Ensuring high quality health and social care for our older population: residential care in Ireland as a case example

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Irene O’Connor has a varied professional background, having worked in intensive therapy nursing in the UK and Switzerland before returning to Ireland to work in midwifery and nurse education. Subsequently she moved into leadership and management in older people’s services, where she led the first project on elder abuse in Ireland. She is currently Matron at St Ita’s Community Hospital, Ireland, and was a member of the HIQA group on the formation of residential standards for older people.

ABSTRACT

Southern Ireland faces similar challenges to the rest of Europe in that it has a rapidly increasing older population, seemingly infinite demand for health and social care and growing financial pressures. Against such a background, there are concerns about the quality of care provided for frail older people, especially in long-term care settings. This paper considers some recent policy development in Ireland, with a particular focus on long-term care. It describes the response to a series of inquiries about the quality of care in such environments and the subsequent formation of the Health Information and Quality Authority (HIQA). HIQA has just introduced a series of new inspections standards, and these are presented in the article. However, whilst these standards are to be welcomed, it is argued that standards alone will not result in improved quality unless there is also a recognition of the role and value of long-term care as a positive care environment for older people.

KEY WORDS

Long-term care inspection quality standards improving care care environment Ireland
INTRODUCTION

Delivering services that provide a positive experience for older people who need support is a significant future challenge, as the quality of such services is a reflection of the value we place on our seniors and the respect we accord them as members of society. Such considerations apply particularly to their healthcare needs, as this is when older people are generally at their most frail and vulnerable. Nowhere is this more apparent than in the case of residential care, where generally the oldest and frailest members of society are supported.

Recently, considerable attention has been given to the notion of dignity in care, which extends beyond basic rights such as privacy to include respect not only for the person but also for that person’s decisions and their right to make choices that affect their life (Stratton, 2006). Older people are entitled to be partners in their own healthcare, to be kept informed about their treatment and to be treated with honesty and respect if something goes wrong (Madden, 2008). Whilst such rhetoric is to be applauded, meeting these aspirations on a day-to-day basis is undoubtedly a challenge facing every healthcare system and the people who work in it. Such challenges are likely to increase in the future as demographic changes result in a rapid growth in the numbers of frail older people. The position is exacerbated in older people with a greater incidence of complex comorbidities and multiple treatment regimes. A key question, therefore, is how do models of service delivery such as anticipatory care, long-term condition management and the provision of services closer to the person’s home rise to meet future need whilst maintaining high quality care that reflects the values above?

This paper considers the situation in Ireland, which, in common with the rest of Europe, has an increasing older population whilst also facing pressures from the changing financial situation and the issue of how to balance significant and growing demand within finite resources. It uses residential care as a case example, highlighting a number of recent issues that have arisen. In order to place the debate into an appropriate context, it begins with a brief description of the organisation of health and social care in Ireland.

THE IRISH HEALTH SERVICE STRUCTURES

To contextualise the challenges facing Ireland in striving to provide a quality service for the increasingly ageing population, it is important to have a basic understanding of the current Irish health care services, which, unlike many other countries, includes the social care services. What follows is a brief overview of some significant recent policy initiatives that have driven changes to the system.

In his budget statement of 5 December 2001, the Minister for Finance announced the establishment of a Commission on Financial Management and Control Systems in the Health Services, indicating that the independent commission would examine, evaluate and make recommendations on relevant financial systems, practices and procedures throughout the health services. The Brennan Report (Brennan, 2003) that arose from this commission stated that in a modern, democratic society, every citizen should have access to a quality public health system. Furthermore, it stated that the people who work at all levels of that service are equally entitled to expect the system to be organised in a way that best allows them to use their skills and energy to provide quality care. Many of the problems are fundamentally structural (Brennan, 2003) and primarily related to how the system is organised and managed. Improving the systems of financial management and control alone is unlikely to improve the efficiency and effectiveness of care services unless there are also fundamental reforms of the way the system is organised and managed. Improving the systems of financial management and control alone is unlikely to improve the efficiency and effectiveness of care services unless there are also fundamental reforms of the way the system is organised and managed. The Brennan Report placed particular emphasis on the need to improve the management of public expenditure, recommending that the health service should be managed as a single national system and all costs
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incurred should be capable of being allocated to individual patients. The two central weaknesses in the system that surfaced regularly in recent reports were that no single institution or person was responsible for the day-to-day management of the service as an integrated national entity and that management and control were too fragmented. In order to rectify this, a single healthcare organisation known as the Health Service Executive (HSE) was established in 2005.

Consequently, Ireland now has a comprehensive government-funded health service. The HSE is the state organisation with overall responsibility for managing the Irish public health service, which includes social care, and it works closely with the Department of Health and Children (DoHC). The establishment of the HSE represented the beginning of the largest programme of change ever undertaken in the Irish public services. Prior to this, services were delivered through a complex structure of 10 regional health boards, the Eastern Regional Health Authority and a number of other different agencies and organisations. The HSE replaced all of these organisations. It is now the single body charged with the responsibility for ensuring that everybody can access cost-effective and consistently high quality health and personal social services.

Health expenditure in Ireland has increased rapidly from €3.7bn in 1997 to €15bn in 2008. In 2006, when the HSE launched its Transformation Programme, the integration of hospital and primary care services was identified as a necessary antecedent to its success. The need for a system-wide focus on quality and safety has been an enduring theme in the organisation for a number of years.

RECENT DEVELOPMENTS

The report of the Commission on Patient Safety and Quality Assurance, *Building a Culture of Patient Safety* (Madden, 2008), published in September 2008, adds urgency to the HSE agenda. This was commissioned following a number of high profile and damning investigations into health services practices in different areas in Ireland. These included the Lourdes Hospital Enquiry (Harding Clarke, 2006) on the rate of caesarean-hysterectomies in a particular hospital. The enquiry concluded that any institution that operates in isolation and does not have a rigorous process in place for outcome review, conducted by peers and benchmarked against comparators, could potentially find itself in the same situation. It recommended that a system of obligatory and regular audit be established, as well as mandatory continuing professional development and skills assessment for staff at all levels.

The enquiry gave particular attention to the role of senior ward sisters, who it said should regularly update their skills in order to recognise outmoded and unnecessary practices and change them in light of the latest available evidence. The recommendations extended beyond a single discipline, however, and it was suggested that hospital management should have more authority and training but that there should also be more medical input at this level. On the other hand, it was recognised that the power of medicine to act in a largely independent manner should also be reviewed. Consequently, clinical independence should no longer be interpreted as a licence for arrogant behaviour, a disregard for patient choice and dignity or freedom from accountability (Harding Clarke, 2006).

Recently, a Directorate of Clinical Care and Safety has been established, and a Chief Clinical Officer appointed, to lead and consolidate the above developments. The purpose is to provide leadership and the necessary focus to ensure that quality and safety are integral to service delivery. The challenge now is to ensure that the patient safety agenda is a core part of work at all levels of the organisation and that accountability structures are clearly defined for all. The mission of the HSE, as stated in its corporate plan for 2008-2011, is ‘to enable people live healthier and more fulfilled lives’. The HSE’s 2010 vision is that ‘everybody will have easy access to high quality care and services that they have confidence in and staff are proud to provide’.
It is against the above background that current concerns about the quality of care provided to older people need to be viewed. Such concerns are not new, however, and indeed can be traced back over many years. Fuelled by growing awareness that older people were not receiving the level or standard of care that they required, Age Action Ireland commissioned a number of reports, the most important being The Years Ahead – A policy for the Elderly (Robins, 1998) and its subsequent review. The initial report identified the need for significant changes in the service delivery models for the older person and placed particular emphasis on the need for more extensive rehabilitation and respite services, the delivery of a multidisciplinary service and the need to engage with older people in a more meaningful way. It emphasised that provision of care should be home-based, and sought greater investment in home care services. The review acknowledged that significant improvements had occurred but that changing the emphasis from residential care to home care was slow to the point of being almost negligible. It again argued for greater investment in home supports and home care services and stated that, where residential care was required, it must respect both the older person’s dignity and their right to privacy.

Although some years have passed since the launch of these reports and Ireland has been through an economic boom, the increasing elderly population and more recent reports (O’Neill, 2006; O’Reilly, 2008) indicate that all is not well with the quality of care provided for older people. With respect to older persons’ services, poor standards of care and abuse have become both more frequently reported and more serious in nature. For example, following the submission of a complaint by the daughter of one woman in her late eighties, an investigation highlighted serious inadequacies in the care given to the woman. She had been admitted to an HSE nursing home for respite care, and within a week of her admission was dehydrated and malnourished (O’Reilly, 2008). Following a report on the television programme Primetime on the care provided to the residents of a private nursing home, the Leas Cross review (O’Neill, 2006) found that there were numerous deficiencies at all levels, with inadequate numbers of appropriately trained staff, no documentary evidence of proper management of the home and no clinical leadership with regard to meeting residents’ needs (O’Neill, 2006). It was concluded that the management at Leas Cross had neither the insight nor the capacity to introduce meaningful change (O’Neill, 2006). Overall, the documentary suggested a regime that was indicative of institutional abuse, with poor standards of care, limited attention to the complex needs of older residents, rigid routines and inadequate staffing.

Developments such as these have precipitated a number of current changes to care standards and inspection processes in Ireland. These are based on the principles that outcomes of care improve when older people are cared for by nurses with demonstrated competence in older person nursing, and when care is structured around the needs of the older person (Harrington & Kovner, 2001; O’Neill, 2006). Indeed, the importance of nurses focusing on the older person’s needs pervades every part of the healthcare system (An Bord Altranais, 2009). The findings of the Leas Cross investigation represent a watershed in the residential care of older people in Ireland and have had a very significant influence on the new inspectorate process that has been introduced this year, and the standards used to inform such inspections. Recent studies support the need for such changes, again with a particular focus on the quality of life experienced by residents. Murphy (2007) and Murphy & O’Shea (2008) found that nurse managers in Ireland are central to the quality of life of older adults, as they shape the ethos of care within the facilities. In identifying ‘quality of life’ as one theme, the study focused on managers’ perceptions of key quality of life issues for older adults. Six categories were identified:
1. the physical environment
2. making it like home
3. involving the family
4. the social environment
5. meaningful recreational activities
6. community connections.
The nurse managers perceived that residents’ quality of life was particularly affected by the physical and social environments in which they lived (Murphy, 2007).

**NATIONAL QUALITY STANDARDS FOR RESIDENTIAL CARE SETTINGS FOR OLDER PEOPLE IN IRELAND**

Residential care for frail older people is provided in a wide variety of settings in Ireland, including large public HSE community hospitals, many dating back to the 1840s and with their origins in the famine workhouses. More recently, a number of smaller public community nursing units have been built. Residential care is also provided in an ever-expanding private nursing home sector and, to a lesser extent, by the voluntary sector.

Until recently, the setting of standards and the monitoring of such standards within residential care settings was the responsibility of the local health services, and inspections were confined to the private nursing home sector. Public services were expected to be led and monitored by the director of nursing responsible for those services. This changed with the establishment of the Health Information and Quality Authority (HIQA) by the Minister for Health and Children in 2007. HIQA was set up to generate standards of provision based on national and international best practice, and to ensure independence and transparency in investigating complaints. It is also charged with the responsibility of inspecting all residential care services, including public, private and voluntary residential care services for older persons. The intention is to instil confidence in the people using the service, and their families.

Following extensive public consultation, new standards on the quality of service expected in residential care have been established. These National Quality Standards for Residential Care Settings for Older People in Ireland (HIQA, 2009) are a key component in ensuring the quality and safety of services for our older population in the years to come. The Standards provide a baseline for those with the responsibility for providing care to assess the quality of care planning, strategically develop appropriate and sustainable resources, and provide continuity and stability to the lives of those in their care (HIQA, 2009).

The Standards also provide very clear guidelines for residents, their families and carers as to the rights of a resident living in a residential care setting. Every resident should expect to live as full and as independent a life as possible and, together with the care provider, to direct their own care.

On 1 July 2009, HIQA took over responsibility for inspections of all residential care settings for older people. It is expected that HIQA will carry out inspections across the public, private and voluntary sectors to ensure that the Standards are being met (see Table 1) and that residents are receiving the highest quality of care. What impact such developments will have remains to be seen and, while they hopefully will lead to improvements in care and services for frail older people, at best they represent a necessary - but not a sufficient - condition for change. For change to occur, there also needs to be a reappraisal of the place of residential and long-term care in the spectrum of services to support older people.

**RESIDENTIAL CARE: VALUED OR NOT?**

Care homes have always tended to occupy an ambiguous place within the range of support available to older people. Since the damning critiques of the 1960s (Robb, 1967; Townsend, 1962) there has been marked ambivalence, with older people viewing entry to a home as the ‘final sign of failure’ (Victor, 1991) and work in such environments being accorded little status or prestige. Whilst there has been recognition of the need for such places for a small
### Table 1: The Standards

#### SECTION 1: RIGHTS

<table>
<thead>
<tr>
<th>Standard</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>Standard 1</strong></td>
<td><strong>Information</strong>: Each resident has access to information, in an accessible format, appropriate to his/her individual needs, to assist in decision making.</td>
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<tr>
<td><strong>Standard 2</strong></td>
<td><strong>Consultation and participation</strong>: Each resident’s rights to consultation and participation in the organisation of the residential care setting, and his/her life within it, are reflected in all policies and practices.</td>
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<tr>
<td><strong>Standard 3</strong></td>
<td><strong>Consent</strong>: Each resident’s consent to treatment and care is obtained in accordance with legislation and current best practice guidelines.</td>
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<tr>
<td><strong>Standard 4</strong></td>
<td><strong>Privacy and dignity</strong>: Each resident’s right to privacy and dignity is respected</td>
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<tr>
<td><strong>Standard 5</strong></td>
<td><strong>Civil, political and religious rights</strong>: Each resident is facilitated to exercise his/her civil, political and religious rights in accordance with his/her wishes.</td>
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<tr>
<td><strong>Standard 6</strong></td>
<td><strong>Complaints</strong>: The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.</td>
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<tr>
<td><strong>Standard 7</strong></td>
<td><strong>Contract/statement of terms and conditions</strong>: Each resident has a written contract/statement of terms and conditions with the registered provider of the residential care setting.</td>
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#### SECTION 2: PROTECTION

<table>
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<th>Standard</th>
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<tr>
<td><strong>Standard 8</strong></td>
<td><strong>Protection</strong>: Each resident is protected from all forms of abuse.</td>
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<tr>
<td><strong>Standard 9</strong></td>
<td><strong>The resident’s finances</strong>: Each resident’s finances are safeguarded</td>
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#### SECTION 3: HEALTH AND SOCIAL CARE NEEDS

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<tr>
<th>Standard</th>
<th>Description</th>
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<tr>
<td><strong>Standard 10</strong></td>
<td><strong>Assessment</strong>: Each resident has his/her needs assessed prior to moving into the residential care setting, a full assessment upon admission, and subsequently as required to reflect changes in need and circumstances during his/her period in residence.</td>
</tr>
<tr>
<td><strong>Standard 11</strong></td>
<td><strong>The resident’s care plan</strong>: The arrangements to meet each resident’s assessed needs are set out in an individual care plan, developed and agreed with each resident or, in the case of a resident with cognitive impairment, with his/her representative.</td>
</tr>
<tr>
<td><strong>Standard 12</strong></td>
<td><strong>Health promotion</strong>: Each resident benefits from policies and practices that promote his/her health, rehabilitation and wellbeing.</td>
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*continued*
Table 1: The Standards (continued)

<table>
<thead>
<tr>
<th>Standard 13</th>
<th>Healthcare: Each resident’s assessed health needs are reviewed and met on an ongoing basis in consultation with the resident.</th>
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<tr>
<td>Standard 14</td>
<td>Medication management: Each resident is protected by the residential care setting’s policies and procedures for medication management and, where appropriate, is responsible for his/her own medication.</td>
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<tr>
<td>Standard 15</td>
<td>Medication monitoring and review: Each resident benefits from his/her medication to increase the quality or duration of his/her life. He/she does not suffer unnecessarily from illness caused by the excessive, inappropriate or inadequate consumption of medicines.</td>
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<tr>
<td>Standard 16</td>
<td>End of life care: Each resident continues to receive care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.</td>
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SECTION 4: QUALITY OF LIFE

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<tr>
<th>Standard 17</th>
<th>Autonomy and independence: Each resident can exercise choice and control over his/her life and is encouraged and enabled to maximise independence in accordance with his/her wishes.</th>
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<tr>
<td>Standard 18</td>
<td>Routines and expectations: Each resident has a lifestyle in the residential care setting that is consistent with his/her previous routines, expectations and preferences, and satisfies his/her social, cultural, language, religious, and recreational interests and needs.</td>
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<tr>
<td>Standard 19</td>
<td>Meals and mealtimes: Each resident receives a nutritious and varied diet in pleasant surroundings at times convenient to them.</td>
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<tr>
<td>Standard 20</td>
<td>Social contacts: Each resident maintains contact with his/her family, friends, representatives and the local community according to his/her wishes.</td>
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<tr>
<td>Standard 21</td>
<td>Responding to behaviour that is challenging: The needs of each resident with behaviour that is challenging, including behaviour that poses a high risk to him/herself or others, are managed and responded to effectively in an environment that promotes wellbeing and has the least restrictions.</td>
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SECTION 5: STAFFING

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<th>Standard 22</th>
<th>Recruitment: Staff are recruited in accordance with best human resource management practices</th>
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<tr>
<td>Standard 23</td>
<td>Staffing levels and qualifications: There are appropriately skilled and qualified staff sufficient to ensure that services are delivered in accordance with these Standards and the needs of the residents.</td>
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continued
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A similar situation exists in Ireland where, traditionally, older people have been supported at home as part of the extended family. While this has been the case in many countries, the tradition is probably more firmly embedded in Ireland than elsewhere. Again in common with other countries, however, changing patterns of female employment and greater geographical mobility have seen such long-held traditions under increasing strain.

Table 1: The Standards (continued)

| Standard 24 | Training and supervision: | Staff receive induction and continued professional development and appropriate supervision. |
| Standard 25 | Physical environment: | The location, design and layout of the residential care setting are suitable for its stated purpose. It is accessible, safe, hygienic, spacious and well maintained and meets residents’ individual and collective needs in a comfortable and homely way. |
| Standard 26 | Health and safety: | The health and safety of the resident, staff and visitor to the residential care setting is promoted and protected. |

SECTION 6: THE CARE ENVIRONMENT

| Standard 27 | Operational management: | The residential care setting is managed by a suitably qualified and experienced nurse with authority, accountability and responsibility for the provision of the service. |
| Standard 28 | Purpose and function: | There is a written statement of purpose and function that accurately describes the service that is provided in the residential care setting and the manner in which it is provided. Implementation of the statement of purpose and function is clearly demonstrated. |
| Standard 29 | Management systems: | Effective management systems are in place that support and promote the delivery of quality care services. |
| Standard 30 | Quality assurance and continuous improvement: | The quality of care and experience of the residents are monitored and developed on an ongoing basis. |
| Standard 31 | Financial procedures: | The continued viability of the residential care setting is assured through suitable accounting and financial procedures. |
| Standard 32 | Register and residents’ records: | Each resident is safeguarded by the residential care setting’s record-keeping policies and procedures. |

Table adapted from National Quality Standards for Residential Care Settings for Older People in Ireland (HIQA, 2009)
The provision of residential-based care has therefore increased markedly over the last 40 years but, as noted previously, and notwithstanding a growing private sector, much of this provision remains within the mainstream health service.

However, recent policy from the DoHC and the HSE promotes the notion of ‘ageing in place’, with the home being seen as the best place to be. While, of course, this is what most of us would want, the risk is that it will further stigmatise residential care as the option of last possible resort. When such care is required, the creation of a home-like environment is actively promoted. This is based on the Irish notion of teaghlach (which translates into ‘household’ in English). This model of care, which originated in the United States, focuses totally on the older person and their needs, and looks at how care can be delivered in a hospital setting that, as far as possible, reflects the environment of the patient’s own home. The new approach promotes the principles of privacy, autonomy and self-determination for the older person. Implementation requires a significant change in the physical environment to reflect a normal household, such as including the residents in the preparation and presentation of meals, thereby enhancing the sensory and social experience that is a part of everyday family mealtimes.

However, promoting such an environment is easier said than done. The creation of such a home-like setting is consistent with a range of models emanating from the United States, such as Wellspring and the Eden Alternative (Boyd, 2003; Brennan et al, 2003). But experience from the US indicates that achieving such a change in philosophy takes considerable time (often up to a decade) and commitment, and requires a fundamental change in culture. The complex comorbidities characteristic of older people now being admitted to such care environments also challenges the meaningful implementation of this philosophy. This level of change cannot be brought about by the introduction of standards alone.

Therefore, whilst the new HIQA Standards are a very exciting development and are likely to result in significant improvements, they need to be viewed as the first step. As several authors have noted, what is required is a paradigm shift in the way that residential care is perceived (Dixon, 2003; Ronch, 2004). Stone (2003) has suggested that this will require attention to four types of culture:

- the ‘clinical’ culture, which reflects the nature of the resident population and the goals of care
- the ‘caring’ culture, which reflects the nature and quality of the relationships between staff and residents
- the ‘work’ culture, concerning the way staff are treated and whether they too are nurtured, supported and treated with dignity
- the ‘residential’ culture, reflecting the extent to which a home is seen as part of the wider community.

All four areas will need attention if the vision of high quality care for frail older people is to be realised. Of course, standards for quality are a key part of the jigsaw but perhaps the biggest battle is that for ‘hearts and minds’. Attitudes towards residential care need to change and, as Deutschman (2001) notes, ‘attitudes cannot be changed by rules’. This has been captured eloquently by Baker (2007):

‘While we should continue to push for compliance to high standards the path to deep systematic change does not lie in the threat of regulations, but rather in a new vision that is hopeful and realistic.’

The vision may be captured in the teaghlach, but it has to be realised that change of such magnitude has to be seen as a ‘journey rather than a destination’ (Boyd & Johansen, 2008). Ageism is a major issue in society, in Ireland and in nursing, and it has a significant effect on residents’ quality of life, which ‘is affected by the fact that ageism operates right through society and into our institutions’ (Murphy, 2007). The journey of change may have started in Ireland, but we are still some way from the destination.
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References


