What is long term care for the elderly?

THE DANISH EXPERIENCE

Report of the second conference on 26 April 1979 at the King's Fund Centre

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THE DANISH EXPERIENCE

PART II

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What is long term care for the elderly? -

THE DANISH EXPERIENCE Part II

This conference, held at the King's Fund Centre on Thursday, 26th April 1979, was the second of two designed to examine the ways in which care for the elderly is provided in Denmark, and to compare those ways with the provision of similar services in the United Kingdom. The conference was therefore started by the Chairman, Graham Cannon, reminding participants of some of the reasons why the King's Fund financed the visit to Copenhagen of four specialists in this field and then decided - on the strength of the reports which they brought back - that some more general discussions should take place. The purpose of this second conference was to look critically at what had been said of the Danish services and to consider what we could learn from them.

The members of the team who went to Denmark were invited to speak for a few minutes on their impression of care in Denmark. Professor Millard believed that Denmark has developed many good practices that we could follow. Although Britain led the world in medical services, Denmark had opened his eyes to improvements in long term care for the elderly. Institutional care in Denmark is better, and more domestically orientated, in-so-much that individuals are allowed to keep their own personal possessions around them including furniture.

As a geriatrician himself, he had concentrated more on the freedom of movement of the individual, i.e. the removal of constrictive barriers such as cot sides and chairs with fixed tables, and patients being tied into chairs. He had possibly not been so concerned with the more personal needs of the individual, but suggested that patients should be brought more into the decision-making concerning their own care, and be encouraged to take on responsibilities for their own motivation. Planners should take a hard constructive look at the environment of the institutions that we expect and even enforce elderly people to live in.

Interests of the nurse member of the team, Miss Mollie Clark, were concerned with the people who provided the service - what they did, and how they were prepared for the job. Nurses who work with permanent residents need to be better informed about the special features of this work than the present basic courses of training for the Register or Roll facilitate. Maybe our community nursing staff have the expertise in caring for people in their own homes, that permanent care nurses should seek to acquire. Perhaps there should be a new species of caring staff? It might be useful for nurses to share post basic courses with residential care staff. Alternatively, joint courses for nursing and residential care staff could be set up or post basic nurse training courses which leave out the "basic nursing" component and introduce more psychology and sociology. Necessity often produces solutions, and the nurses known as "Nursing Home Assistants" in Denmark have proved this. The attitudes and feelings of all caring staff are formed during their early training and this experience must acknowledge the rights of the individual. The real challenge that must be faced up to by nurses, especially senior administrators, must be to de-institutionalise their own thinking about the care which they are responsible for providing.

The next speaker, Mr. Roger Burton, looked at the role of the social worker. Social workers, he felt, should be brought in, when the discharge of the patient into the community was being planned. This is of vital importance, to ensure that the services of the Home Helps, and Meals on Wheels, are properly organised and when the patient is most in need of practical support. These support services need new ideas to enable a more flexible approach to be developed. Seven day provision of Meals on Wheels has been achieved in Denmark. Transport is another area where the Danes have solved some of their problems by utilising taxis for transporting clients to and from Day Centres. Is it really impossible to utilize the "idle hours" of vehicles in social services departments? The training of Home Helps was also a point for consideration. What do we really want from them and do we need to broaden the base of their responsibility? Should we not look at the duties of the nurses and health visitors, and possibly re-think the policies and duties of all of these staff who contribute so materially, but differently to the well-being of the elderly? The elderly are people, and must be regarded as such, people who have individual needs, which must be met.

In residential nursing homes, care can be very luxurious, with advanced provision for rehabilitation and leisure activities, but it will amount to very little if the

environment is not comfortable, or is isolated from community amenities and transport facilities. As long ago as 1955 the responsible Minister had said that the elderly should be allowed to bring more of their own furniture and possessions into Residential Accommodation and had urged that any difficulties that might arise in allowing this to happen should be overcome. It is a sad reflection that nearly twentyfive years later so little progress on this score has been made.

Dr. Colin Godber emphasised the differences described by Dr. Esther Ammundsen, between the medical and social needs of patients in long term care. Problems of elderly people retaining their identity may present difficulties. If every residential home had its own residents' committee it would become a power group to make known the needs and wishes of its residents. The common practice of mixing all the elderly in one large room should cease and more respect be given to privacy and the need for occasional spells of being apart. Sheltered housing could be improved to give increased privacy to the individual, but without isolation from the rest of the community.

Professional staff must also assess just how much disability can be coped with within sheltered housing or residential homes. Any such review may well suggest that more staff in these places are needed. What sort of new buildings should we be planning? Old peoples' homes are now dealing mainly with very frail people. Doesn't the community hospital perpetuate the medical model? Why don't we think in terms of merging these two sectors in something like the Danish Nursing Home with health and social services combining in their management.

How do we stem the demand for institutional care? We need to find ways in which collaboration within the services of housing departments, social services and health services can be improved to better selection procedures and reduce duplication.

We do have more investment in family care in this country than in Denmark but we should be able to go out and offer more support when needed in the community. From the point of view of the hospital service we should continue to increase investment in the geriatric and psychogeriatric services: and to encourage the consultants to go out into the community. It would certainly save on the use of institutional beds if geriatric services were included in acute care, leading to assessment and screening for residential care by the consultants.

The following is a list of the topics given to the six syndicate groups and this is followed by a summary of the comments made by them

Topics for syndicate discussion groups - 26th April, 1979

A. How can we maintain a personal environment for elderly people in our hospitals and old peoples homes and head away from the legacy left by the 'poor laws'?

(i) How can the clients control of his life style be protected?
(ii) How far should staff be responsible for decisions taken by the clients/patients?

B. How should we train our staff to meet the joint needs of residential and nursing care in

(i) Continuing rehabilitation
(ii) Motivation to continue mobility and independence
(iii) Right use of equipment and aids
(iv) Terminal care

while preserving the personal environment of the client.

C. What practical changes can be made in our existing institutions allowing for·

(i) Restrictions in structure
(ii) Fire regulations
(iii) Union agreements
(iv) Inter-departmental boundaries

How can their images and staff moral be improved?

D. What sort of institution should we be building in the future?

(i) Community hospitals
(ii) Nursing homes
(iii) Supervised sheltered housing
(iv) Others

Where would the psychiatric services fit in to deal with the acute confused state and the elderly mentally infirm?

E. What can we learn from Denmark about integration of resources?

(i) What are the present advantages and disadvantages of organising care?
(ii) What should we retain?
(iii) What could we alter?

F. How should we ensure that the elderly can be maintained as long as they need or wish to be in the community?

(i) Training needs of Home Helps
(ii) Coordinating voluntary help
(iii) Suitable housing
(iv) Health education

Should the elderly have more real choice in using these services?

A. How can we maintain a personal environment for elderly people in our hospitals and old peoples' homes and head away from the legacy left by the 'poor laws'?

(i) How can the client's control of his life style be protected?

(ii) How far should staff be responsible for decisions taken by the clients/patients?

1) The first point with the most emphasis was on the attitudes of 'everyone' concerned with care of the elderly

b) Putting the client's needs first, and, to encourage their participation in all areas which include independence, andallowing a freedom of choice in selection of resources, and planning for their own future care. This can cause staff some concern in allowing a certain amount of risk taking.

2) Training of staff at all levels and all disciplines is vital in all areas of working with the elderly. Some aspects of the Danish training programme could be incorporated in our training syllabus. Staff must have the time to listen.

3) Better selection of provision, and use of resources should be studied.

4) Communication and interprofessional understanding of each others' roles, goals and limitations.

5) Public awareness, and more thought into ways of re-awakening the "family type" caring in the community could be undertaken.

If people are aware during their younger life, that consultation and awareness of their needs and wishes would be taken into account when they are old, a large part of the morbid fear of growing old would disappear, and be less of a preoccupation.

B. How should we train our staff to meet the joint needs of residential and nursing care in

(i) Continuing rehabilitation

(ii) Motivation to continue mobility and independence

(iii) Right use of equipment and aids

(iv) Terminal care

while preserving the personal environment of the client

This group discussed modules of training in various places.

1) Community physio-therapists trained relatives and district nurses in rehabilitation in the community

2) Training is required by staff to teach them to assist the elderly to cope with being admitted and with the trauma of leaving their familiar surroundings and accepting the fact that they need help, was a point for consideration.

3) Early recognition of problems affecting the elderly in their own homes. The need for hospital staff to visit people in their own homes and recognise early, signs of approaching problems.

4) The need for full team involvement in rehabilitation with multi-purpose meetings between the social services staff and the health services staff to plan the care of the elderly in their districts.

5) To assess patients carefully, to prevent 'bed blocking' in hospitals and residential homes and to develop early screening and regular checks as a preventative measure, with use of age/sex register.

6) To educate the staff and public that death is a normal part of life, and that interest is growing in this subject and is influencing public attitudes on this topic.

7) If management is secure, then staff feel secure, each level of staff influences the one below. With a secure and happy staff an atmosphere develops to enable patients and people to remain independent individuals.

8) Too much legislation cocoons people and restricts independence, and risk taking.

C. What practical changes can be made in our existing institutions allowing for

(i) Restrictions in structure

(ii) Fire regulations

(iii) Union agreements

(iv) Inter-departmental boundaries

How can their images and staff morale be improved?

1) A planned programme of replacement of buildings should be formulated

2) To adapt existing buildings so that appropriate care can be given, with an emphasis on a more domestic and homely environment.
To experiment with design, and look at different models of caring.

3) Attitudes of the staff at all levels and the public, to buildings of long-standing, need to be changed. This can be done if the community is involved in planning some of the changes.

4) Fire regulations can restrict improvements but in any buildings used by the elderly escape measures are very important and routines must be practised and adhered to.

5) Jointly developed and implemented procedures are basic to a harmonious and working environment. Worker participation should also be at management level. Professional attitudes cause barriers, and need to be tactfully broken down.

6) Encouragement of various professional and voluntary organisations and associations to provide care for their members in their retirement and old age.

7) Continuing support of the elderly in the community is of economical importance as well as more acceptable to the individual.

8) A clear distinction is needed between the responsibility of provision between the Social Services and the Health Services.

9) Greater emphasis must be placed on the changing of attitudes which must start with the training of the professions in all disciplines.

D. What sort of institution should we be building in the future?

(i) Community hospitals

(ii) Nursing homes

(iii) Supervised sheltered housing

(iv) Others

Where would the psychiatric services fit in to deal with the acute confused state and the elderly mentally infirm?

1) The adaptation of existing buildings is likely to be the main source of future institution care

2) Sheltered housing offers privacy and self-determination and with better staffing could greatly reduce the need for conventional Part III accommodation. A central pool of staff that can be called on in emergencies and sickness would be one way of extending warden cover.

3) A wider spectrum of sheltered housing, perhaps with residential care homes and sick bays on site.

4) Many existing Part III homes could then be adapted to play a role more like that of the Danish Nursing Home.

5) Community Hospitals should play an important part in the acute care, rehabilitation and assessment of the elderly but the Danish concept of the nursing home offers a better model for long stay care.

6) There should be more uniform development of the psychogeriatric services, with more training of staff for this important and specialised work.

E. What can we learn from Denmark about integration of resources?

(i) What are the present advantages and disadvantages of organising care?

(ii) What should we retain?

(iii) What could we alter?

1) It was generally agreed that there is an accepted philosophy of care in this country, but there are deprived groups - e.g. some who are unable to obtain the services of a GP or who were not adequately catered for in nursing homes

2) Are we making the best use of the services? Merely increasing resources, especially finance, will not be adequate in the future as demand will always outstrip supply

3) We are in the process of change and are transferring skills from the medical to the social model.

4) The housing of the elderly, including hospital and residential care, often necessitates the elderly person having to transfer from place to place. Such moves can mitigate against the elderly person and their personal feelings must always be remembered.

5) The integration of services at the point of delivery was questioned. Should staff of residential care sheltered housing and overall domicillary services be an integrated group?

6) Improving relationships between geriatricians and the social services was an area for discussion and also between family doctors and geriatricians.

7) The label of "Geriatrics" was one that did not readily attract staff to working with the elderly.

8) Care staff training was considered and it is believed that this is not being tackled properly. Collaboration between the Joint Consultative Committee, the Joint Care Planning Team, and field work staff was needed. Community physicians were too few in planning teams.

F. How should we ensure that the elderly can be maintained as long as they need or wish to be in the community?

(i) Training needs of Home Helps

(ii) Coordinating voluntary help

(iii) Suitable housing

(iv) Health education

Should the elderly have more real choice in using these services?

1) A multi-disciplinary team of a GP, Nurse, Social Worker and Home Help organiser and client should be available at point of referral. There is a need to explore different uses of resources for the optimum of a mix of several services, and be aware of the whole spectrum of care.

2) Denmark has a comprehensive Home Help service but the group questioned whether this is so necessary in this country. Home Helps can do most tasks. Increasing needs means that the service becomes more stretched. There is a difference of provision in urban and rural areas. Job descriptions are vague and non-existent in some places. Many Home Helps with little or no medical knowledge support the elderly, but who supports them? More community nursing services, with Social Workers attached to primary care teams, are required if there is to be a real improvement in the standard of service.

3) A volunteer coordinator should be attached to every area social work team. His or her job is:- to find volunteers and train and sustain them: to coordinate transport and liaise with wardens of sheltered flats, meals on wheels organisers, and staff of voluntary and private homes. Volunteers can be recruited from the newly-retired.

4) Continuous assessment of the elderly should take place to ensure an acceptable quality of life. When necessary, admission to short term care, to give relief to relatives, should be arranged. More and better use should be made of sheltered housing, and admission arranged to homes at the discretion of the multi-disciplinary teams. Never losing sight of the possibilities of rehabilitation and return of the elderly person to their own home.

5) Health education should start in school, where the right attitudes to age can be learnt. Pre-retirement courses should start early at 40-45 years, allowing people to accept and come to terms with the ageing processes of slower reactions and failing memory.

6) Continuous stimulation to provide a reason for getting up each day. Adherence to a daily routine is essential for an active, interested, retired person.

There appeared to be a general feeling at the end of the conference that the discussions, and indeed the earlier papers from our Danish colleagues, had provided much food for thought. That the conferences had proved to be so stimulating was largely due to the thoughtful and articulate response from all those who had attended, as well as to the presentations made by the Danes and by the team of four who had visited Copenhagen.

One of the objectives of the second conference was to try to establish whether there are issues concerning the care of the elderly in the U.K. which might be further discussed in conferences or workshops at the King's Fund Centre. The following were suggested:

Sheltered housing. There are different interpretations put on these words in different parts of the country. Alternative solutions to providing care in this way might be examined, and solutions geared to rural as against urban populations, to the over and under 85, to the physically handicapped and to the fit, could all be examined. The participation of those responsible for housing as well as the directly "caring" staff would be essential.

Training. The fact that there are existing barriers between professional groups has to be recognised. What could be done to widen the appreciation of multi-professionals working together and to improve communications between those working towards the same ends?

Communications. Perhaps one of the most significant needs, and one which may be the most difficult to meet, will be to improve communications with the elderly. Certainly at future discussions a conscious effort should be made to involve old age pensioners in the debates on topics which concern them more than anyone else.

Good practices. Let it not be forgotten that up and down the country experiments and good practices are being developed. There is a great need to think more of these and not to allow the magnitude of the problems we are facing to create a situation where the best is the enemy of the good. This need not happen and subsequent conferences at the King's Fund Centre on the above themes will aim to identify some of the many existing and worthwhile developments that are already taking place.

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WAR/JH

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King Edward's Hospital Fund for London KFC 79/79

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WHAT IS LONG TERM CARE FOR THE ELDERLY

THE DANISH EXPERIENCE

Tuesday 20 March and Thursday 26 April 1979

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