minister decided to give a grant of 7620 € to enable a State Enrolled Nurse to convert to State Registered Status. A number of State Enrolled Nurses have taken up this offer and are currently completing their hospital training in Great Britain.

Last year the Minister for Health and Children announced that he was making provision for the intake of increased numbers of student nurses. An intake of 1,500 new students into the university degree course in nursing is already nearing the completion of year one. This coupled with the increased recruitment of overseas nurses and the SEN conversion course will, hopefully address the needs of Nursing in the Healthcare service for the future.

With more Care Assistants opting to train for NVQ standards, it will not be long before this qualification will be mandatory for entry into the healthcare area. In most of the teaching hospitals and the larger private nursing homes this standard is already required.

It is now totally accepted in both the public and private sectors, that training must be ongoing in every area of health-care, so we face the new millennium with a confidence not previously experienced.

It may be worthwhile noting that as the people who care for older people, advance educationally in their efforts to provide a more professional and sensi-tive continuum of care, older people are also increasing their efforts to progress towards a more healthy retirement.

9.3. Plan for the Future and Elderly Orientative Studies:

◆ We have shown in our previous paragraph that plans are now well advanced to ensure continuity of nursing care, which should take the health services well into the next decade.

We have made considerable progress during the past one hundred years. We have arrived at the point where a reasonably good healthcare and social care structure is in place. We must now build on this structure with the information we have in order to orientate ourselves for the future.

It is difficult to predict the future. Those of us who work in the care of older people are endeavoring to take all the studies, which have been done on the subject and implement them as best we can, in our own care facilities.

Statistics have shown that with the onset of middle age, life expectancy figures in Ireland have begun to slip down the EU rankings, and by the age of 65, life expectancy for both men and women, is lower than our European counterparts. It is also worth noting that the average life expectancy for males following retirement is two years.

With this information it is while taking a little trouble to put in place a schedule which will not only prolong life expectancy but will allow the older person to enjoy good health for a longer period in his/her life. In this regard, it may be worth looking at the United State's example. While geographical elements have to be taken into consideration in respect of climate, disposable income and facilities available, if we really want to aim for a healthy, cost effective lifestyle, we should plan for it early in life, as our North American peer group do!

The National Council on Ageing and Older People in their publication The Years Ahead Report: A Review of the Implementation of it's Recommendations, have suggested a possible framework for a future strategy for care of older people. It suggests, following assessment of needs, a comprehensive continuum of care options with ongoing monitoring of quality and evaluation of outcomes.

It also points out that for the above to be effective, there must be coordinated inputs by older people themselves, government departments, employers, trade unions and the mixed economy of welfare. Integrated service structures, training and support, information about options and pathways to care aimed at older people and frontline service providers will enable the development of innovative packages of care.

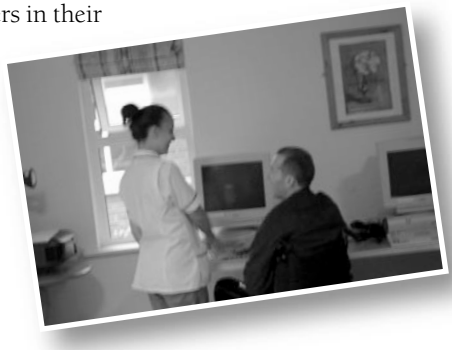
The Ottawa Charter for Health Promotion, (1986), states:

”Health promotion is the process of enabling people to increase control over, and to improve their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realise aspirations, to satisfy needs and to change or cope with the environment”

What does the future hold? The idea of total care, from the cradle to the grave is exciting. The older people of to-day, to a great extent, have suffered from the effects of poor nutrition, wars, pestilence and an educational system which was exclusive. It would be desirable if we could learn from past experiences in order to build positive strategies for the future.

We do have the opportunity to do this and should endeavour to instruct our students not alone in the concepts of care, but to imbue our courses with enthusiasm and humanity.

Surely, it is by caring for others in their vulnerability that we receive a sense of our own worth as human beings and become role models for the next generation.



10. References:

Adams, L., Gary, P.J. and Rhyne, R., (1990) Alcohol Intake in the Healthy Elderly, Journal of American Geriatric Society, Volume 38:211-216

Dewey, M.E., et Al., (1993) Cross Cultural Comparison of Depression and Depressive Symptoms in Older People, Acta Psychiatrica Scandanavica, Volume 87: 369-373

Lawlor, B., et. Al. (1994) Prevalence of Mental Illness in the Community Dwelling Elderly in Dublin Using AGECAT, Irish Journal of Psychological Medicine, Volume 11:1157-160.

Shasby, Michael, (2001) "Emerging Services for Older People in Ireland",

Roper, et. Al. (1985), The Elements of Nursing, a model of nursing based on a model of living," Edinburgh, Churchill Livingstone.

National Council on Ageing and Older People Publications:

The Years Ahead Report, (1988)

"It's our Home" - The Quality of Life in Private & Voluntary Nursing Homes

The Role and Future Development of Nursing Homes in Ireland

Mental Disorders in Older Irish People: Incidence, Prevalence & Treatment

Nursing Homes in the Republic of Ireland - A study of the Private and Voluntary Sectors.

The Years Ahead Report: A Review of the Implementation of it's Recommendations.

Comhairle, Entitlements for the Over Sixties, (January 2001)

Watson's Medical-Surgical Nursing and Related Physiology

Mosby's Textbook for Nursing Assistants.

Legislation:

Ministers and Secretaries (Amendment) Act 1946

Health (Homes for Incapacitated Persons) Act, 1964

Health Act 1970

Health (Nursing Homes) Act, 1990

Nursing Homes (Subvention) (Amendment) Regulations, 1998.

Redundancy Payments Acts 1967-2001

Minimum Notice and Terms of Employment Acts 1973-2001

Terms of Employment (Information) Acts 1997-2001

Unfair Dismissals Acts 1977-2001

Maternity Protection Act 1994

Protection of Employees (Young Persons) Act, 1996

Organisation of Working Time Act 1997

Employment Equality Act 1998

Protection of Employees (Part-time Work) 2001

Government websites:

Department of Health & Children **www.doh.ie**

Department of Social, Community and Family Affairs www.welfare.ie

Central Statistics Office website **www.cso.ie**

Office of Attorney General website **www.dppireland.ie**

Public Service Information for Life (Oasis) **www.oasis.gov.ie**

11. Glossary:

An Bord Altranais	:	The Nursing Board
Bog	:	An area of land which produces peat/turf.
County Councils/ Corporations.	:	Municipal bodies.
County Home	:	Geriatric Hospital
Comfort Money	:	Pocket money
Enteral Feeding:	:	Percutaneous, endoscopically guided gastrostomy tubes, (feeding directly into the stomach)
Flat	:	Apartment
Lunatic Asylum	:	Mental Hospital
Oireachtas	:	House of Parliament
P.R.S.I.	:	Pay Related Social Insurance
Public/Private Partnerships	:	Governing bodies in conjunction with Private Enterprise merging to provide services to the public.
Sonas	:	Sonas is a system devised for activating potential for communication in older people, using multi-sensory approach.
Subvention	:	A Grant or Subsidy
On-the-job training/	:	Workplace training/experience.

Acknowledgements

This Handbook has been produced by the Irish National Team

Mrs. Anne Browne (retired)	Whitehall College of Further Education - Dublin
Mrs. Patricia Mackey	Whitehall College of Further Education
Mrs. Mary McCormack	Tara Winthrop Private Clinic, Swords/Dublin
Mrs. Mary McKevitt	Childcare Development, City of Dublin V.E.C.
Mrs. Mary Kinsella	Whitehall College of Further Education
Mrs. Julie Fitzpatrick	Whitehall College of Further Education
Mrs. Christina Brunton	Whitehall College of Further Education (2003)
Mrs. Breda O´Brien	Whitehall College of Further Education (2003)

In addition the Irish National Team wishes to express grateful thanks to the following for their guidance, support, donation of appropriate materials and proof reading for accuracy of this package of information.

Mrs. Catherine Donleavy	Director of Nursing and staff at Tara Winthrop Private Clinic
Mrs. Rena Galvin	
Mrs. Monica Keating	University of Central England

Staff at Childcare Development, City of Dublin V.E.C.

Health Board Personnel - City of Dublin

Mrs. Lynette Dowling	Supervisor Whitehall College Creche

Staff at Whitehall College Creche

Mrs. Yvonne Dunne	Equality Officer, Irish Preschool Playgroup Association

All materials of the project are downloadable for free from partners websites:

www.caritas-mg.net/frame9.htm
www.haus-berg.com
www.davinci.nl
www.whitehallcollege.com
www.hesote.edu.hel.fi/english
www.linkoping.se/birgitta
www.linkoping.se/ljungstedtska
www.dundeecoll.ac.uk/work_placements_abroad