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Positioning Turnaround Services for Older People

Discussion Paper

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Positioning Turnaround

1 Introduction

- 1.1 Demand for health and social care in older old age is primarily driven by morbidity prior to death. The longer the period of morbidity, and/or the larger the population, then the greater the level of demand. It is likely that this trend will continue given that advances in medicine help to keep more older people alive but with more disabling conditions.
- 1.2 In the next fifteen years shire counties will face a significant rise in the population aged over 80. When combined with the need to restrict public expenditure, this is likely to mean huge challenges to the spend on older people. Consequently, it is imperative that authorities try to limit the need for high cost provision such as residential care and intensive home care support.
- 1.3 There are already a number of initiatives in place designed to maintain people within the community such as; intermediate care, the development of re enablement, extra care housing, improvements in stroke care and continence services and a greater focus on dementia.
- 1.4 However, provision of services tends to be reactive, ie, who comes through 'the front door' is who gets considered for a service. Such an approach may mean that resources are not necessarily spent on those in greatest need or those where there is the best chance of reducing potential demand or high intensity, high cost provision.
- 1.5 Existing forms of performance measurement concentrate on outputs and processes, ie, number of procedures, bed days, etc, not on who recovers or how effectively future demand is reduced.
- 1.6 Health, social care and housing are not mutually exclusive. The more older people are admitted to acute care the greater the likelihood of an increase in demand for care home admissions. Failure by social care to maintain more people within the community may well increase health care spending. The absence of suitable accommodation into which health and care services can be delivered certainly hampers the preventative aspirations of both organisations. Therefore, there is a clear need for a co-ordinated approach to prevention and early intervention and also a case for predictive modelling of those who are most likely to need hospital admissions and/or a care home admission.
- 1.7 The approach suggested here is one that can identify target populations with the characteristics likely to drive towards high levels of intervention, using proven methodologies to promote the fullest possible recovery in a way that is most acceptable to service users/ patients.

2 The research

Demand

- 2.1 In 2008 /09 The Institute of Public Care (IPC) together with a southern England County engaged in a programme of background research exploring how preventative provision may best be targeted. The research involved a quantitative analysis of files and a set of interviews of those admitted to care homes. In total there were 115 cases examined via the file audit and 21 interviews conducted with older people who had been admitted to a care home.
- 2.2 Some of the key characteristics surrounding admissions to care were also subject to literature reviews. These looked at two things. Testing whether there was wider evidence of a link between the characteristics identified in the research and care home admissions/ repeat hospital admissions, and whether there were proven approaches that could lessen the likelihood of these outcomes.
- 2.3 Key characteristics identified amongst care home populations were the proportion of older women (71%), who live alone (64%), aged 85 and over (58%), with difficulty in walking (56%), urinary incontinence (45%), bowel incontinence (34%), dementia (40%), experiencing a fall in the last 12 months (41%) and admitted from hospital (61%).
- 2.4 In many cases deteriorating health and well-being had begun with a stroke or bereavement of a partner. In those cases, where the older person did not have dementia, falls and incontinence or Urinary Tract Infections were recurring themes. Stroke looked to be less common from the file audit although the interviews revealed it as an unrecorded factor which had often occurred earlier along some people's care pathway.
- 2.5 Although not evident from the file audit, the impression gained from the number of people living alone was that social isolation and depression were underlying conditions influencing progression along the pathway to care.
- 2.6 Inappropriate or inaccessible housing was an issue for more than one quarter of older people admitted to a care home.
- 2.7 All three of the people with dementia covered by the interviews were living alone, but all were receiving support from non-resident family members. Carers' stress was exacerbated by lack of information and appropriate support.

Supply

- 2.8 All the older people had followed fairly complex pathways into care. 84% of those admitted to care homes in 2008-2009 were already known to social care and receiving a service. However, 50% were not getting an intensive care package. These trends were confirmed by the interviews.
- 2.9 A high proportion of admissions were from hospital. This may reflect the greater frailty of people going into care homes, or may reflect discharge practices, or some other factor in operation. For example, 73% of people living alone were admitted from hospital compared with 46% of those living with others.
- 2.10 The transfer of care from hospital is a concern where people are discharged with medical issues that affect their health and well-being, such as incontinence, that were already present or that developed during the admission, and were unresolved.
- 2.11 There was a surprisingly limited take-up of intermediate care and telecare recorded in the social care files. Although the falls service was mentioned by some interviewees, there was no mention of the continence service.
- 2.12 Limited mobility indicates that re-ablement and intensive work to support mobilisation may also help to reduce or delay admission to care homes in Borchester.
- 2.13 Delays in receiving a service, the shortness of some visits and consistency in who provided care were all negative factors listed by service users.
- 2.14 In the two areas from which the samples were drawn (one urban and one very rural) there were variations in practice suggesting both differences in the application of eligibility criteria, the services available and differences in the economic wealth of the populations.

Abstracts from the literature reviews

- 2.15 **Falls:** Half of all older people who have had one fall will go on to have further falls. Around half of A&E and MIU don't routinely screen people who have had a fall for risk of future falls. Less than half are screened for osteoporosis risk. Only 31% of hospitals and PCTs provide a proper risk reduction programme. Only 35% of patients provide a written agreed intervention plan to patients. 50% of trusts do not provide training to care homes on referral to falls service¹.

¹ Royal College of Physicians report on Falls March 2009.

- 2.16 **Continence:** In the Royal College of Physicians review, just over half of hospital sites and care homes, and only a third of mental health sites, offer structured training in continence care. Whilst the majority of sites have access to continence services, truly integrated services are few. Documentation of continence assessment and management for older people is described as "*wholly inadequate*", even after a specialist assessment and especially in secondary care where two-thirds have no cause documented. Where a continence problem is identified, assessment or management of that problem is still not guaranteed. Management regimes for older people demonstrate the predominance of containment using pads and catheters. The pressure to control costs is demonstrated by the frequent rationing of supplies in three-quarters of primary care settings and care homes.²
- 2.17 **Stroke:** Fewer than 40% of trusts have achieved the minimum standard on stroke care. Even the best region in England delivers the standard in only half of its trusts and in the worst, the East of England, only 29% of trusts achieve the required standard. There is very little research to show the relationship between severity of stroke, quality and quantity of rehabilitative effort and outcome³. Yet once a person has an acute stroke, the risk of having another within the next five years is between 30 – 40%. It is noticeable that The National Clinical Guidelines include more than 400 recommendations, but only 16 cover the care given to patients more than six months after the stroke. There is a strong suggestion that care and support should be substituted for rehabilitation and re-enablement when a patient returns home.
- 2.18 **Dementia and Carers:** As the National Dementia Strategy⁴ reported: "*People currently wait up to three years before reporting symptoms of dementia to their doctor. Seventy per cent of carers report being unaware of the symptoms of dementia before diagnosis, whilst 64% of carers report being in denial about their relative having the illness and just over half believe the symptoms to be just part of ageing. Only 31% of GPs believe they have received sufficient basic and post-qualification training to diagnose and manage dementia, a decrease since the same question was asked in for the Forget Me Not report eight years ago*". A recent Alzheimer's Society report⁵ identified that in hospitals the quality of physical care suffers because of a person's dementia, that staff feel ill-equipped to manage the condition and that there is an excessive use of anti-psychotic drugs in order to manage patients. A number of studies⁶ have shown that carer capacity and skills to care have a strong influence on the likelihood of someone being admitted to a care home and whether that admission is early.

² Royal College of Physicians Report on Continence Care 2006

³ Progress in Improving Stroke Care, National Audit Office, Feb 2010

⁴ Living well with dementia: A National Dementia Strategy Department of Health 2009

⁵ Counting the cost – Caring for people with dementia on hospital wards, Alzheimer's Society 2009

⁶ Lippa, M., Luck, T., Braehler, E., Konig, H., Riedel-Heller, S.G., (2008), Prediction of Institutionalisation in Dementia. *Dementia and Geriatric Cognitive Disorders* 2008; 26:65-78

Gaugler argues there is a need to "*refine targeting when administering interventions early in the dementia care giving process*"⁷.

3 Conclusions

- 3.1 People who come into care homes are not strangers to care or health services. Therefore, in identifying target populations it may not be necessary to go too far back in people's care and health histories. It also suggests that current interventions do not pick up people with a higher likelihood of future problems or if they do the interventions given are not sufficient to prevent continued deterioration. Clearly, the literature reviews suggest that in terms of preventing hospital admission and/or admission to a care home then health or social care are unlikely to achieve those goals working alone.
- 3.2 In the areas of health care identified above the reviews detailed a track record of poor performance, although in the case of falls, the county actually lies above the national average. Yet it is important to note that in many of the studies cited they are only referring to a minimum standard of intervention and that what constitutes success is still very process-driven. Even if these targets were a 100% met they may still not ensure that people's full rehabilitative potential is achieved.
- 3.3 The characteristics are not predictors of needing care, although in combination with the literature reviews it seems clear they have a strong influence on demand for high intensity services. In addition many people who came to a care home appeared to have more than one of the characteristics. This suggests that interventions need to step outside the 'straight jacket' of single conditions needing a single service response. It may be that it is in the complex relationships between different health conditions and between these and social factors that the real drivers towards admissions may be found.
- 3.4 There is a need to focus on the impact of the hospital experience on admission. It may be some people are coming to hospitals who need not be there, eg, referred for assessment or observation, but that the discharge process may mean people are discharged before they are ready to return home, or that older people come under pressure to accept a care home admission.
- 3.5 Although not fully evidenced, the suggestion from the interviews is that people's route to care is not a steady deterioration but more a series of downward steps, each of which represents a significant incident. This may start with a stroke or death of a partner, followed by a fall or incontinence, with the person becoming more socially isolated after each key event.

⁷ Gaugler, J., (2005), The effects of duration of caregiving on institutionalisation. The Gerontologist. Vol. 45, Iss. 1; pg. 78-89

4 Targeting provision

- 4.1 The hypothesis the work so far leads to, is that if repeat hospital and care home admissions are to be prevented then there is a need to identify and target populations who possess characteristics which are likely to drive those admissions.
- 4.2 Such an approach would need to be based on the premise that (a) the populations can be identified and distinguished from other populations of older people, that (b) there are methodologies available that can change the pathway which people are following and (c) that people will be amenable to following or undertaking the proposed interventions.
- 4.3 There remain a number of unanswered questions and issues:
- There may be a range of characteristics present amongst the population admitted to a care home, but are some characteristics more predictive than others, either on their own or in combination with other characteristics?
 - In targeting populations the approach may pick up people who, if they did have a care home admission, would have been self funders rather than those funded by social care. This would be acceptable under universal provision of health services but may not be justifiable under a means tested social care model.
 - It is anticipated the majority of those who would benefit from the approach at the time of contact would fall below eligibility criteria.
 - As the interviews demonstrated the pathway to care may be quite long. Therefore, there may need to be an elongated timescale between 'turnaround' occurring and a measurable result. Alternatively there may be other benefits to health and well being that occur which should be both measured and valued. Being able to assess cost-benefits may be important in judging the value of the approach.
 - The evidence base on successful interventions is varied and in places 'thin'. For example falls interventions that occur over a longer time period or at a greater intensity may be more successful than the same interventions at a lesser level of intensity. There will be a need for close monitoring of cause and effect.
 - As in a number of the POPPS pilots it may be social care expenditure and effort that delivers a health care 'result' or vice versa.
 - It may not prove possible to work in the interdisciplinary way suggested due to professional barriers or to find a provider that is prepared to take on the degree of risk that this work suggests.

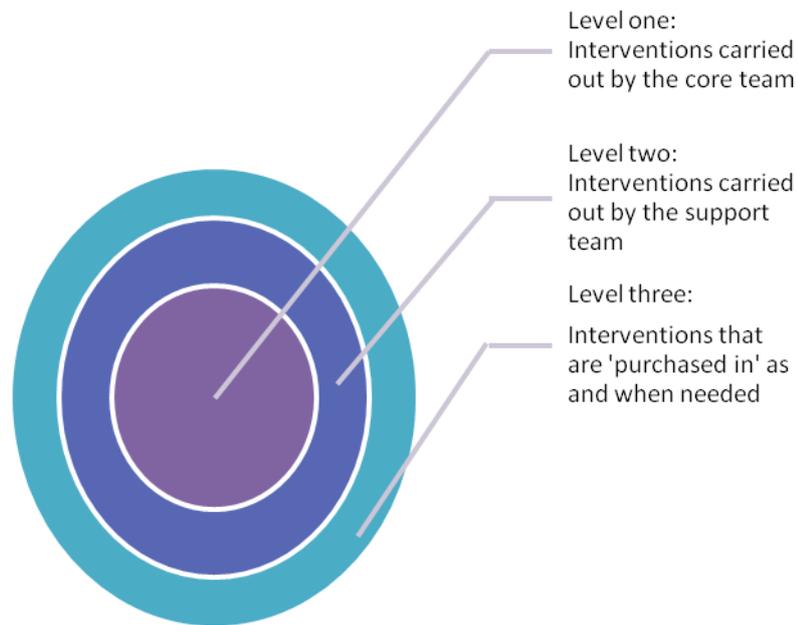
5 Characteristics of Turnaround

To date the approach has been entitled 'Turnaround' in that the attempt is both to turn people around from their health and well being deteriorating and that the interdisciplinary, inter-conditions approach represents a turnaround in terms of thinking about service provision. It is suggested that the 'Turnaround' approach should embody the following features:

- **An approach not a service.** Turnaround should be about demonstrating whether and how targeting populations has an impact on people's potentiality to have repeat hospital admissions or a care home admission. If it works, or elements of the approach work, they should change the preventative interventions that social care and the PCT adopt rather than drive the creation of another service or initiative.
- **The approach needs to be interdisciplinary.** Whatever is provided needs to cut across professional disciplines and be capable of successfully intervening with a range of conditions?
- **The volume and type of input needs to be determined by the outcomes to be achieved.** This means it is not necessarily determined by the staff available, by the skills of employees or by time boundaries. Where new or additional skills are needed the duty would be on the provider to assess in advance and ensure that they are available as and when required. Payment for the approach needs to be based all or in part on the successful achievement of outcomes. Staff should be encouraged to adopt a 'doing what it takes' approach.
- **Delivery needs to be flexible.** The service developed needs to be flexible and available when needed in order to achieve the agreed outcomes. This is not the same as office hours but neither is it on demand from the service user.
- **The approach adopted needs to be based on identifiable, agreed and proven methodologies.** This applies in two ways. First, in identifying the targeted population and secondly in defining appropriate methodologies of intervention that have the best chance of success. In the case of the former then the literature reviews have already identified a number of failings where poor outcomes may be predicted. Where the results from other schemes may not be definitive then in the absence of clear research evidence there should be a lesser test of non-harm and 'more likely than not', eg, giving Vitamin B and D to older people at risk of falls may not have been conclusively demonstrated but on the evidence available there is a greater potential benefit than any risk of harm.

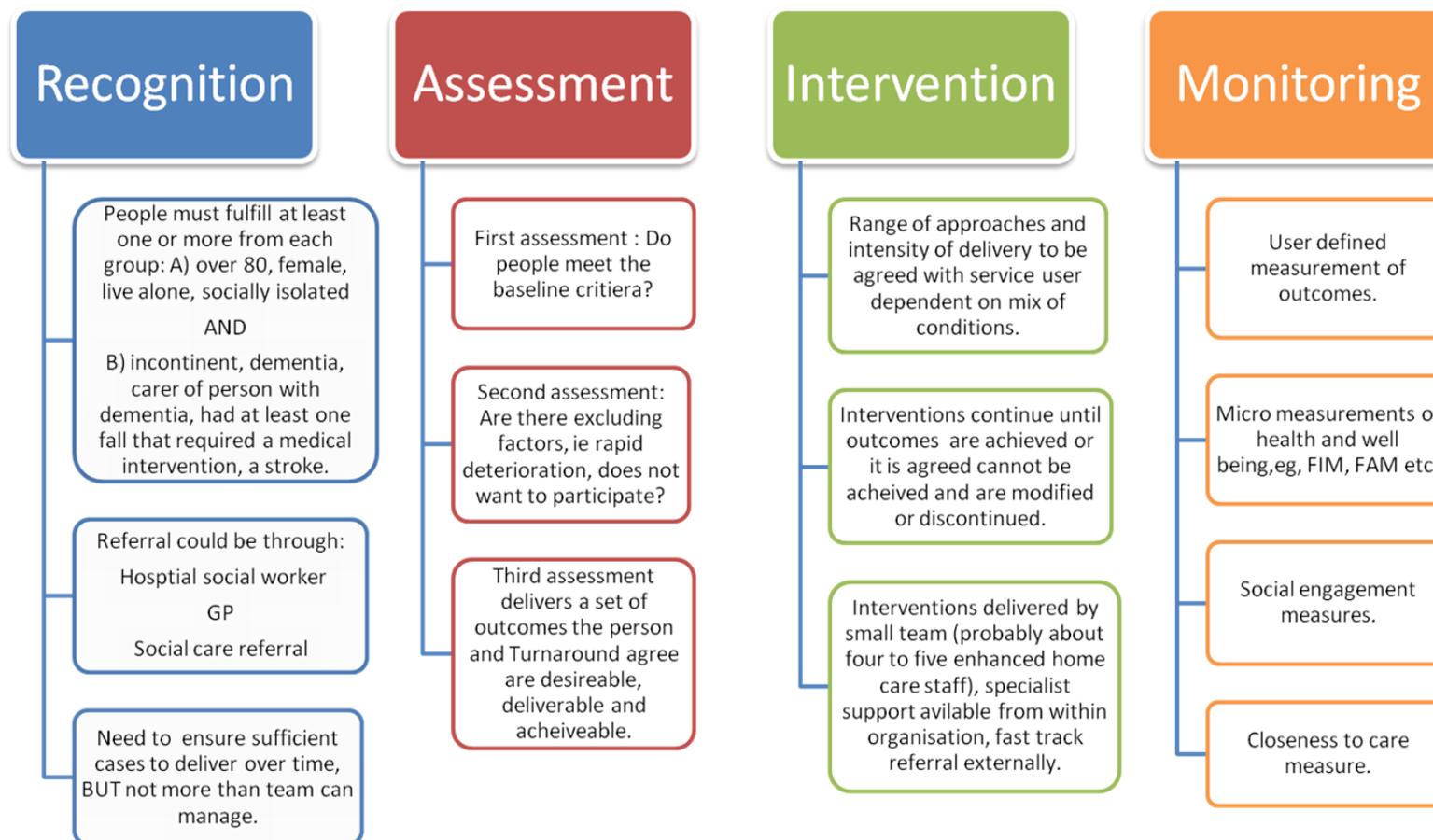
6 How will Turnaround work?

- 6.1 The need is to construct a service based on bringing together a range of personnel based on their capacity to deliver the outcomes required rather than constructing provision based around existing health care conditions (eg, stroke, fractures etc), service boundaries (eg, home care, intermediate care) or professional disciplines (eg, physiotherapist, occupational therapists, social workers).
- 6.2 The focus of the approach would be on developing provision that does not necessarily just maintain a person in the community or slow deterioration, but lessens the likelihood of admission to hospital or care, or lessens demand for high intensity community provision. This should be achieved through a focus on the range of issues or conditions somebody may possess, and through the development of a holistic approach which focuses on improvement, recovery and rehabilitation based on methodologies that can be shown to deliver. Clearly such an approach does not need to work for everybody, only those where there is the greatest likelihood of success and where the reduction in demand delivers the highest potential cost benefit.
- 6.3 Therefore, Turnaround may comprise a mixture of any or all of the following:
- A combined community care capacity bringing together home care, assistive technology, care and repair and some nursing skills.
 - Some enhanced health care based capability, (knowledge of medical risk, medication, capacity to fast track health care when needed).
 - A focus on improving mobility (physiotherapy, occupational therapy, personal trainer skills).
 - A focus on improving diet and nutrition (help and support to change and improve diet) may also involve receiving dental care if dental decay or poor fitting dentures are a barrier to healthy eating.
 - Delivering social contact (ensuring social contact with others is increased and sustained).
 - Welfare benefits and income maximisation where alleviable poverty is a driver towards poor health and care.
- 6.4 Figure 1 suggests a model that has three levels of delivery.

Figure 1 Turnaround model of delivery

- 6.5 Level one has at its heart small groups of enhanced home care workers. These groups may comprise six staff working with around 30 people. All workers in the team will be known to those taking the approach which will help to deliver a more flexible service.
- 6.6 Level two will offer workers at level one access to a range of specialist support, for example, physiotherapists, occupational therapists, etc. These people will use their specialist skills to help apply methodologies and approaches.
- 6.7 Level three then offers additional skills that may be brought or bought in such as dentistry, community alarm, care and repair.
- 6.8 Figure 2 overleaf suggests some of the components of the overarching approach that may be adopted.

Fig 2 Defining the Turnaround process



7 Methodologies and approaches

Intervention	Evidence
Interconnection of problems and social isolation	
<p>Check for inter-connectedness.</p>	<p>A lack of mobility may increase the likelihood of someone being incontinent because they cannot reach the toilet quickly enough.⁸ Equally falls may occur because someone gets up in the night to go to the toilet.</p> <p>Older people who have had strokes will frequently have ongoing issues with mobility, maybe continence and sometimes dementia.</p> <p>People who fall and have a hip fracture may leave hospital with a continence problem they previously did not have.</p> <p>Support to carers of people who have had a stroke in terms of rehabilitation, benefits advice, lifting and handling may improve both the carers capacity to maintain someone in the community as well as maintain their own health.</p>
<p>Home check for repairs need to make house secure and habitable. Use care and repair services where necessary. Take immediate action where home may increase the likelihood of falls. Check where falls have previously occurred and why the service user thinks this is happening.</p>	<p>Concern over housing repairs can be a source of anxiety and a motivator towards care home admissions. They may increase isolation if people are ashamed of where they live and home circumstances may be a hazard for falls.</p> <p>Older women, especially those living alone struggle with maintaining homes as they get older in terms of DIY and require assistance with this⁹.</p>
<p>If person is reluctant to go out due to continence issues look at mechanism and approaches for getting around this, eg, assisting service users to have an outdoor bag with ready supplies, helping service users plan a route out where there will be public toilets.</p>	<p>Improvements in continence can lessen social isolation as people gain greater confidence in going out.¹⁰</p>
<p>Support worker to develop a 'before' and 'after' activity schedule, ie explore what the</p>	<p>Higher levels of loneliness have been found to increase the likelihood of nursing home admission and to decrease the time until such</p>

⁸ Slack. M. et al (2008) FAST FACTS: BLADDER DISORDERS. Oxford: Health Press.

⁹ Care Services Efficiency Delivery (CSED) – Anticipating Future Needs (2007)

¹⁰ Help The Aged Taking Control of Incontinence, Exploring the links with social isolation (Jan 2007)

Intervention	Evidence
<p>person used to do, where they used to go, why that has stopped and what maybe done to overcome potential fears and anxieties.</p> <p>Support worker to facilitate re-engagement with community life.</p>	<p>an admission. The influence of extremely high loneliness on nursing home admission remained statistically significant after controlling for other variables, such as age, education, income, mental status, physical health, morale, and social contact, that were also predictive of nursing home admission¹¹.</p>
Mobility	
<p>Where people have had a previous fall(s) carry out a range of assessments such as ADL, mobility and home environment assessment (also cognitive tests if appropriate) carried out by occupational therapist.</p>	<p>Home Hazard assessment along with advice on safe and effective performance of activities of daily living is a proven component of falls reduction programmes, particularly if patients have experienced a recent change in health such as a hospital admission or injurious fall.¹²</p>
<p>Put in place adaptations work where necessary. Check that adaptations will actively encourage independence rather than increase dependence.</p> <p>In the past CSED suggest service users have had to wait unacceptable amounts of time for equipment that is needed to support independent and comfortable living at home¹³</p>	<p>Research also indicates that having appropriate adaptations in place increases people's feelings of safety and improvement in mental health by 70%¹⁴.</p> <p>Adaptations are effective and promote physical as well as good mental health¹⁵.</p>
<p>Put in place a detailed falls prevention programme. Need to make sure it is of sufficient time duration to deliver lasting results¹⁶.</p>	<p>An effective comprehensive exercise programme should include interventions to address:</p> <ul style="list-style-type: none"> • Low muscle strength • Poor Balance • Gait deficiencies • Addressing fear of falls.

¹¹ Russell, Daniel W.; Cutrona, Carolyn E.; de la Mora, Arlene; Wallace, Robert B. Psychology and Aging. Vol 12(4), Dec 1997, 574-589.

¹² National Audit of the Organisation of Services for Falls and Bone Health of Older People (Royal College of Physicians)

¹³ <http://www.dhcarenetworks.org.uk/csed/Solutions/homeCareReablement/>

¹⁴ Dolan P, Torgerson DJ, The Cost of treating osteoporotic fractures in the UK female population. Osteoporosis International 1998 8: 6-11-17

¹⁵ Poor G, Jacobsen, SJ Melton LJ. Mortality after hip fracture. Facts, Research in Geratology. 7: 91-109

¹⁶ Skelton D and Dinan M Exercise for Falls management: Rationale for an exercise programme aimed at reducing postural instability

Intervention	Evidence
	<p>FaME programme is a practical approach that can be set by Physios and individualised to the service user¹⁷ These programmes can be delivered in the home as well as outside the home by a Physiotherapist.^{18 19 20}</p> <p>OTAGO exercises also effective and established approaches to falls reduction/prevention²¹</p>
Training for carers of people with dementia	
<p>Refer to Borchester programme or if reluctant develop through support worker tailor made programme.</p>	<p>It is widely recognised that providing support for carers of people with dementia may delay care home admission^{22 23}. Brodaty et al found that training carers of people with dementia delays admission to a nursing home by an average of 20 months²⁴.</p> <p>Prince Henry Hospital in Sydney, Australia developed a training and support for carers of people with dementia. The interventions included a structured, residential, intensive 10-day training programme, boosted by follow ups and telephone conferences over 12 months. The research found that even if it did not avoid admission then carer training programmes can demonstrably delay placement into care²⁵.</p>
Health improvement (Podiatry, medication, dental care, nutrition, dehydration).	

¹⁷ Tailored group exercise (Falls Management Exercise – FaME) reduces falls in community-dwelling older frequent fallers (an RCT)

¹⁸ Royal College of Physicians, (2009), National Audit of the Organisation of Services for Falls and Bone Health of Older People

¹⁹ Lundin-Olsson L, Nyberg L, Gustafson Y 1997 'Stops walking when talking' as a predictor of falls in elderly people. *Lancet* 349: 617

²⁰ Lundin-Olsson L, Nyberg L, Gustafson Y 1998 Attention, frailty and falls: The effect of a manual task on basic mobility.

²¹ (ibid)

²² Coon, D. W., Gallagher-Thompson, D., Thompson, L. W., (eds) (2003), *Innovative Interventions to Reduce Dementia Caregiver Distress*. Springer Publishing Company Inc.: New York.

²³ Association of Public Health Observatories, (2008), *Indications of Health in the English Regions: 9: Older People*. www.apho.org.uk/apho/indications.htm

²⁴ Brodaty H, Gresham M, Luscombe G.(1997) The Prince Henry Hospital dementia caregivers' training programme. *Int J Geriatr Psychiatry* 1997 Feb;12:183-92

²⁵ Brodaty, H., Gresham, M., Luscombe, G., (1997), *The Prince Henry Hospital Dementia Caregivers' Training Programme*. *International Journal of Geriatric Psychiatry*, Vol 12: 182-192.

Intervention	Evidence
Older people are offered a sight check. Transport delivered by support worker. Vision is assessed and reviewed.	Causes of falling can be in part related to vision ²⁶ .
Feet are checked and assessed for fungal infections, poor toe nail cutting, growths etc. Podiatry offered ²⁷ .	Help the aged estimated in 2005 that 1 in 4 people aged over 65 needed foot care that they were not receiving ²⁸ .
Dental check offered and carried out. Transport delivered by support worker.	Many older people do not have dental checks and hence have tooth decay, gum diseases or poorly fitting dentures ^{29 30} .
<p>Support workers should take an initial weight check and regularly weigh until desired weight is sustained.</p> <p>Consideration should be given to vitamin D supplements for people who rarely go outside. If deficiencies are found, energy, calcium, iron and zinc content of meals should reach 40% of the Dietary Reference Values, and the folate and vitamin C content to 50%³¹.</p> <p>Where there is evidence of malnutrition or of dehydration then a plan for addressing this should be developed and put in place.</p>	<p>As activity lessens, calorie requirements fall. However, if insufficient food is eaten, the level of nutrients in the diet can become dangerously low, leading to a vicious circle of muscle loss, even less activity, and even lower appetite.</p> <p>Mouth problems and swallowing difficulties may also lead to low food intake.</p> <p>There are more underweight than overweight older people and, in old age, being underweight poses far greater risks to health than being overweight.</p> <p>Good guidelines exist for the nutritional intake required by older people³².</p> <p>Buckinghamshire in 2005 estimated that 30% of older people referred to accident and emergency services had a dehydrated related condition³³.</p>

²⁶ National Institute for Clinical Excellence (2004) Clinical practice guideline for the assessment and prevention of falls in older people. National Collaborating Centre for Nursing and Supportive Care

²⁷ See Feet for purpose, Age Concern 2007, for good practice examples.

²⁸ Best foot forward: Older people and foot care, Help the Aged 2005.

²⁹ The orodental status of a group of elderly in-patients, McNally, Gosney, Dopherty, Field, Gerontology Volume 16 December 1999

³⁰ Pearson NK, Gibson BJ, Davis DM, Gelbier S, Robinson PG, The effect of a domiciliary dental service on oral health related quality of life: a randomized control trial, British Dental Journal 2007, 2003.E3

³¹ The Dietary Reference Values prepared by COMA (the Committee on the Medical Aspects of Food Policy) in 1991 should be used as the basis for the nutritional guidelines for food prepared for older people.

³² Eating well for Older People: The Expert Group Report The Caroline Walker Trust, 1995 revised 2004.

³³ Just add water, Community Care October 2005.

Intervention	Evidence
Medication is reviewed and systems in place for safe administering of medication.	Evidence shows that some medication can increase the risk of falls ³⁴ . Adjusted medication regimes can be effective in reducing falls. For example gradual and assisted withdrawal from some types of drugs for sleep deprivation, anxiety and depression has been shown to reduce incidence of falls ³⁵ ³⁶ .
For stroke survivors support workers to motivate, prompt and instruct exercises set by a Physiotherapist to improve limb function or tasks.	Low intensity home-based therapy can improve lower limb function more than one year after a stroke ³⁷ Evidence that these approaches can improve rehabilitative outcomes ³⁸ . Some studies have shown significant gains through occupational therapy intervention resulting in reduced hospital admission and more appropriate aids and adaptations ³⁹ .
For stroke survivors, develop an action plan for support workers so that they can recognise and respond to TIAs or further strokes.	
Consider whether psychological support may be necessary for stroke survivors and if so ensure its delivery.	Evidence that there is high prevalence of depression following a Stroke but that this can be averted and is not an inevitable long term side effect if treated ⁴⁰ .

³⁴ Interventions for preventing falls in older people living in the community; Gillespie LD, Robertson MC, Gillespie WJ, Lamb SE, Gates S, Cumming RG, Rowe BH (Online publication 2009)

³⁵ National Institute for Clinical Excellence (2004) Clinical practice guideline for the assessment and prevention of falls in older people. National Collaborating Centre for Nursing and Supportive Care

³⁶ Kerse, N., Flicker, L., Pfaff, J.J., Draper, B., (2008), Falls, Depression and Antidepressants in Later Life: A Large Primary Care Appraisal. Public Library of Science. June 2008 Volume 3 Issue 6

³⁷ Lin, J.H., Hsieh, C.L., Lo, S.K., Chai, H.M., Liao, L.R., (2004), Preliminary study of the effective of low-intensity home-based physical therapy in chronic stroke patients. Kaohsiung Journal of Medical Science. 2004; 20:18-23

³⁸ Walker, M.F., (2007), Stroke rehabilitation: evidence-based or evidence-tinged. Journal of Rehabilitative Medicine 39 (3):193-197.

³⁹ Occupational therapy for stroke patients after hospital discharge — a randomized controlled trial (Corr and Bayer 1995)

⁴⁰ Kneebone, I. & Dunmore, E. (2000). Psychological management of post-stroke depression. *British Journal of Clinical Psychology*, 39, 53–66.

Intervention	Evidence
Continence	
Ensure particularly where person displays signs of incontinence or is in a high risk category, eg, women who have had multiple births that full continence assessment is completed, together with diagnosis and full treatment plan.	A diagnosis following comprehensive assessment increases likelihood that incontinence will be <i>pro-actively</i> treated ^{41 42} .
Supporting service users through the continence assessment process with bladder diaries, urinanaylsis to aid assessment process and information and support re: potential medical interventions. Ensuring service users are assisted and engaged in any continence plan increases the likelihood of successful outcome ⁴³ .	Older people benefit from taking control of their incontinence ⁴⁴ .
If appropriate assist to motivate, prompt and instruct exercises set by a Physiotherapist to improve	Evidence that Pelvic floor exercises can reduce both stress urinary incontinence (SUI) Urge Urinary Incontinence (UUI) and faecal incontinence ^{45 46 47 48 49 50 51} .

⁴¹ Department of Health (DH)(2000) Good practice in continence services' and National Service Framework for Older People Outlines good practice in relation to managing incontinence

⁴² National Audit of Continence Care For Older People – Royal College of Physicians Peters. Tim J;et al.; (2004) Health and Social Care in the Community 12 (1), 53 – 62. Factors associated with variations in older peoples use of community-based continence services

⁴³ DH Good Practice in Continence Services (2001)

⁴⁴ (ibid)

⁴⁵ Tan TL (2003) Urinary incontinence in older persons: a simple approach to a complex problem

⁴⁶ Hay-Smith EJ Bo Berghmans LC Hendricks HJ de Bie RA Vab Waalwijk van Doorn ES (2003) Pelvic floor muscle training for urinary incontinence in women Cochrane Database of Systematic reviews issue1

⁴⁷ Berghmans L Hendricks H Bie RD Doorn EVWV Bo K Kerrebroeck PV (2000) Conservative treatment of urge incontinence in women: A systematic review. British Journal of Urology International

⁴⁸ Solomon MJ, Pager C, Rex J, Manning J, Roberts R. Randomised, controlled trial of biofeedback using anal manometry, transanal ultrasound or pelvic floor retraining with digital guidance alone in the treatment of mild to moderate fecal incontinence. *Diseases of the Colon & Rectum* 2003; 46: 703 – 710

⁴⁹ Newman D. *Managing and treating urinary incontinence*. Baltimore, MD: Health Professions Press; 2002

Intervention	Evidence
continence.	Postural and breathing exercises help with some incontinence issues ⁵² . Correct toilet positions help with some incontinence issues ⁵³
Where peoples are incontinent, regular cleaning may help to ensure home is free from odour.	
Skin integrity needs to be checked as part of daily routine of care.	
Assistance to wash and dress and assist with helping service user to wear and feel comfortable in adapted clothing if required.	
Improve access to lighting at night. Good positioning of commodes may also help.	

⁵⁰ Bowel and Bladder Foundation website

⁵¹ Katherine Wilkinson MA, DN, RGN, FAE 730/7, non-medical prescriber. A guide to assessing bladder function and urinary incontinence in older people
9 October, 2009 Nursing times.net

⁵² Grewer H, McLean L (2008) The integrated continence system: A manual therapy approach to the treatment of stress urinary incontinence. MANUAL THERAPY; 6: 5, 375-386.

⁵³ Bowel and Bladder Foundation website

Measurement

7.1 We suggest that there are four domains of measurement.

- The outcomes that the service user wants to achieve.
- Micro measure of improvement in physiological or mental condition.
- Social isolation and well being measures.
- An overall determination of whether the person has moved closer to or further away from a care home admission.

No	Type	Who defines	Measures	Example
1	Outcome Measures	Defined by the service user and the LA based on assessment	LA to agree with providers the range of outcomes and the methodologies to be used from which measures might be derived. However, it would be anticipated that most of these would be on a simple binary approach of achieved / not achieved.	"I would like to have the confidence to walk to the shops which are 500 yards away."
2	Targeted Health Conditions	Administered by providers and LA, based on pre determined and verified measures	This would involve a range of different measures dependent on the health problems identified at the assessment stage	Has this person's gait improved? Has their blood pressure reduced?
3	Well-being	Administered by LA with the service user based on pre-determined verified measures	Would probably suggest combining elements of the Australian index of well-being with the World Health Organisation DAS 11.	"I am feeling less lonely than I previously was."

No	Type	Who defines	Measures	Example
4	Assessors positioning in relation to higher intensity care.	Assessed by LA based on a simple scoring chart and summary of measures 1-3 above	<p>Five point scale, with explanations based on other measures for the conclusions drawn:</p> <ol style="list-style-type: none"> 1. Has moved closer to higher intensity care. 2. No discernable change, has maintained current position. 3. Minor improvement in dependency and a lessening of some characteristics that might lead to HIC. 4. Substantial change in some areas but not in others. An increase in independence and less need for care but some concerning characteristics remain. 5. Considerable increase in independence and well being. Substantial diminution in care needs. 	Person has moved back two points on a five point scale