Irish Nurses and Midwives Organisation

Working Together

Submission to the Department of Health

Home Care Packages

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There are so many areas of concern with the current home care scheme, that it is extremely difficult to identify where the scheme works well. However, a study undertaken in 2016 of older people utilising the home care scheme highlighted that where a strong multidisciplinary team approach was taken, good practices were identified (Donnelly, 2016). As part of the multidisciplinary team, it is essential that the public health nurse (PHN) and community registered general nurse (CRGN) role is recognised throughout the process and that clear lines of accountability are established and recognised throughout the country.

The INMO believes that home care services do not work consistently well across primary care, acute care or alongside formal carers. It is well documented that the current home care provision is not fit for purpose. There are vast differences across geographical areas, professional disciplines and the use of both private and public services has led to a chaotic system, one which is not reflective the needs of those requiring the service. It is essential that in developing an integrated model of care, that all sectors of the health service, including primary, community and acute are working for the good of the patient/client and are directly hired and answerable to the public service provider.

As stated earlier, where a strong multidisciplinary team exists, home care services can work well alongside community, and primary care services. However, there currently exists much confusion and inconsistencies. The PHN/CRGN provides the initial assessment, however, once the assessment goes to an administrative process, their recommendation for care hours - required to provide assistance with activities of daily living - are reassessed based on financial availability. The PHNs/CRGNs clinical judgment role becomes increasingly difficult and is essentially taken out of their hands as the ultimate decision is based on cost of care not clinical need.

Equally, when dealing with private home care services, the role of the PHN/CRGN and direct contact with the client/patient can be diminished. Although, the services provided by the private home care provider may be good, this lost connection with the PHN/CRGN is something which cannot be overlooked and needs to be rectified to provide a seamless service fit for purpose.

Similar issues exist in relation to the acute services working alongside home care services. One study identifies that overreliance on the hospital setting has led to a

"reactive rather than preventative approach to the health and social care needs of older people" (Donnelly, 2016). 81% of delayed discharges from acute hospital services are aged 65 > and delays are directly related to waiting lists for the Nursing Home Support Scheme (NHSS) or a home care package (HSE, 2016). It is therefore essential, in the context of providing more health services through the primary and community sectors, that the appropriate infrastructure, resourcing and planning are developed in tandem with any developments in home care.

Informal care still makes up most of care provided at home and is essential to the health service. The clear majority (89.5%) of caregivers for community dwelling older people are unpaid (Care Alliance Ireland, 2015). The 2016 census indicated that the number of carers now stands at 195,263. The number of caring hours in the day is also increasing (CSO, 2017). The National Carers Strategy (2011) vision is to recognise and respect carers as key partners and to ensure they will be supported to maintain their own health and well-being. Carers are to work in conjunction with formal care supports, not to replace them. However, experiences have shown that this is not always the case. It has been identified, on some occasions, that when a carer is in place the patient/client is less likely to receive formal care supports. Carers also experience problems in accessing respite, and not being provided with clear plans.(Donnelly, 2016).

Under pinned by the United Nations/World Health Organization, participation of the population in health-related decision-making at national and community levels is a fundamental part of our human rights. To provide a person-centred home care service, one which supports and empowers people, it is essential that those in receipt of the care have more involvement in the range of services provided now and into the future.

Many people requiring home care services can be vulnerable or have reduced capacity and these people must be assured appropriate powers to ensure they are involved in the decision-making process in a meaningful way. The Assisted Decision Making (Capacity) Act 2015 will have a key relevance in ensuring that the rights, autonomy and dignity with respect to decision making are adhered to.

In Ireland, providing care in the home has been identified as a key requirement both for the needs of the person/client and for economic sustainability since 1968. However, to date, a clear national model with appropriate regulation and resources

has not been realised. It is essential that the inconsistencies described earlier are addressed and a high quality, appropriately resourced home care service, providing suitable and timely supports to those that require the service is developed.

The INMO welcomes the government commitment in the Sláintecare report to increasing spending on home care services, however, it is essential that plans be put in place to ensure this commitment is actualised and funding secured, now and into the future. This must include workforce planning and recruitment for the 900 nursing posts recommended for the community in this report. Future demographics indicate that a perfect storm is brewing in terms of our ageing population, increasing chronic illness and co-morbidities. Figures from the CSO show the substantial growth in the number of adults aged 60 and older that will be seen between 2011 and 2046 (2017). The number of people aged 65 and over suffering from dementia is expected to increase significantly in the coming decades from 531,600 in 2011 to almost double (991,000) in 2031 (Pierce et al., 2014). These pressures will have to be addressed and a sustainable level of investment in providing appropriate home care services will be essential.

As stated earlier, those in need of home care support services are sometime those most vulnerable amongst the population. The current problems being experienced in terms of accessing supports need to be addressed as a priority.

In order to have a fair and equitable home care service with clear, transparent and accountable processes, it is important that national policies exist for the application, assessment, monitoring and appealing processes. Relying on different approaches, for example in terms of assessments, can only lead to confusion amongst staff and clients alike. A plethora of documents, policies and procedures have been drafted over the years. However, the problem is not with identifying policies and procedures but rather in developing and implementing them nationally. Clear communication of national policies will also be required once these have been established.

There appears to be an issue around terminologies used and definitions of what constitutes home care services. This can cause confusion and frustration to those applying for services and therefore clear definitions and terminologies should be established and communicated.

Eligibility is also a cause for concern. Home care packages are now opened to all with no means test required. There are inconsistencies leading to blurring of boundaries here. For example, the PHN, as legislated for under the Health Act 1970, works with patients who have medical cards but now is this is opening to all who require home care packages with no commitment for extra staffing or funding. This situation cannot continue.

The INMO supports the development of national quality standards for provision of home care services. This should apply to all home care providers. To date, there have been standards drafted and then developed into two separate standards applying to home care packages contracted by the HSE and those directly employed by the HSE. Much of home care is not subject to quality standards and self-regulation has been the way in which the private home care providers have operated. HIQA has no powers to investigate home care services (NESC, 2012). This is a situation which must change. The shear complications surrounding the current quality standards that do exist cannot continue.

However, in developing national standards on quality, the emphasis must be place on the client or person utilising home care services. The standards must be clear, devoid of complexity and develop clear accountability structures. They must recognise the key importance of the multidisciplinary team in providing and assessing the needs of the person requiring the services. They must also recognise the role of both the PHN and CRGN in home care services.

To safeguard the client/person receiving home care services, it is vital that a minimum level of training is provided to all home care workers. All home care workers should be directly employed by the HSE and should be clinically governed in relation to direct care by the nursing service The standards that apply to hospital based health care assistances should apply, - QQI level 5 as a minimum - and an additional module must be developed in relation to caring for dependant persons in their own home.

The INMO supports the Sláintecare recommendations for free universal healthcare. The INMO also believes that the issue of older people seeking access to the fair deal schemes must be evaluated as it is a feature that some older people are waiting longer to receive state aid due to the state scheme requiring information regarding personal assets etc.

The current basis for staffing in care of the older person has been very negatively affected by the introduction of cost of care as the design model used by the HSE in quantifying staffing levels. Older people, regardless of what they contribute, will still receive care based on the €989 per week. The limit is set for private providers and staffing levels are based on that, this is inadequate as it does not measure best outcomes for patients, safety or avoidance of admissions to acute hospitals as a result of poor and inadequate staffing and incorrect skill mix. Cost of care staffing ratios provide minimum care without providing for reflective and socialisation programmes.

It must be acknowledged that many of the people who require home care services are vulnerable and do not always have the means to fund the services and supports which they require. It is imperative that any means testing system determining the right home care services is not a barrier in allowing people to access the supports and services required for them to stay at home. Means testing "may lead to greater costs in the long run as individuals denied homecare deteriorate and end up needing nursing home care." (Age Action Ireland, 2017).

Any changes to home care services in Ireland, must be done reflecting the Sláintecare report's call for a single tiered universal health care model, one which supports integrated care, is person centered and provides quality excellence. This can only be achieved by clear planning, funding and governance structures and ensuring the appropriate level of health care staffing throughout the entire health service. Only this can guarantee the ever increasing complexities of providing home care services will be met.

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