An Chomhairle Náisiúnta Eacnamaíoch agus Shóisialta
National Economic & Social Council

Quality and Standards in Human Services in Ireland: Home Care for Older People

An Oifig Náisiúnta um Fhorbairt Eacnamaíoch agus Shóisialta
National Economic & Social Development Office NESDO

National Economic and Social Council

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Quality and Standards
in Human Services in Ireland:
Home Care for Older People

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Abbreviations

CARF
Commission on Accreditation of Rehabilitation Facilities

CSAR
Common Summary Assessment Report

EAG
Expert Advisory Group

FETAC
Further Education and Training Awards Council

HIQA
Health Information and Quality Authority

HSE
Health Service Executive

ICT
Information and Communications Technology

ISO
International Organisation for Standards

JCI
Joint Commission International

LHOs
Local Health Offices

LRC
Law Reform Commission

NCAOP
National Council on Ageing and Older People

NESC
National Economic and Social Council

NESF
National Economic and Social Forum

NGOs
Non Governmental Organisations

OECD
Organisation for Economic Co-Operation and Development

SLAs
Service Level Agreements

UN
United Nations

Quality and Standards in Home Care for Older People: Non-Technical Summary

This report is one of a series in a NESC[1] project that examines how quality processes, standards and regulations contribute to continuous improvement in delivery of services. This report focuses on the standards regime in place for formal home care of older people.

In Ireland, formal home care consists mainly of home help[2] and home care packages.[3] In 2011, nearly 51,000 people (the majority aged over 65) received home help; and 15,000 a home care package. Both types of home care are provided mainly by the HSE, with a smaller proportion provided by voluntary organisations and private companies.

In 2008, the Health Service Executive (HSE) agreed draft national quality standards on home care, to promote consistent quality in this service. These 2008 standards were then incorporated into two other sets of standards drafted later, with one set to apply to home care packages contracted out by the HSE, and the second to home help delivered directly by the HSE. A number of private home care companies have also voluntarily adopted a version of these 2008 standards. However, only the standards applying to home care packages contracted out by the HSE have been implemented, and so the majority of home care (i.e. that provided directly by the HSE, and that provided on a private basis by voluntary or private organisations) is not yet subject to standards' requirements.

Thirteen stakeholders interviewed as part of this research (representing the public, private and voluntary sectors) identified a number of strengths in the progress towards standards for home care, including:

- The development of draft quality standards by the HSE, with the participation of all stakeholders;

- Inclusion and development of these draft standards in later draft standards applying to different types of home care, such as home help services, and home care packages;

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[1]   NESC, the National Economic and Social Council, is an agency that analyses and reports to the Taoiseach on strategic issues relating to development of the economy, and social justice.

[2]   Until recently, home help consisted of domestic care, such as assistance with cleaning, cooking and washing, but it now includes more personal care, such as assistance with personal hygiene, bathing and dressing.

[3]   Home care packages usually provide personal care such as bathing and dressing, as well as more medical care such as nursing, physiotherapy, chiropody, etc.

- The requirement for organisations providing home care packages contracted out by the HSE to meet high quality service standards;

- Voluntary application of the HSE's 2008 draft standards, and participation in quality accreditation regimes, by some home care providers;

- The Government commitment to bring in standards for home care, inspected by Health Information and Quality Authority (HIQA)[4]; and

- The emphasis on service user involvement in the draft standards.

There are, however, many challenges in progressing implementation of these draft standards, as follows:

- The standards being implemented are only required for home care packages contracted out by the HSE. Other types of home care are not required to meet quality standards;

- Notwithstanding progress to date, implementation of the draft standards in home care services traditionally provided by the HSE is slow;

- There is no legislative backing for any of the standards currently drafted;

- Cutbacks are leading to the 'time available' increasingly influencing the quantity and quality of home care given, rather than the wishes of the client;

- It is increasingly difficult for an older person to choose the carer they want to employ, when that carer is paid for from HSE funds;

- The State does not provide any guidance to home care providers on how to increase the quality of the service they provide; and

- There is no standardised data to allow comparison of the quality of home care given by different providers.

Given these strengths and challenges, the following are pointers for future policy development:

- Implement the commitments made and standards drafted in relation to quality in home care; and inspect to ensure these standards are met;

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[4] The Health Information and Quality Authority, an independent inspectorate established under the Health Act 2007.

- Prioritise application of the existing draft standards to HSE-provided home care services;

- Improve efficiency and increase use of IT in the management of home care services, and support contracted-out home care, to help ensure quality services at lower cost; and

- A standardised data set, which would allow better comparison of quality of care and methods to reach it, should be put in place and used by all providers and commissioners of home care.

Executive Summary

Introduction

This report examines standards and quality in relation to home care in Ireland, with a particular focus on the care of older people. It is one of a series of reports that make up the NESC project, *Quality and Standards in Human Services in Ireland*. This project assesses how quality processes, standards and regulation can contribute to continuously improving human services.

Home care provides a range of services for those who need assistance with basic activities of daily living, such as getting in and out of bed, bathing, dressing, eating, etc. Typically, this care is provided either informally by family and friends, or formally, by professional home care providers. Formal care in Ireland consists of home help,[5] and home care packages,[6] and these are delivered mainly by the HSE, but also by voluntary and private organisations. In 2011, through the HSE, nearly 51,000 people (the majority aged over 65) received home help and 15,000 a home care package. Formal home care in Ireland is currently largely unregulated, although a variety of draft standards to promote quality services do exist. Some of these draft standards are being implemented, but they either cover only a proportion of home care, or are implemented on a voluntary basis. These developments are the subject of this report. The information in the report is based on documentary evidence, and interviews with thirteen stakeholders representing the public, private, and voluntary sectors.

Home Care Quality Frameworks

Draft standards to regulate the quality of care of older people in their homes were first agreed by the HSE in 2008, in partnership with stakeholder groups. A number of private home care operators are now implementing a version of these standards on a voluntary basis. The HSE does not yet implement these standards in the home help and home care package services it provides, but is working towards implementing them. Some home care providers have also been accredited with the Q Mark and ISO quality standards. However, the HSE has recently awarded a tender for organisations to provide new home care packages on its behalf, and this requires those awarded the tender to demonstrate quality standards in a range of areas. This new process should increase the overall quality of management and

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[5]   Until recently, home help consisted of domestic care, such as assistance cleaning, cooking and washing, but it now includes more personal care, such as assistance with personal hygiene, bathing and dressing.

[6]   Home care packages usually provide personal care such as bathing and dressing, as well as more medical care such as nursing, physiotherapy, chiropody, etc.

care in home care packages, and has been dubbed 'regulation by the back door' by one stakeholder interviewed.

The government also committed in 2011 to bringing in standards for home care, which would be inspected by HIQA.[7] A recent Law Reform Commission report (Law Reform Commission, 2011) on regulation of home care providers includes specific guidance on how the Health Act 2007 can be amended to allow this.

Five Key Themes

How these standards frameworks are relevant to the five key themes addressed in this NESC project is now outlined. These five key themes are – responsive regulation (which is how implementation of quality standards is encouraged by a balance of sanctions and supports); involvement of the service user; monitoring and learning; devolution and accountability; and addressing costs while improving quality.

Responsive Regulation

The tender to provide home care packages has good enforcement mechanisms to ensure delivery of a quality service, although it remains to be seen how these will be implemented in practice, and what resources will be devoted to this by the HSE. Otherwise, few of the draft home care standards are being implemented, and those that are are voluntary, so there are no sanctions where these standards are not met. Meanwhile, supports to help home care providers implement quality standards are quite limited. They consist of private and voluntary sector home care operators seeking standards accreditation that receive support from accreditation inspectors; and the HSE providing some supports to its staff to ensure greater consistency in provision of home care packages. In future, with more home care contracted out, it may be necessary for State bodies to provide more supports to home care providers to ensure good quality care is provided at optimal cost.

Involvement of the Service User

The involvement of the service user is stressed in all the standards frameworks drafted to date. However, in practice it seems that reductions in HSE care budgets mean that the older person has less say in how care is provided, with the time available increasingly determining how the care is given. The ability of the older person to choose how to spend funding they may be allocated for home care has also been reduced, as home care grants that could be used by an older person to directly employ a carer of their choice are being phased out. However, in Canada, involving the service user in managing the home care services they receive (without employing a carer directly) has been found to reduce costs, as well as yielding improved outcomes for service users. It may, therefore, be useful to promote

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7   The Health Information and Quality Authority, an independent inspectorate established under the Health Act 2007.

greater involvement of the service user in managing the services they receive in Ireland.

Monitoring and Learning

The HSE has established a number of internal task groups and best-practice groups, to take on board learning from developing the various standards frameworks. The HSE 2008 draft home care standards have also been progressed by different working groups over time. For example, they have been incorporated into the later HSE tender for companies to provide home care packages on its behalf, and into the draft guidelines for the HSE's home help service. All of the draft home care standards frameworks outlined in this report also require providers to put procedures in place to regularly improve their service, and to assess its quality, in conjunction with the service user. Meanwhile, outside the HSE, less sharing of learning may be taking place, as several private and voluntary providers compete to be successful in the HSE tender to provide home care packages.

If the InterRAI assessment tool[8] and common minimum data set recently piloted by the HSE is adopted on a national basis, it would have the potential to provide significant data on the cost and outcome of different home care (and other eldercare) services, as well as learning, on the optimum ways to provide these services.

Devolution and Accountability

The awarding of the tender to supply home care packages on behalf of the HSE is very positive, as it ensures accountability for the quality of this aspect of home care. However, standards for home help and home care package services delivered directly by the HSE, or by other organisations to private individuals, are voluntary or non-existent, so accountability for the quality of these home care services is weak. Mandatory implementation of the draft standards covering these areas, and inspection to ascertain if they are met, is needed to ensure more consistently safe and high quality home care.

Addressing Costs While Improving Quality

A review of international research on costs and quality in home care indicates that a number of mechanisms can be used to decrease costs, while maintaining or improving quality. These mechanisms include improving process management; cutting out repetition of needs assessment; providing client input to case management; putting in place IT systems that optimise staff schedules and route planning; and contracting out home care to private and voluntary providers. It would be useful to adopt these mechanisms in Irish home care, although in contracted-out services, support may be needed to put in place IT systems, and to ensure that experienced staff are employed, and that their turnover is low.

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[8] This assessment tool collects a minimum data set to assess an older person's need for care, whether that be in a hospital, a long-term care setting, or at home.

Meanwhile, it is unclear what the costs would be of implementing the Irish draft home care standards to improve quality. Some stakeholders interviewed believe that the cost of bringing in standards for home care would be high, but others argue that a good standards and inspection regime would comprise a very small proportion of the entire budget spent by the State on home care, providing strong motivation for all providers to increase standards of care, and therefore providing a better quality service for the budget currently spent.

Are There Things that Need to Change to Ensure the Provision of a Quality Service in this Area?

Only one aspect of home care services (new home care packages tendered out to private and voluntary organisations by the HSE) has strong requirements to meet certain standards. Other types of home care services are not subject to standards, although draft standards for these services exist. This compromises the ability of the existing standards framework to prevent abuse and serious harm in the area of home care. A legislative underpinning to these standards, and inspection to ensure they are met, would help to improve the quality of all types of home care delivered, rather than a proportion, as is currently the case. This will become increasingly necessary in the future, with more older people likely to be cared for at home, in line with both Government policy and the wishes of older people.

Chapter 1
Introduction

This report examines standards and quality in relation to home care in Ireland, with a particular focus on the care of older people. It is one of a series of reports that make up the NESC project on *Quality and Standards in Human Services in Ireland*. This project assesses how quality processes, standards and regulation can best contribute to continuously improving human services. An earlier report, *Overview of Concepts and Practice* (NESC, 2011), set out the main approaches to quality, standards and regulation both in Ireland and internationally. Other reports from the project review quality and standards in the service areas of residential care for older people, end-of-life care in hospitals, disability, the schools system and policing. A synthesis report draws together the conclusions of the overview and the individual human services reports and includes suggestions for the way forward.

Before proceeding, what is meant by home care is outlined. This is care provided in the home to a person who needs assistance with activities of daily living over an extended period of time. Activities of daily living are 'self-care activities that a person must perform every day, such as bathing, dressing, eating, getting in and out of bed, moving around, using the toilet', etc. (OECD, 2005: 17). The majority of such care is provided at home, informally, by relatives and friends. The HSE and a number of other organisations also provide formal home care, which consists of home help (both non-personal care, such as cleaning and cooking, and more personal care, such as bathing and dressing); and home care packages (which include personal care, as well as medical and therapeutic care). As the majority of these services go to older people,[9] this report focuses on home care for older people. This focus also complements the NESC report on standards and quality in residential care for older people (see NESC, 2012c). Home care is currently unregulated in Ireland,[10] which is in contrast to the mandatory standards applied to residential eldercare. Therefore, study of these differing approaches to promote quality in eldercare provides interesting lessons on the successes and challenges of different approaches, and so highlights areas for potential synergies, learning and good practice.

In this report, the demand for home care services, the level of existing services, and the policy documents that have called for standards to be introduced in Irish home

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[9]   The OECD (2005: 15, 20) notes that 'long-term care services are needed by individuals with long-standing physical or mental disability, who have become dependent on assistance with basic activities of daily living ... demand for long-term care grows exponentially with age, and the bulk is concentrated on persons aged 80 years and older '.

[10] This is the case for home care workers. However, care delivered at home by professional health care workers (e.g. nurses) may be covered by the standards of their professional bodies.

care will be outlined in Chapter 2. In recent years a number of draft standards have been developed and progressed, and these will be described in Chapter 3.

Chapter 4 then outlines how these standards frameworks and their implementation are relevant to the five key themes of the overall project, *Quality and Standards in Human Services in Ireland*. Finally, in Chapter 5, a summary and conclusions are provided, before addressing three key questions about the overall efficacy of these standards in improving home care services. These key themes and questions are outlined in Box 1.1.

Box 1.1   Quality and Standards in Human Services in Ireland: Key Themes and Questions

Five key themes

1.   Responsive Regulation and Standards

To what extent is the regulatory, standards and quality improvement regime driven from a command-and-control, self regulatory, or responsive regulation perspective?

2.   Involvement of Service Users

To what extent, and in what way, are service users involved in the provision and/or regulation of services?

3.   Monitoring and Learning

What, if any, are the mechanisms for continuous learning?

4.   Devolution with Accountability

Who are the main actors (State, local, private, voluntary providers) driving the regulatory, standards and quality improvement regime, and what are their respective roles?

5.   Addressing Costs While Improving Quality

Have attempts been made to improve quality, while reducing costs?   If so, how?

What impact, if any, has this had on the quality of outcomes? Are there any barriers preventing implementation?

Three key questions

1.   How convincing is this regulatory, standards and quality assurance regime?

2.   To what extent does this regime (a) prevent the most serious harms/abuses; and (b) promote quality improvement?

3.   Are there things in this regime that need to change to ensure the provision of a quality service?

Source   NESC (2011)

The first five themes outlined in Box 1.1 are key issues considered in this project, and addressed in this report with respect to home care. Some explanation of them is provided below.
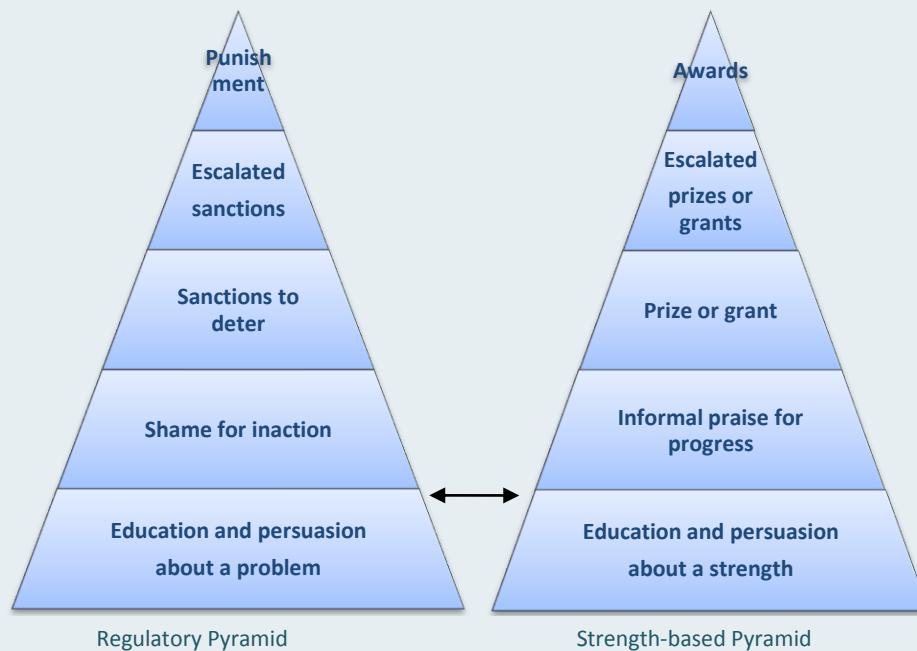
1.1   Responsive Regulation

Regulation is one of a number of quality enhancing mechanisms that can improve the quality of services. The concept of responsive regulation arises from studies indicating that regulation is less effective when it is one of two extremes, which are 'command and control' (with rules and regulations implemented through a top-down approach directed by a central regulator), and 'self-regulation' (a bottom-up approach where service providers and professionals self-regulate).   Responsive regulation instead aims to combine both approaches, and is often depicted as a regulatory pyramid of approaches, with self-regulation and voluntary approaches at the base and sanctions at the top (Braithwaite *et al.,* 2007). To ensure standards are met, the regulator or oversight organisation begins at the bottom of the pyramid with information provision and persuasion, but with the capacity to escalate towards punishment if persuasion fails, sometimes referred to as 'the gorilla in the closet'. Regulators will seek to persuade, but will act further if matters do not improve.

This pyramid alone, however, does not capture sufficiently the importance of rewards to spur effective regulation. Therefore, Braithwaite has since developed a 'strengths-based' pyramid to complement the 'regulatory' pyramid, which promotes 'virtue' while the regulatory pyramid restrains 'vice' (Braithwaite, 2008). Standards, which are a tool for regulation, are used differently in the two pyramids, being pushed up through a floor to provide a minimum standard of provision in the regulatory pyramid, and pulled up through a ceiling to provide continually improving services in the strengths-based model. This is similar to the distinction made by Seddon who focuses on increasing purpose and *performance* in services rather than on compliance with regulations, and who sees frontline staff heavily involved in driving improvements (Seddon, 2008).

The complementary pyramids – regulatory and strengths-based – are illustrated in Figure 1.1.

Figure 1.1   **An Example of a Strengths-based Pyramid Complementing a Regulatory Pyramid**

Regulatory Pyramid:
- Punishment
- Escalated sanctions
- Sanctions to deter
- Shame for inaction
- Education and persuasion about a problem

Strength-based Pyramid:
- Awards
- Escalated prizes or grants
- Prize or grant
- Informal praise for progress
- Education and persuasion about a strength

Source   Braithwaite (2008:116)

Overall, taking the two pyramids together, the focus is on continuous improvement, by identifying problems and fixing them, but also by identifying opportunities and developing them. The strength of this dual-pyramid approach is at the bottom, where the focus is on education and persuasion. This is where most of the activity takes place within the service delivery organisation, with limited support and/or intervention from external organisations, such as regulators and overseers (NESC, 2011).

A range of approaches can be taken within responsive regulation, one of which is particularly relevant to this study of home care standards. This is 'smart regulation' (Gunningham & Grabosky, 1998), where a range of non-State bodies are involved in supporting regulation, for example, professional organisations, trade unions and NGOs. These groups may be able to act as 'quasi-regulators', for example, NGOs that provide supports to implement standards, although it may be necessary for the State to enforce such standards with organisations who do not respond to the persuasive work of the NGO or other third parties.

1.2   Involvement of Service Users

An increasing trend in the provision of human services is a focus on how the *service user* receives the service. This means growing references to 'person-centred' services,[11] 'tailored services',[12] 'money following the patient/client', and so on. There is greater emphasis on taking into account the views of service users through consultation, ongoing engagement and, in some cases, the co-production of services and associated standards, for example, through student councils, patients' committees, residents' committees and joint policing committees. Associated with a greater emphasis on service users is an increasing focus on outcomes – for the service user, but also for the service providers, and the service system more widely (NESC, 2011).

1.3   Monitoring and Learning

Seeking feedback on the delivery and quality of services is a vital element of all quality assurance systems and is key to continuous improvement. What is needed is a mechanism for practitioners to learn from their practice, as well as monitoring on an ongoing basis to ensure that review and learning, which can be described and demonstrated, are a constant feature of what people do at a local service delivery level (NESC, 2011; Sabel, 1994). According to Kendrick, monitoring and evaluation can point to the need for changes in service models: 'They [quality and monitoring] are not in themselves capable of assuring quality, unless they are subsequently combined with feasible measures to improve service practice and models' (Kendrick, 2006: 3).

A key message from all the evidence reviewed by NESC in its *Overview of Concepts and Practices* (2011) is the need for a learning culture in the provision of quality human services. Ideally, learning should take place at a number of levels, an approach sometimes referred to as 'triple-loop learning'. The first loop of learning occurs when practitioners monitor their achievement and make adjustments to gain improved outcomes. The second loop occurs when this kind of practical learning is noted by managers who subsequently adjust their systems and routines to take note of this. And the third loop occurs when regulators and oversight authorities learn from monitoring the organisation's improved goals and revise their strategy for the entire field. Meanwhile, diagnostic monitoring[13] and other service-review

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[11] Person-centred services focus on the wishes of the service user in relation to the kind of services received and how they are delivered. This is the opposite of more 'task-focused' services that are often provided.

[12] This refers to mainstream services that have supports specifically tailored to the needs of the person accessing them, so that the person can overcome obstacles arising from disadvantaged social circumstances. See also NESC's report on the *Developmental Welfare State* (NESC, 2005).

[13] In this approach, monitoring of services is used to diagnose problems and find solutions.

approaches focus on asking 'why?', in a systematic way with a view to sharing learning, to change systems at the highest level.

1.4   Devolution with Accountability

There is some evidence from practice and in the literature that those who are delivering services directly to the service users know well what is required. Devolving responsibility to service providers to maintain quality but with clear accountability mechanisms to 'the centre' can be an effective part of a regulatory system. The evidence suggests that a fruitful approach is to set a broad regulatory framework or a small number of guiding principles 'at the centre'[14] and then devolve their application to the local context. The centre continues to have an oversight role to ensure compliance but local providers have the opportunity, and, in some cases, the incentive, to improve quality and performance. The overriding priority is on achieving and improving outcomes for service users (NESC, 2011).

1.5   Addressing Costs While Improving Quality

In the current economic climate, cost is to the forefront of any debate on providing public services. In this context, an emphasis on quality may seem like a luxury. Should emphasis instead be put on securing basic services and access to them? This is an understandable stance but care should be taken about creating a division between 'basic' and 'quality' human services, as if the latter is somehow superfluous. Quality should be seen as a basic expectation for all users of human services and not something that might supplement the delivery of services, if resources happen to be available. Rather, quality should be seen as intrinsic to the delivery of human services provided by the State, private sector, voluntary sector and communities (NESC, 2012d forthcoming). In this context, a corresponding perspective is that strategies are needed to ensure that quality is not jeopardised, i.e. that services do not deteriorate when there are budget reductions (NESC, 2011).

This raises the question of the costs and savings associated with quality improvement initiatives. A review by Ovretveit (2009) of a range of quality improvement initiatives in the health services, found that few studies actually included all relevant costs, meaning that the evidence available to assess the costs of quality improvement was weak. Nonetheless, savings have been reported in some cases. There is strong evidence that quality improvement changes will improve outcomes for patients, but Ovretveit's review showed that savings depend on the type of improvement, on who pays for the cost of poor quality, and the

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[14]   Depending on the context, 'the centre' can be government, a government department, a regulator, etc. The important point is that power (to varying degrees) is devolved from a central to the local or 'frontline' context.

intervention cost of the solution. For example, changes to reduce pressure ulcers can reduce extra treatments and admission rates to hospital. This is beneficial to patients, but will only save the provider money if the cost to the provider of implementing the change is lower than the losses made from the problem before the change. But it is not always the provider who saves through implementation of such initiatives. In some payment systems, longer stays in hospital due to infection are not a cost to the hospital, but extra income. A hospital can also spend time and money improving, for example, discharge information, but might not gain savings, because the next 'downstream' service will benefit instead from this information.

Another important influence on savings associated with quality improvement initiatives is how well they are implemented, which can vary considerably. External support, or previous experience with making changes effectively, will reduce the cost of implementation.

These findings show that addressing costs while improving quality is not a straight-forward process. Nonetheless, the limited evidence suggests that some quality approaches can reduce the cost of provision, for example, cutting out waste, changing the way services are provided to make them more efficient and effective (such as more care at home, or changes in staff skill-mix), and taking a person-centred approach. The challenge is to organise work systems and practices in such a way that staff resources can deliver the optimal quality service within the financial resources available, and that associated regulation, standards and quality improvement initiatives support this approach.

1.6   Methodology

The methods used to gather the information outlined in this report include documentary research, to outline the standards frameworks in existence; and interviews with key stakeholders, representing the public, private and voluntary sectors. These interviews were carried out to gain greater insight into how the standards were progressing in practice, from several viewpoints. A list of those interviewed is outlined in Box 1.2.

Box 1.2   Stakeholders Interviewed on Standards in Home Care

Organisation	Number Interviewed	Comments (see Section 2.34 for further detail)
Department of Health	Two managers from the Services for Older People division.	The Department of Health formulates policies for the health service, and so is the key Government department influencing strategic development of standards in home care.
HSE	Two managers working on home care; One manager working on monitoring systems.	The HSE runs all public health services in Ireland. This means it is implementing standards in eldercare in the services it provides or contracts out (e.g. in home care provision).
Home Care Association	Two members.	The Home Care Association is a trade association representing private home care providers in Ireland.
Home Care Company (Private)	One manager.	
Home Care Organisations (Voluntary)	Two managers; Two staff members.	

To preserve anonymity, quotes and examples given by those interviewed are presented using the numeric identifiers R1 (Respondent 1) to R13.

A workshop was also held with thirteen key stakeholders (including some of those detailed in Box 1.2), representing those designing and implementing standards, in the areas of home care, residential care and end-of-life care in hospitals.[15] NESC would like to thank all of those interviewed for their interest, and the time they gave to explain the design and progress of these standards frameworks.

All interviewees were selected due to either: (a) their key role in this area (e.g. those in the HSE) or (b) a recommendation to speak to them, due to their particular

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[15] These standards frameworks are covered in two separate NESC reports (NESC, 2012b; 2012c) .

experiences in designing or progressing quality improvement standards. However, as the number of people met is not very large, it is difficult to give weight to some of the issues raised in terms of their representativeness, so some caution is advised in their interpretation. Nevertheless, the discussions held do begin to reveal key issues arising in the implementation of standards and quality in the area of home care for older people.

In the next chapter, some background context on the need for home care, and on the policy and research documents calling for regulation and standards of this care, is outlined.

Chapter 2
Home Care – The Context

2.1   Demand for Home Care Services

Home care is received both by older people, and younger people with chronic diseases and disability. To provide some context on the demand for this type of care, key statistics on the number of older people, and people of all ages with a disability that limits their activities of daily living, are outlined here.

Census 2011 showed that there were 535,393 people aged 65 and over in Ireland, accounting for almost 12 per cent of the population. People aged 80 and over made up 24 per cent of those aged over 65, with more women than men in these older age groups (Government of Ireland, 2012).

Census 2006 shows that there were 360,529 persons with a disability[16] in Ireland at that time (more detailed data is not yet available for 2011), and that 38 per cent of these (138,571) were aged over 65. For a number of disabling conditions, the majority of those affected were aged over 65, and many of these conditions necessitate support to help the person to carry out activities of daily living. These conditions are indicated in Box 2.1.

A 2008 report (Working Group on Long Term Care, 2008) estimated that in Ireland in 2012, 41,700 people aged over 65 would need moderate care supports (10.5 hours of support per week), 18,000 would need high care support (21 hours per week), and 40,200 would need continuous care (42 hours per week) – a total of 99,000 older people. This figure was estimated to grow to 129,000 by 2022, due to the increase in the proportion of older people in the Irish population, and the increase in their life expectancy (Department of Health, 2011: 7).

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[16] Census 2006 defined a person as having a disability if they answered yes to any part of the two following questions: first, a five-part question that asked about the existence of the following long-lasting conditions: (a) blindness, deafness or a severe vision or hearing impairment (sensory disability); (b) a condition that substantially limits one or more basic physical activities such as walking, climbing stairs, reaching, lifting or carrying (physical disability); (c) a learning or intellectual disability; (d) a psychological or emotional condition and (e) other, including any chronic illness; second, a five-part question that asked whether an individual had difficulty doing any of the following activities: (a) learning, remembering or concentrating (mental disability); (b) dressing, bathing or getting around inside the home (self-care disability); (c) going outside the home alone to shop or visit a doctor's surgery (going outside the home disability); (d) working at a job or business or attending school or college (employment disability) and (e) participating in other activities, such as leisure or using transport (Government of Ireland, 2007: 200).

Box 2.1   Number of People, and Proportion Aged Over 65, with Certain Disabilities

Type of disability	Total number of persons[17]	Total aged over 65
Difficulty in dressing, bathing, or getting around inside the home	82,857	54,536 (66 per cent of all those affected)
Difficulty in going outside alone	110,712	70,943 (64 per cent of all those affected)
Difficulty in participating in leisure activities	127,964	64,654 (51 per cent of all those affected)
A condition that substantially limits one or more basic physical activities	172,603	94,400 (55 per cent of all those affected)
Blindness, deafness or a severe vision or hearing impairment	72,635	39,571 (54 per cent of all those affected)

Source   Government of Ireland (2007: Table 9a)

As the proportion of women (traditionally the informal carers of older people) in the paid labour force increases, and family sizes are smaller, it is expected that less informal family care will be available for older people in the future, and that the State will need to provide more support in this area (Working Group on Long Term Care, 2008). In the next section, the extent to which different types of home care are provided to support people who have difficulties carrying out activities of daily living is outlined.

2.1.1   Informal Care

Most care provided to people who need support with activities of daily living is informal. Census 2006 shows that 161,000 people provided regular unpaid personal care to a friend or member of the family with a long-term illness, health problem or disability, including those due to age.[18] It is not known how many carers are

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[17]   Some people may have a number of these disabilities.

[18]   The Census asked persons aged 15 years and over whether they provided regular unpaid personal help for a friend or family member with a long-term illness, health problem or disability, including problems due to old age (Government of Ireland, 2007: 200).

providing care to older people, but the statistics outlined in Box 2.1 give some indication of the numbers of older people who may need such care.

Of these 161,000 unpaid carers, almost 41,000 people are providing such care for in excess of 42 hours per week. The majority (over 60 per cent) of unpaid carers are women, with the key age cohort providing this care aged 45–64 – 10 per cent of women and 6 per cent of men in this age group provide care to a family member. Meanwhile, unpaid carers aged over 65 represent 22 per cent of those providing at least 43 hours of care per week (Care Alliance Ireland, 2010). Providing care can be an enriching and rewarding experience, particularly where adequate supports are available.   However, a 2009 study of family carers showed that over half experienced being physically and mentally drained by their role, and the majority reported major restrictions on their social or leisure activities (Carer's Association and the Irish College of Psychiatrists, 2009). A second study found that over two-thirds of carers expressed difficulty in making ends meet (O'Shea, 2000). Overall, the Care Alliance (2010) estimated that the 161,000 unpaid carers work 3.7 million hours every week, which is worth over €2.5bn every year. This informal caring is the mainstay of care for dependent people, with formal home care and residential care[19] complementing this. A National Carer's Strategy to address the needs of informal and family carers was approved by Government in summer 2012.[20]

2.1.2   Formal Home Care

In terms of formal home care, a variety of types are provided in Ireland. As outlined earlier, the HSE offers two main types of services - home help hours (usually this is non-personal care, such as cleaning, cooking, shopping etc; but increasingly more personal care, such as bathing and dressing, is included), or a home care package (which includes personal care, and can also include medical care such as physiotherapy, chiropody etc). Home help hours have been provided by health boards since the 1970 Health Act empowered them to do so. Home care packages are more recent, with the first State funding allocated to these in late 2006.   In 2011, the HSE spent €211m on home help services, and €138m on home care packages (Duncan, 2011). 11.09m home help hours were provided, benefitting nearly 51,000 people; while 15,270 people received a home care package (HSE, 2012a)[21.] Compared to 2010, the numbers receiving home help declined, while the numbers receiving a home care package increased. Overall, there has been a significant increase in the number of older people in receipt of formal home care in Ireland, from almost 16,000 in 2000 to the current figure of over 66,000 (see Timonen *et al.*, 2012).

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[19]   Quality in residential care for older people is the subject of a separate NESC report (NESC, 2012c).

[20]   It includes high level goals on income support, training, labour market issues, respite, information, housing, transport and young carers. See Department of Health (2012).

[21]   Not all home help hours and home care packages go to older people, with some younger people with disabilities and chronic diseases also receiving these services, but the vast majority of these services are used by older people.

Home care is delivered by a range of bodies. A report commissioned by the Irish Private Home Care Association[22] in 2009 estimated that 7 per cent of the home care market[23] was provided by private providers, 23 per cent by the voluntary sector, and the remaining 70 per cent by the HSE (see PA Consulting Group, 2009b, Figure 2). In general, private companies offer a greater range of home care services than the HSE, including companionship, recreational activities, and 24 hour emergency assistance, for example (see Timonen *et al.*, 2011).

Despite the amount of home care provided, and the increase in the number of private-sector home care providers in recent years, formal home care is as yet unregulated. However, there have been calls for such standards to be introduced, and the relevant organisations and documents are outlined in the next sections.

2.2   Organisations and Policy Documents Relevant to Standards in Eldercare in Ireland

A large number of organisations – Irish and international, statutory and NGO – and a variety of policy documents have influenced the development of standards in eldercare in Ireland. In the following sections, the main international strategy documents influencing the development of standards in home care in Ireland are outlined, followed by the key Irish organisations, and strategy documents. This is not an exhaustive description of all organisations and strategies influencing standards in Irish eldercare, but a brief overview to give some idea of the range of organisations and policy documents involved (for a list of relevant organisations and documents, see Appendix A).

2.3   International Context

First, the international organisations and policies that influence Irish home care standards are outlined.

In many Irish policies, the EU has a strong regulatory influence, with, for example, an EU directive on environment being transposed into Irish law by the Department of the Environment, and then implemented by local authorities. However, no such clearcut international context exists in relation to standards on eldercare. The EU has little jurisdiction over health policy, with its work in this area mostly confined to public health, occupational health and safety, and access to health care for EU

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[22]   Since renamed the Home Care Association.

[23]   This figure covers all home care provided by private providers, whether contracted from the HSE or paid for by individual clients.

citizens outside their member states. The UN does have a number of policy documents on older people that the Irish government has signed up to (see NESC, 2009). However, it seems that the main influence of international bodies on Irish policy and practice on standards in eldercare is quite indirect, with these bodies appearing to act as a repository of ideas and best practice that influences standards development. A number of the particularly influential documents are described here.

2.3.1   UN Influence

The Second UN World Assembly on Ageing was held in Madrid in April 2002. At this Assembly, a political declaration and the *Madrid International Plan of Action on Ageing* were adopted and signed by the participating Governments (including Ireland) (see United Nations, 2002). The Plan of Action was very wide-ranging, and listed 117 recommendations covering three main priority areas:

- Older persons and development;

- Advancing health and well-being into old age; and

- Ensuring enabling and supportive environments.

One of the Plan's recommendations is relevant to standards in home care, calling for the development of 'regulatory mechanisms at appropriate levels to set suitable standards of health care and rehabilitation for older persons'. However, the Plan of Action falls into the category of 'soft law', in that it is not legally binding, and States are under a moral rather than legal obligation to follow its recommendations on the treatment of older people (Law Reform Commission, 2011).

2.3.2   OECD Influence

In 2005, the OECD published Long Term Care for Older People (OECD, 2005), a study that looks at long-term care policies in nineteen OECD countries, including Ireland. It contains a chapter on monitoring and improving the quality of long-term care, both residential and in the home, listing initiatives for better regulation and standards in long-term care services, and highlighting that effective monitoring is needed to ensure that such regulation and standards actually lead to improvements in quality of long-term care. It notes that regulation of home care has lagged behind that of residential care in most OECD countries. This report has influenced day-to-day development and implementation of standards on long-term care in Ireland, as it contains information on how regulations and standards have been introduced in

different countries, and it is referenced substantially in the Report of the Irish Working Group on Long Term Care (see Section 2.4.6 for more detail).[24]

2.4   Irish Context

2.4.1   Organisations Involved in Design and Implementation of Home Care Standards in Ireland

The key organisations involved in the development and implementation of home care standards in Ireland (some of which were referred to in Box 1.2) are outlined in Box 2.2.

Box 2.2   Key Organisations Involved in Developing Standards in Home Care in Ireland

1. **The Department of Health**, which formulates policies for the health services, and so is the key Government department influencing strategic development of standards on home care. It contains a number of divisions that have a particular role in this area. These include the Office for Older People, which was set up in 2008. This Office has six main responsibilities,[25] including nursing home regulations, and inspection / accreditation.

2. **The HSE (the Health Services Executive),** which runs all public health services in Ireland. It has drafted a number of standards frameworks to regulate home care. The HSE is due to be reconfigured under the Programme for Government (2011), and its future role in relation to such standards is not yet certain.

3. **HIQA (the Health Information and Quality Authority**), which is a State agency set up by statute in 2007 to promote quality and safety in health care. It has devised standards for eldercare in residential settings, and inspects and regulates these settings. The government has committed to HIQA inspecting home care providers in the future.

4. **The Home Care Association**, a trade association representing private home care companies, whose members implement a voluntary set of standards on home care.

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[24]   In 2011, the OECD also published *Help wanted? Providing and paying for long-term care* (OECD, 2011), which examines policies relevant to both the formal and informal provision of long-term care and its financing. Key issues covered include supporting family carers, improving the supply and retention of long-term care staff, the financing of long-term care, and possibilities for better value for money in the sector. However, it does not look at the issue of quality and standards in any detail.

[25]   See www.dohc.ie/about_us/divisions/services_older_people.html for further detail, accessed 24 March 2011.

2.4.2   Care of the Aged

Calls for standards in the care of older people date back to the first policy document focusing on this issue in Ireland, *Care of the Aged*, which was published in 1968 (Inter-Departmental Committee on Care of the Aged, 1968).   This report was written by a working group appointed by the Minister for Health, to report on 'the general problem of the care of the aged and to make recommendations regarding the improvement and extension of services' (p. 22). The report did not look at standards in detail, but noted that 'the standards of services, both domiciliary and institutional ... provided for the aged has improved greatly in many countries in recent years', and that 'this country must aim to provide similarly improved standards' (p. 49). In relation to the role of home helps, the report stressed their importance in ensuring that more dependent older people could remain at home rather than enter institutional care. It noted that 'the quality of the services available for the aged will depend, to a very large extent, on the availability of properly trained workers ... [and that] the present training of ... workers will need to be extended' (p. 113).

2.4.3   The Years Ahead: A Policy for the Elderly

Twenty years later, *The Years Ahead* was drafted by an inter-departmental and inter-agency group appointed by the Minister for Health, and was published in 1988 (Working Party on Services for the Elderly, 1988). Its main overall recommendation was that older people should be supported to remain in their homes as long as possible (a stance reiterated a number of times since in Irish policy on care of older people). However, it did not look at the issue of standards in home care.

2.4.4   Reports by Other Organisations

A range of other organisations also looked at the issue of standards in home care, and a number of reports on this were published, in particular by the National Council for Ageing and Older People (NCAOP), the National Economic and Social Forum (NESF), the Irish Private Home Care Association,[26] and the Law Reform Commission.

The NCAOP[27] has published a number of reports on home care, starting with its 1994 report, *Home Help Services for Elderly People in Ireland*, which called for training for home helps and home care organisers as well as universal guidelines to assess eligibility, dependency, needs of carers and levels of home care service that the health board would provide (Lundstrom & McKeown, 1994). A more detailed publication, *The Future Organisation of the Home Help Service in Ireland* (National

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[26]   Now the Home Care Association.

[27]   The NCAOP has had several names. From 1981 to 1990, it was the National Council for the Aged which was replaced by the National Council for the Elderly from 1990 to 1997; and then by the NCAOP from 1997 to 2009, when it was dissolved. At all times, its terms of reference were to advise the Minister for Health on the welfare and care of older people.

Council on Ageing and Older People, 1998), concluded that 'to produce a core, quality service with agreed quality standards, the future organisation of the home help service must ... clarify the nature of the service; ... reflect this ... in training programmes [and] rates of remuneration and conditions of work for home helps; draw up explicit and agreed criteria for assessment of client need ...; standard criteria for entitlement ...; and determine national guidelines for level of service-provision based on assessed needs' (p. 74).

During the 2000s, the NESF produced a number of reports looking at care of older people. The first and most comprehensive, *Care for Older People*, (NESF, 2005), recommended that standards of care should be developed for all care services provided to older people, including not only residential and home care, but also services provided in the community. As with more recent NCAOP reports, it emphasised the importance of quality of life of older people. For example, the NESF report noted that service users needed to be consulted about what they consider quality care to be. It called for standards to be developed and renewed in partnership with key stakeholders (older people and their families, service providers, etc.); for these standards to be measurable and for the results to be publicly available; and for the standards to be viewed as a mechanism of continuous improvement. The report also emphasised the key role that high quality staff play in the provision of high quality care. Finally, it recommended that standards be put on a statutory basis, be inspected by the Social Services Inspectorate[28], and that there would be sanctions for non-compliance.

In 2009, the NESF published *Implementation of the Home Care Package Scheme* (NESF, 2009). While focusing mainly on how this scheme should be implemented, it also recommended that standards for delivery of the Home Care Package Scheme be agreed and passed. The NESF stated that these standards should focus on how home care packages are allocated, and on how they should be delivered, in order to ensure a more consistent service to older people.

In 2009, the Irish Private Home Care Association commissioned a report analysing the Irish home care market from PA Consulting (2009b). While focusing mainly on aspects of the market for home care in Ireland, the report also noted that the absence of quality standards created risk for clients, such as variable practices on the vetting and training of staff, and inconsistent monitoring of services delivered across the country. It also caused unease among potential home care providers, who were unclear whether or not they were meeting required quality standards.

Finally, the Law Reform Commission published two reports (Law Reform Commission, 2009; 2011) calling for the regulation of professional[29] home care, and

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[28] This is now part of HIQA. For more information, see http://www.hiqa.ie/about-us/who-we-do-it/social-services-inspectorate, accessed 25 July 2012.

[29] The Law Reform Commission (2011) defined this as formal home care (p.1), and further clarified this as the services required so that adults can continue to live independently in their homes, including for example, the services of nurses, home care attendants, home helps, various therapies, personal care and palliative care (p. 30).

outlining legal changes that would support this. The recommendations of these two reports will be looked at in greater detail in Section 3.1.7.

2.4.5   Quality and Fairness: A Health System for You

The health strategy, *Quality and Fairness: A health system for you* was published in 2001, and outlined an action plan for the development of health services, including services for older people. It has a strong emphasis on standards, with 'high performance' one of the four national goals outlined. Under this goal it is specified that 'this objective is concerned with ensuring that the quality and safety of care in the Irish health system meet agreed standards and are regularly evaluated/benchmarked' (Department of Health and Children, 2001: 25). It committed to prioritising both community and residential care of older people for the drawing up of national standards for quality care. It also had a number of commitments on monitoring, including the establishment of an 'independent Health Information and Quality Authority', which would be able to set and monitor standards; and putting the Social Services Inspectorate on a statutory footing.

2.4.6   Partnership Agreements

There have been seven social partnership agreements since 1987, and, over time, they tended to include more on services for older people, and more on standards in public services. Often the commitments in the agreements were in line with the recommendations of the relevant strategy documents outlined above.

The first agreement to refer to services for older people was the *Programme for Economic and Social Progress* in 1991 (Government of Ireland, 1991). *Sustaining Progress* in 2003 was the first to look at standards in relation to eldercare. In it, regulatory and standards issues are listed as an issue to investigate when implementing a strategic approach to infrastructure of care services for older people and others (Government of Ireland, 2003). Most recently, *Towards 2016*, published in 2006, includes a number of commitments on services for older people (Government of Ireland, 2006).

More particularly, *Sustaining Progress* (Government of Ireland, 2003), included a commitment that a Working Group would be established to examine the strategic policy, cost and service delivery issues associated with the care of older people. There was particular concern about the increase in the number of older people needing care, and the decline in the number of informal carers available, given smaller families and the increase in women's labour force participation. Arising from this, an Inter-Departmental Working Group on Long Term Care was established in 2005, chaired by the Department of the Taoiseach, and comprising senior officials from the Departments of Finance, Health and Children, and Social and Family Affairs. Its terms of reference were to identify the policy options for a financially sustainable system of long-term care; and to rationalise the range of benefits, services and grants (both statutory and non-statutory) currently in place, and address associated issues. It focused on the long-term care needs of those aged over 65.

The Group noted first that the majority of care for older people is provided informally, usually by families, and that this will 'remain a cornerstone of long-term care policy' (Working Group on Long Term Care, 2008). It also agreed a number of principles that should underline future policy, including the following:

- The use of community-based care should be maximised;

- The important role of family carers should be recognised and supported;

- Where community-based care is not appropriate, quality residential care should be available on an equitable basis in accordance with financial circumstances and as between public and private provision; and

- Any model adopted must be financially sustainable over the long term.

It also recommended reducing the proportion of older people in residential care, from 4.3 per cent of those over 65, to 4 per cent. It argued that improved home care support would help minimise requirements for residential care, and in most cases could be provided at lower cost than residential care. However, it noted that the OECD 'have warned against overly optimistic assumptions about savings arising from people availing of community rather than residential care' (Working Group on Long Term Care, 2008: 7). [30]

The report made several recommendations in relation to home care packages, supporting carers, developing supported housing for older people, financing, and a better system of co-payment.[31] It did not make many recommendations in relation to standards, apart from stating that home care packages should have clear quality standards and also noting that legislation was being prepared to establish HIQA, which would monitor standards of care in services for older people. This report is the most recent outlining principles for policy on long-term care for older people in Ireland. It reiterates the earlier policy aim that older people should be supported to remain at home, that informal care is key in this, and that formal home care should support this.

2.4.7   Summary of Key Policy Documents Relevant to Standards on Home Care

This review of policy documents relevant to standards in home care shows that since 1988, it has been Government policy to support older people to remain at

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[30]   In fact, in a more recent report, the OECD (2011) outlines a number of reasons why home care may not cost less than institutional care. For example, home care costs would be high for service users residing in remote areas with limited home care support, and for high-need users requiring around-the-clock care and supervision. Due to this, some countries have a cost threshold above which a service user is moved to a residential setting. And in some cases, inappropriate or inadequate home care is argued to lead to higher and more costly institutionalisation in the future.

[31]   The sharing of care costs between the individual and the State.

home as long as possible. This is seen as a more financially sustainable model for long-term care – although the OECD has cautioned against over-ambitious expectations of cost reductions arising from more use of home care (Working Group on Long Term Care, 2008). Nonetheless, the use of home care is growing internationally and has quadrupled in Ireland since 2000. This has led to increasing calls for standards in home care for older people. However, no legally binding standards yet exist in relation to home care in Ireland. This is in a context where there are three times as many older people receiving formal care in the home as are receiving residential care, and so a large group is still in need of the protection that can be provided by the existence of mandatory standards for home care. This is similar to the situation in many other countries, with residential care often prioritised for regulatory standards, and home care lagging behind (see OECD, 2005).

Although there are no legally binding standards for home care in Ireland, a number of draft standards frameworks have been developed. Chapter 3 will outline the development and progress of these various frameworks for standards in Irish home care.

Chapter 3
Standards Frameworks
for Home Care

3.1   Existing Standards Frameworks

Timonen & Doyle (2007: 13) have described the increasing provision of home care in Ireland by private companies as a considerably more complex care regime that 'calls for increased regulation, monitoring, … and quality controls' than previously. They argue that there is a mistaken belief that the traditional networks of family and community are in a position to perform the role of 'regulator' of home care, and consider that this is instead the duty of the State. Although there are as yet no legally binding standards in relation to home care, the State has become increasingly involved in developing standards that have potential to improve quality in home care provision, and these will be described below.

3.1.1   Tenders and Service-Level Agreements

Until the late 2000s, the only way in which attention to quality and standards had been incorporated into State-funded home care in Ireland was through requirements for quality standards in some tenders for home care issued by the HSE and through service-level agreements (SLAs) for home care, which are signed by the HSE and the organisation providing the home care service, and stipulate what is to be provided for the funding paid by the HSE.

A tender to provide home care packages was used in the Dublin-Mid Leinster area in the late 2000s, with twelve companies chosen to provide these packages on behalf of the HSE. One tender shown to NESC indicated that successful tenderers had to meet a number of minimum required standards, including security clearance, and training and supervision of staff and had to have a procedure to prevent elder abuse, a complaints policy, and a system for reporting incidents. Companies providing the home care service were to be monitored by the HSE, and this monitoring could include examination of records and complaints, and consultation with service users [R8]. The use of this tender, which entailed a contract being signed between the HSE and those awarded the tender, meant that the HSE could inspect the provider to ensure that services were being delivered to the standard specified. The tender also specified that if the service provided was unsatisfactory, the HSE could terminate the contract. However, this tender only applied to home care packages delivered in the Dublin-Mid Leinster area.

SLAs, meanwhile, were more commonly used, existing in most HSE Local Health Offices (LHOs). SLAs can be comprehensive, with one shown to NESC staff by a home care organisation requiring, for example, Garda vetting and supervision of

staff, a certain level of staff qualification, care plans, a complaints procedure, risk management, and adequate financial governance [R8]. However, a number of those interviewed for this research indicated that SLAs were not in place in all HSE LHOs, or in some cases they did not apply to all home care providers within an LHO, some of whom had more informal agreements to provide home care, dating back decades. In addition, where SLAs do exist, the references to quality standards vary, with no single national format for an SLA [R1, R8]. This is confirmed by the findings of the Comptroller and Auditor General in 2005, who found in a study of disability services funded by the HSE that SLAs tended to differ substantially in format, content and detail of services to be provided (see NESC, 2012a forthcoming). This situation is changing, with signed SLAs and grant agreements now in place for 94 per cent of HSE funding to non-statutory agencies, and with standard documentation for the governance and management of these organisations now agreed by the HSE, and being put in place from 2012.[32] However, the inconsistent use of SLAs until recently has meant that their ability to ensure quality home care services countrywide has been weak. In addition, one stakeholder described implementation of SLAs as 'meaningless ... there is no substance to it' [R1]. This view is substantiated by provider descriptions of how the HSE monitored companies providing home care. Following a television documentary that highlighted the lack of standards in home care, in 2011 staff from HSE LHOs reviewed how home care packages were provided by companies. Providers interviewed for this research reported that these reviews varied by area, as there was no standard procedure to assess providers. Some LHO staff met providers, or checked their policies, and several also interviewed clients [R1, R8]. Timonen *et al.* (2011: 169) have also described monitoring of SLAs by the HSE as 'erratic'.

3.1.2   The Development of Standards Frameworks for Home Care Provision

Recognising the need to develop nationally applicable quality standards, since 2005 a number of national standards have been drafted for home care, some of which are being implemented on a voluntary basis. These are summarised in Box 3.1 and described in detail in the following sections.

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[32]   Personal communication from the HSE.

Box 3.1   **Existing Standards Frameworks on Home Care Provision**

Year	Standards	Organisation that drafted the standards
Awaiting approval	Draft *National Quality Guidelines for Home Care Support Services* (will be referred to as the 'draft home care standards')	HSE
2010	National guidelines and procedures for standardised implementation of the home care packages scheme (will be referred to as the '2010 standardised procedures for home care packages')	HSE
2010	National Standards for the Provision of Home Care Support Services (will be referred to as the 'Home Care Association standards')	Home Care Association
2011	Invitation to tender for the provision of high quality, enhanced home support and personal care services for older people, to complement existing community services (will be referred to as the '2011 tender for home care packages')	HSE
Under development	National Guidelines for the Standard Operation of the Home Help Service for Older People	HSE
Proposed standards & regulations	Legal Aspects of Professional Home Care	Law Reform Commission

Some of these standards have been developed to apply to all types of home care, some to home care packages only, and some to home help services only, as will be described in the more detailed sections below.

In relation to the four standards frameworks drafted by the HSE, there have been two main phases of development. First, in December 2005 the HSE Services for Older People division launched *Advancing the National Agenda,* a programme that was established to implement government policy on health and social care services

for older people in a nationally consistent way.[33] A number of working groups and sub-groups worked on this initiative, with membership representing a range of statutory and non-statutory organisations. One working group focused on home support services, with a sub-group looking at home help services. The first draft of the *Draft National Quality Guidelines for Home Care Support Services* was produced by this group. Other groups focused on community care (covering supported housing and eldercare), on residential care, and on legislation [R7].

Advancing the National Agenda evolved into the HSE's National Governance Group for Services for Older People, and since December 2009 has existed as the National Services for Older People Team.[34] Under this, a National Task Group on Home Care Packages and Home Help was set up, consisting of HSE staff members. The Task Group used the standards developed by the earlier groups as a base on which to build, setting up sub-groups to progress these standards further towards implementation [R7]. As the various draft standards are based on the those first developed, this does mean that differentiating between them all can be difficult at times. However a description of the development and content of each of the draft standards developed is included in the following sections, to help differentiate between them.

3.1.3   Draft National Quality Guidelines for Home Care Support Services

As noted above, the first draft standards for home care, *the Draft National Quality Guidelines for Home Care Support Services*, (referred to from here on as the 'draft home care standards') were begun as part of *Advancing the National Agenda.* Under this, in 2005 an inter-agency group was set up by the Services for Older People Expert Advisory Group (EAG) in the HSE, to develop these draft standards to cover home help services, provided by all providers, whether public, private or voluntary. A variety of stakeholders were represented on this group, including the HSE, voluntary providers, private providers, groups representing older people, and hospital staff. The guidelines focus on the quality of care given to an older person in the home, and are divided into five sections – rights, protection, home care support needs, staffing, and governance.

The rights section outlines requirements on information for the older person, consultation with them about their care, and obtaining their consent. A good complaints system should also be in operation.

Under protection, safe working practices for home care support workers are outlined, as well as practices to protect service users from abuse and neglect. Guidelines for the security of the older person's finances and home are also provided.

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[33] This was separate to the work of the Working Group on Long-Term Care, which had been established by the Department of the Taoiseach (see Section 2.4.5).

[34] Governance of service delivery shifted from the national Director of Services for Older People to the regional Directors of Operations in December 2009.

On home care support needs, a guide to needs assessment is given, as well as a guide on the home care support plan, which outlines the work that will be undertaken by the home care worker. A record should also be kept in the person's home of the time and date of every home care worker visit, and of any significant occurrences. Guidelines on giving medication are also included. This section of the guidelines concludes by outlining the importance of continuity in relation to home care workers.

The fourth section covers issues in relation to staffing, such as the HR policy of service providers; staff induction training and development; and supervision of staff.

The final section contains standards on governance of providers, covering provider premises, management and planning systems; accounting and financial procedures; record-keeping; and the need for an effective quality assurance system (HSE, 2008; NESF, 2009).

These standards were approved by the EAG in 2008. They were then passed to the HSE's Services for Older People Governance Group for approval. However, they were not approved by this group, who considered that some changes would be needed before they could be implemented. In 2010, the National Task Group on Home Care Packages and Home Help services, established by the HSE, was given a number of tasks, including progressing these guidelines to a stage where they could be implemented, particularly in services delivered by the HSE. The name of these standards was then changed to *the National Quality Guidelines for Home Help Services for Older People*. Answers to a Parliamentary Question in June 2010 indicate that these standards were to be voluntary. However, stakeholders interviewed for this research suggested that a range of procedures to implement the guidelines have now been agreed [R2, R7]. The National Task Group is expected to finalise its work in 2012, and to pass the revised draft standards to the Department of Health for final approval.

3.1.4   2010 National Guidelines and Procedures for Standardised Implementation of the Home Care Packages Scheme

As outlined in Section 2.4.6, in 2003, the partnership agreement *Sustaining Progress* recommended that a working group be established to look at the future financing of long-term care in Ireland. Among other things, the report of this Working Group on Long Term Care recommended that home care packages should be introduced 'on the basis of a national standard approach, with clear criteria in terms of access, quality standards and availability' (Working Group on Long Term Care, 2008: 7). Standardised systems of assessing need and financial support were to be developed, as well as national protocols for delivery of home care packages, and 'an appropriate structure to ensure quality standards' (p. 8). In line with this, guidelines for standardised implementation of home care packages were drafted, but they were not implemented due to issues around eligibility and cost-sharing.

Following two evaluations of how the home care package scheme was being implemented (PA Consulting Group, 2009a; NESF, 2009) the HSE National Task

Group on Home Care Packages and Home Help services was asked to produce new guidelines and procedures on how to implement home care packages in a standardised way across the country. As a result, the *National Guidelines and Procedures for Standardised Implementation of the Home Care Packages Scheme* (which will be referred to as the '2010 standardised procedures for home care packages') were drafted, and are currently being implemented.

As these are procedures for standardised national implementation of the scheme, a significant part of the document (HSE, 2010) is therefore focused on HSE administration – e.g. how a home care package should be organised, how decisions on eligibility for receiving a home care package are made, what data should be collected, and what budget lines are affected. The document also notes that there is a limit on the amount of home care package resources available, and so individual applicants may not receive all of the services or supports recommended, or may have to wait to receive them. A section outlines exactly how risk assessment for those on waiting lists should be prioritised. These administrative aspects of the document are not standards, but the document does also include some standards procedures, i.e. there are guidelines on how the service should be delivered to the service user, and following these guidelines helps to promote a quality service. For example:

- A standard application form is included, which is to be completed by all those applying for a home care package;

- A standard information booklet is to be circulated to all applicants;

- A care needs assessment is to be carried out for each applicant, which will provide data for the CSAR (Common Summary Assessment Report) for home care package applications;

- A schedule of the services to be provided to the older person each week is to be drawn up, and a standard schedule format is available;

- A care plan will be completed, which sets out the agreed care outcomes and actions to be undertaken by all services, taking account of the identified needs and opinions of the older person. Again, a standard format is available;

- The contents of the standard home care package client[35] file are outlined;

- A review of each home care package is to be carried at least once every three months by HSE staff, or on request by any health professional, care provider or service user. The purpose of the review is to reassess the older person's needs and ensure that the home care package continues to support those needs. The

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[35] Many HSE standards documents refer to the client, which is the person receiving care.

client/family/carer are also asked to complete a standard questionnaire to provide feedback to the home care package manager on benefits and any problems encountered; and

- There is a process for making complaints and appeals, which is included in the home care package information booklet.

The procedures also include an implementation plan, which outlines that there will be regional briefings for senior managers; briefing and training for all appropriate staff both in primary care and hospital care settings; and a national best-practice group to deal with queries, provide clarifications and recommend amendments to achieve best practice. As part of implementation, the procedures will also be reviewed after two years of operation. The implementation section of the document notes that there will be a need for additional staff for day-to-day management, particularly to collect and input data on a national Information and Communications Technology (ICT) system, and to update individual client files etc. (although paradoxically it also notes that no additional staff would be provided to do this in 2011, and instead must be found from within existing HSE resources) (HSE, 2010).

3.1.5   2010 National Standards for the Provision of Home Care Support Services

In 2010, the Home Care Association, representing a number of private home care providers, decided to adapt the draft home care standards developed by the HSE, and implement a version of these standards among their member companies. The version that the member companies apply will be referred to from here on as the Home Care Association standards. The key aspects of these standards are outlined in Box 3.2.

The Home Care Association employs a home care inspector, who has previously worked with the Regulation and Quality Improvement Authority in Northern Ireland, and who visits each member company a number of times per year to assess the extent to which member companies are meeting these standards. This is done by auditing a number of client case files and speaking with the manager. Oral and written feedback is given to the manager. Companies must meet these standards in order to remain members of the Home Care Association [R1, R4].   Twelve companies are currently members of the organisation, with a number of these operating in multiple locations.

Box 3.2   Overview of Standards Adhered to by Home Care Association Members

- **Referral assessment and care planning:** Arrangements are in place to ensure that the identified needs of each client can be met and are kept under review.

- **Staff recruitment and selection:** There is a rigorous recruitment and selection procedure which meets the requirements of the legislation and ensures the protection of service users and their relatives.

- **Staff training and development:** Staff receive the necessary training, ongoing development and supervision to ensure the necessary competency levels are achieved and sustained.

- **Protection from abuse or exploitation:** Service users are protected from abuse.

- **Quality assurance:** The service is run in the best interests of its clients.

- **Premises management and planning systems:** The business operates from premises with a management structure in place, including clear lines of accountability, enabling the service provider to deliver services effectively on a day-to-day basis.

- **Handling complaints:** All complaints are taken seriously and dealt with promptly and effectively.

- **Miscellaneous employment-related issues:** These cover the minimum wage, smoking and alcohol consumption, health and safety legislation, insurance, and tax clearance.

Source   Home Care Association (2010)

3.1.6   2011 Invitation to Tender for the Provision of High Quality, Enhanced Home Support and Personal Care Services for Older People, to Complement Existing Community Services

In early 2011, the HSE brought out a national tender for organisations to apply to provide enhanced home care packages on behalf of the HSE (which will be referred to as the 2011 tender for home care packages). This tender was developed by the HSE National Task Group on Home Care Packages and Home Help.

Service providers awarded this tender must sign an SLA with the relevant HSE LHO, requiring them to comply fully with the tender specifications and local service delivery requirements. Successful service providers will then be subject to continuous performance monitoring and ongoing review. According to stakeholders [R1, R2], the invitation to tender states that there will be a robust contract management process to ensure high quality services are being delivered. Unlike earlier SLAs, this tender contains many very specific requirements to promote quality service. For example, there is a marking scheme, and tenders will

be evaluated on the basis of the systems in place for recruitment, training and supervision of staff; protection of service users; governance and monitoring; service delivery and project management proposals; and cost [R1].

In addition, the tender document includes a framework agreement to be signed by both the HSE and the provider applying for the tender. By signing it, the provider agrees to terms and conditions on which the service is to be supplied. This agreement is reported to be much more comprehensive than that applying under earlier SLAs (see Section 3.1.1) [R1].

In terms of standards, this framework agreement also includes greater detail in a section entitled 'Minimum Required Specifications'. Providers are required to provide services to meet the standards outlined in the Minimum Required Specifications, to the satisfaction of an authorised HSE office. These specifications were adapted from the draft home care standards. They include, for example, requirements for a home care plan, care needs assessment, a medication management policy, a complaints policy, and an effective continuous quality control system. Tenderers must provide written evidence to demonstrate they have these requirements in place [R1].

Implementation of the tender, and governance of it, will be carried out by a contract management group comprising HSE older persons' services and procurement representatives nationwide, as well as a contract manager in each HSE LHO. This contract manager will be responsible for micro-management of local service levels, including upholding high quality standards.

Tenderers applied for this contract in April 2011, and it was awarded on 1 July 2012. The tender applies to all new home care packages approved from that date. A total of 26 'approved providers' have been approved nationally, and each HSE LHO area will have four approved providers available to provide services locally. Approximately 15 per cent of the organisations awarded the tender are voluntary not-for-profit organisations, 50 per cent are for-profit home care companies operating under franchise agreements, and the remainder are for-profit non-franchise companies. Service agreements will initially be for 12 months, and the HSE will tender again for home care services in 2013.[36]

3.1.7   Legal Aspects of Professional Home Care

In addition to these HSE-developed standards, the Law Reform Commission (LRC) has made a number of recommendations on how legislation can be changed to regulate the provision of professional home care. The LRC has published two papers on this – a 2009 consultation paper, *Legal Aspects of Carers*, and a final report in 2011, *Legal Aspects of Professional Home Care* (Law Reform Commission,

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[36]   See HSE press release, 'New approved service providers in home care services', at http://www.hse.ie/eng/services/News/Approvedhomecare.html, accessed 3 July 2012.

2009, 2011)[37].   The 2009 paper looked at the lack of regulation of home care in Ireland – not just for older people, but for all who need such care. The LRC was particularly concerned that lack of standards and regulations for home care was leading to inconsistencies in terms of quality and delivery, and that people needing home care are a vulnerable group, and so in need of greater protection than currently exists.

The 2009 report noted that there is no clear legislative provision stating that HIQA can set standards for, and carry out, inspections of home care providers. The LRC therefore provisionally recommended that the relevant section of the Health Act 2007 be amended to allow HIQA to carry out such work. Consultation on this 2009 recommendation showed that there was broad consensus that Government should regulate professional home carers. Therefore, the LRC recommended in its final 2011 report that the relevant section of the Health Act 2007 be amended to allow HIQA to set standards for home care, and to register and monitor all home care providers; and for the Minister for Health to be empowered to make regulations regarding the provision of professional home care services (Law Reform Commission, 2011: 105). It is recommended that the principles underlying the proposed legal framework include independent living (similar to person-centred care); privacy and dignity for the care recipient; and protection from abuse.

In terms of standards, the paper recommends that HIQA should publish standards specifically tailored to home care, based on the existing *Draft National Quality Guidelines for Home Care Support Services* (which also reflect provisions in the HIQA standards for residential care). Attention should be paid, in particular, to needs assessment, complaints, involvement of the service user, elder abuse, administration of medications, the care contract, health and safety, and the recruitment, training and supervision of staff. A number of recommendations focus on the potential employment relationship between a carer and care recipient, and how this can best be handled. It is recommended that a care recipient should have the option to contract with an intermediary to supply care, which would mean that the intermediary takes on the employer responsibilities of hiring a carer, rather than the care recipient (see also Section 4.2). The HSE, or a voluntary body, could act as such an intermediary. Standards should cover the arrangements with such intermediary bodies (Law Reform Commission, 2011).

Since it was established in 1975, 70 per cent of the LRC's proposals for law reform have resulted in new legislation (see www.lawreform.ie). The Appendix of *Legal Aspects of Professional Home Care* (Law Reform Commission, 2011) includes a Draft Health (Professional Home Care) Bill as a model for such legislation, were it to be adopted.

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[37]   LRC consultation papers are based on initial research on an area, and then written submissions are invited from interested parties on the provisional recommendations made in the consultation paper. These are taken into account when drafting the final Report on the issue.

3.1.8   Other Standards Frameworks

The Task Group on Home Care Packages and Home Help has also drafted *National Guidelines for the Standard Operation of the Home Help Service for Older People,* which the HSE is aiming to complete and approve in 2012 (HSE, 2010). As they are still in draft form, copies were not available to NESC. However, it was reported [R7] that these guidelines set out a standard approach to application, eligibility, needs assessment, allocation and resource management of the home help service, in order to improve service delivery. These guidelines for the standard operation of the home help service are therefore similar in approach to the 2010 standardised procedures for home care packages, as both outline a standardised way in which a service should be administered. These guidelines for the standard operation of the home help service will complement the draft home care standards (now renamed the *National Quality Guidelines for Home Help Services for Older People*, see Section 3.1.1), which outline the quality of the care to be delivered by the home help service.

HIQA has also recently published *National Standards for Safer Better Healthcare* (HIQA, 2012). These standards, which aim to drive improvements in the quality and safety of health care services in Ireland, apply to all health care services (excluding mental health) that are provided or funded by the HSE including, but not limited to, hospital care, ambulance services, community care, primary care and general practice. However, they do not apply to home care, which is considered social care rather than health care.

3.1.9   Programme for Government 2011

A final relevant development is that the *Programme for Government 2011* states that the Government will 'develop and implement national standards for home support services which are subject to inspection by the Health Information and Quality Authority.'[38] This is a positive development, although there are few details on how this commitment will be implemented. It was reported in December 2011 that the Government was 'examining the options of introducing statutory regulation for home care providers', with the Department of Health looking at changing legislation to apply to regulation and inspection, by HIQA, to home help services (Duncan, 2011). The LRC (2011) report provides a framework to do this.

The Programme for Government also stipulated that, as part of reform of health service administration, 'the HSE will cease to exist as its functions are given to other bodies during this process of reform'(Government of Ireland, 2011: 36). It is not clear yet where responsibility for the home care standards drafted to date by the HSE will rest following this reconfiguration.

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[38]   See http://www.taoiseach.gov.ie/eng/Publications/Publications_2011/Programme_for_Government_2011.pdf p.55, accessed 10 April 2012.

3.1.10   Private and Voluntary Sector Standards

In addition to the standards drafted by the HSE (or initially by the HSE), as described in previous sections, a number of home care providers also apply standards regimes developed by private sector companies. These include franchise agreements and accreditation regimes. Corporate governance codes adopted by organisations can also include requirements on quality assurance.

A number of the private home care companies operating in Ireland operate under international franchises (mainly from the USA). The franchisor companies have developed operations systems designed to promote quality practices, in, for example, staff recruitment and training, and management systems and service quality. All franchisees use these systems, which help to provide quality in home care.

Meanwhile, a number of home care providers have been accredited with the Q Mark quality system. One private home care provider has also been accredited with the ISO 9000 quality system, and at least one voluntary home care provider is developing a standardised system of delivering care, which will be accredited under ISO. A third accreditation company, JCI (Joint Commission International), has recently started consultation in Ireland on its home care accreditation standards. Unlike Q Mark and ISO, which provide general accreditation, or accreditation for health care, these JCI standards are specifically focused on home care companies, but as they have only begun work in Ireland, no home care companies are yet accredited under this system.

At least one voluntary sector home care provider interviewed is preparing for accreditation by the continuous-improvement CARF system (the Commission on Accreditation of Rehabilitation Facilities). CARF is an independent, nonprofit accreditor of health and human services, originally based in the USA.[39]

All such accreditation processes involve a self-evaluation of current service standards by the company seeking accreditation, work towards meeting the required standards, inspection by the accrediting company, identification of changes that need to be made, and accreditation where sufficient adherence to quality standards is demonstrated.

Some providers are also developing more person-centred forms of home care, for example, needs assessment forms that outline what the service user can do for themselves and what they need assistance to do. For instance, this would mean that a care plan would outline that the client can dress themselves with assistance, rather than being solely dressed by the carer. Such a model increases the service users' independence and sense of autonomy. In the USA, the Eden model of home

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[39]   CARF was formed through the merger of two national organisations in the USA, the Association of Rehabilitation Centers (ARC) and the National Association of Sheltered Workshops and Homebound Programs (NASWHP). Both had been developing standards for their respective memberships for about a decade. See www.carf.org.

care[40] is developing similar approaches, where the carer is a partner in care, although to date this model is being used only in residential care in Ireland.

Finally, as noted in the *Overview* report (NESC, 2011), good governance (i.e. how organisations are run) has an important influence on the delivery of a quality service. In line with this, corporate governance codes that many organisations adopt cover issues of quality improvement. For example, the HSE has a Code of Governance framework, and under this the Risk Committee of the HSE is required to review and monitor the annual programme of the HSE's Quality and Patient Safety Directorate, and monitor and assess its role and effectiveness. The Code of Governance framework also refers to the HSE's Quality and Risk Management Standard, and the associated Quality, Safety and Risk Framework, as well as other policies to promote quality and patient safety; and advocacy and customer care (HSE, 2011a). Similarly, the recently published Governance Code for the community, voluntary and charity sector outlines key practices that need to be in place in the governance of these organisations, including issues relevant to quality as outlined in this NESC report, such as complying with relevant legal and regulatory requirements, communicating with stakeholders, and involving service users in planning and decision-making (Boardmatch Ireland *et al.*, 2012). Organisations can take many routes to ensure that the quality improvement aspects of good corporate governance are met, such as applying for accreditation, or carrying out internal audits of quality and processes.

3.1.11   Summary of the Various Draft Standards for Home Care

Overall, the various requests for standards in home care, and the existence of the six sets of draft standards, many with a common base, indicate a strong desire to ensure higher and more consistent quality in home care services. A large amount of work has been carried out by the HSE and the LRC on what such standards should cover. There are many commonalities in the various draft standards and recommendations, including involvement of the older person in decisions about the care received; care planning; protection of older people from abuse; the importance of good communication; the quality of staff and their training and supervision; the governance and management of home care companies; and provision in these companies for quality and continuous improvement.

The work of various groups in the HSE also shows that the draft quality standards first agreed in 2008 have been used and progressed in a variety of later initiatives to improve quality, such as the tender for home care package provision, and the standards now used by Home Care Association companies. These draft standards are also the basis for standards currently being agreed to apply to home help provision; they are also recommended as a basis for legal standards in the LRC (2011) report.

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[40]   See http://www.edenalt.org/eden-at-home, accessed 19 April 2012.

However, it is disappointing that progress on implementing the standards has been so slow. While sets of draft standards for quality home care exist, have been agreed by representative groups of stakeholders, and are being progressed towards implementation in a variety of services, at the moment only private and voluntary organisations that have been successful in the tender to provide new home care packages on behalf of the HSE are required to conform with them.

Reviewing the standards frameworks currently in place suggests that it has been easier to introduce standards into home care packages than into home help services. Home care packages were introduced in 2006 as a new service with a dedicated budget, with a proportion of the packages contracted out. As the HSE is purchasing these home care packages, it can require certain standards of the service providers it is contracting with. For example, the HSE can require providers they are purchasing from to employ only staff with FETAC Level 5 training to deliver these home care packages, and to provide the service at weekends and in the evenings. It seems that it is more difficult to introduce standards in relation to home help services that have been provided directly by the HSE, or on behalf of the HSE, for many years. In these cases the HSE is not in a 'greenfield' position to introduce standards, but instead in some cases needs to change existing work practices. Work is being carried out on this, but is slow to progress. This delay was attributed to a number of issues, for example the cost of ensuring that all existing HSE staff meet the standards' requirements, such as those on training, which not all HSE staff currently meet [R1, R7]; resistance from unions [R1, R2, R7],[41] and lack of consistent engagement from some staff in the HSE [R1, R2], which was not helped by a number of reconfigurations of internal HSE structures, which delayed sign-off of draft standards [R1].

However, it must also be recognised that while implementation of standards has advanced further for home care packages, they are not currently mandatory for all home care package services, with home care packages delivered directly by the HSE not covered by the provisions of the 2011 tender.

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[41]   One stakeholder [R2] also reported resistance from some private sector providers to the tender for home care package supports.

Chapter 4
How the Home Care Standards
Frameworks are Relevant
to the Five Key Themes of this
NESC Project

In this chapter, the extent to which the standards frameworks that exist for home care are relevant to the themes of this project – responsive regulation; the role of the service user; learning; devolution and accountability; and addressing costs while improving quality – is presented. (For a full explanation of each of these themes, see Chapter 1.)

4.1   Responsive Regulation

The first theme considered is that of responsive regulation. This is defined in the *Overview* report of this series (NESC, 2011) as 'seeking to persuade, whilst letting the regulated know that more onerous action will be undertaken if matters do not improve'. So, to what extent do the standards frameworks for home care display elements of this?   What is the balance between 'command and control', self-regulation and supports?

4.1.1   Sanctions

None of the standards frameworks for home care outlined in this report are backed up by legislation. However, the tender to provide enhanced home care packages outlines that only organisations meeting the required standard will be able to receive HSE funding to provide these home care packages. The tender specifies that if the provider does not provide the services in accordance with the agreement signed, then the HSE may exclude it from participation in further contracts, until the provider demonstrates the steps taken to redress the problem. It was also reported that the HSE can terminate the agreement if the provider breaches the agreement and fails to remedy the problem[42] [R1, R2].

These contractual requirements within the tender for home care packages are positive for the quality of home care. However, it is not known yet how adherence to these standards will be checked – it is planned that the HSE LHOs will monitor this, but the methodology to be used, how frequently such checks will be carried out, and their resourcing, is not known yet [R1]. Ineffective monitoring would weaken the power of the tender to ensure the standards set out are met.

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[42] Similar provisions applied under the tender operating for home care package provision in Dublin-Mid Leinster, until it expired in 2009.

Meanwhile, under the Home Care Association standards, if a member company is found by its inspector not to meet them, then that company cannot remain a member of the Association. However, this is not a strong sanction, as membership of the association is voluntary.

So apart from the tender provisions, there are no legal sanctions if the various draft standards are not applied. This is seen as problematic by stakeholders. For example:

> You can't beat the power of an external person coming in ... it's such a powerful tool. ... So that's why HIQA is so powerful ... when it comes to standards you've got to have an outside body coming in looking at your books ... and there has to be consequences to failure. [R1]

4.1.2   Supports

In terms of supports to help those providing home care reach certain standards, the HSE's draft home care standards have acted as a type of support, as they have been adapted and used as a guide to quality standards by several stakeholders. The Home Care Association has adapted and implemented a version of these; the *Minimum Required Specifications* in the 2011 tender for home care packages drew on them [R1, R2]; the LRC recommends using them as a basis for legal standards; and they are also being used as a basis for standards for home help services [R7].

In the meantime, the Home Care Association employs its own inspector who, as part of her role, provides feedback and advice to those inspected. The Q Mark and ISO processes also involve feedback and support as part of the accreditation processes. One interviewee outlined what support the latter accreditation processes provided:

> [The inspectors talked] to senior management for the day – [it was] – are you doing this? Are you doing that? And they came up with some very good suggestions in '09 that helped drive us forward for the next year, and we made those improvements. [R1]

The 2011 tender for home care packages was also reported to require service providers to demonstrate that they have policies and procedures to support practice, and that all staff are trained and familiar with these [R1]. This means that supports to meet good practice are available within the company, although not provided by the HSE.

Meanwhile, in the UK, where home care has been extensively contracted out, some researchers have argued that State organisations commissioning home care[43] need to play an enabling role, to ensure that good private and voluntary quality home care providers continue to exist, to ensure that a good service is available to be

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43   In the UK, local authorities commission home care, while in Ireland the HSE carries out this task.

contracted. Davies & Drake (2007) suggest, for example, partnerships between State commissioning bodies and providers to give the necessary economies of scale on ICT introduction, as some small providers may not be able to afford to introduce such systems. Use of ICT can cut costs for both provider and commissioner, while maintaining quality. To help ensure quality, the State could also train care workers employed by private home care providers, particularly where specialist home care skills are needed. They argue that it is important to ensure smaller providers continue to operate, and in some local authorities they are being encouraged to provide specialist services (Drake & Davies, 2007). Such support may be something that the HSE needs to consider in future, as more home care is contracted out.

In the meantime, the 2010 standardised procedures for home care packages, currently being implemented by the HSE, outline some supports being provided to staff implementing the scheme, to promote quality in service delivery. These include the guidelines themselves, as well as standard application forms, information booklets, schedule of services format, care plan format, client review questionnaires, process for making complaints, and care needs assessment. These mean that each HSE LHO does not have to design separate documents and procedures itself. Briefing and training for all appropriate staff has also been provided on how to implement those guidelines.

Overall, it can be seen that implementation of quality standards in home care in Ireland relies primarily on self-regulation. However, given the vulnerability of those receiving home care, there are reasons for introducing sanctions for those who do not implement the draft standards in existence. Similarly, there are not many supports for providers to help them develop greater quality in home care services. A focus on this may become more important in the future.

4.2   Involvement of Service Users

4.2.1   How are the Views of Services Users Reflected in the Draft Standards?

The views of service users were taken into account when developing the draft home care standards, as organisations representing older people were on the advisory group that developed these. These standards were later adapted for use by the Home Care Association, incorporated into the required minimum specifications contained within the 2011 tender for home care packages, and are a basis for the home help standards currently being agreed. In this way, the views of service users gained in 2006–8 have influenced all three documents.

All of the standards outlined in Chapter 3 refer to involvement of the service user. Typically the issues covered include:

• Providing information on services to the service user;

- Taking their opinions into account when agreeing the services to be provided;

- Outlining that the service user is presumed capable of giving consent, unless in limited, specified circumstances;

- Reviewing the service from the point of view of the service user, and taking this into account;

- Ensuring that the carer can communicate effectively with the client; and

- Dealing with complaints.

Home care packages were also introduced specifically to tailor for individual care needs. A mix of services can be provided through a home care package to an older person, in order to meet their specific needs. A cash benefit (the home care grant) was also available to an older person in certain circumstances, to provide them with the flexibility to organise the care they wish to receive, and from whom.

4.2.2   But How Much Choice do Service Users Have in Practice?

Although the standards do focus on the needs and involvement of service users, it seems that in practice the goals aimed for are not always met. The following sections will consider the issue of employing a carer directly, the impacts of budget cuts on meeting service users' needs, and making complaints.

Options to Employ a Home Care Worker Directly

The option to receive a home care grant through the Home Care Package scheme is now being phased out, with no new applications for home care grants approved since 2010 (HSE, 2010: 35). One reason is that it has been reported that, in general, older people are not as willing as, for example, people with a disability, to take on the responsibility of being the direct employer of a carer (see Weiner *et al.*, 2007; NESF, 2009).   However, in the UK a system is in place whereby a central organisation provides payroll and other employer functions on behalf of the service user. A similar system is not available in Ireland for older people (or others) who employ a carer directly; instead, the older person has to take on the employer responsibilities. The LRC (2011) report recommends that an intermediary body (the HSE or a voluntary organisation) could take on these potential responsibilities under employment law on behalf of the client.

How Could Standards be Applied to Directly Employed Home Care Workers?

Another reason given for phasing out the home care grant is that it would be difficult to apply the standards being brought in under the tender for home care packages to a carer employed privately [R2]. Certainly, the existing draft standards and proposals for monitoring and inspection of home care workers are very much modelled on carers being employed through a home care organisation, rather than directly by an individual. The LRC (2011) report does note that any standards

governing professional home care must also apply to independent home care workers employed by an individual to provide such services in a person's own home. This would mean that the independent home care worker would, for example, need to comply with what the LRC proposed, such as policies on administration of medicine, being suitably trained, and being monitored and inspected by HIQA. A care needs assessment of the older person would also be required, and a care plan. How individual contractors would comply with such standards, and how they would be inspected, is not clear. Although having adequate levels of training is relatively simple to organise, how would a care needs assessment be carried out? In particular, who should carry it out? The carer, or an independent party? The LRC recommends that there be a register of all professional home care providers, so a list of registered home care workers would exist.

In the UK, where use of personalised budgets and direct payments allowing individuals to employ their own home carer has begun (although take-up is still low), more consideration has been given to how greater service user choice can be combined with procedures to protect vulnerable adults from potential abuse. Key concerns are protection from theft and other forms of abuse. Actions being undertaken or proposed to address these concerns include, police vetting, registration and inspection of independent carers; supporting informed choice for those employing the carer, through e.g. support with employment issues, brokerage,[44] and legal advice; information on how to report concerns, and mediation services to help solve problems between carer and service user; and regular reviews of care, particularly for vulnerable service users (see e.g. Department of Health (UK), 2008, Manthorpe *et al.*, 2011).

A possible model to inspect the standard of care provided by independent home care workers (and, indeed, all home care workers) in Ireland would be random, in-depth reviews of the care of an older person. This would have some similarities to QSR (Quality Service Review). QSR is an in-depth case review that examines short-term results for a service user, and the contribution made by local service providers and the system of care in producing those results. The premise is that the case of each individual service user can be used as a test of the service system at a particular place and time. The outcomes of QSR are used to guide practice development and local capacity building, to lead to better results (see NESC, 2011; Human Systems and Outcomes Inc., 2010). In the case of home care, as well as highlighting good practice, such a model could, for example, highlight that better systems are needed to support e.g. training,[45] care needs assessment, administration of medication, etc. where individual home care workers are directly employed, rather than employed through a company that puts in place processes or requirements on these issues for all its care staff. Equally, such a model could

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44   A broker is an independent guide to help a person needing care to organise their own care supports.

45   For example, home carers could be required to undertake a number of hours per year of continuing professional development (e.g. training, attending best-practice networks or seminars), in order to maintain their place on the register of home carers.

highlight that older people need support to employ carers directly, as has been found in the UK.

How Could an Older Person Choose a Carer to Employ Directly?

Meanwhile, the new tender for provision of home care packages could help clients to independently choose providers that provide high quality services, as there is now a list of four approved providers for home care packages in each HSE area. Where older people are made aware of these providers,[46] they will have the opportunity to choose providers found by the HSE to demonstrate that they have good systems in place to provide a high standard of home care.

Other Developments

Meanwhile, Fair Deal, the system to finance residential care, is being reviewed and this review will also look at how a secure and equitable system of financing long-term care in the community could be developed, to support older people to stay in their own homes (Government of Ireland, 2011). The outcomes of this review have the potential to address financial difficulties and inequities faced by older people and their families when organising home care.

What Impacts Are Budget Cuts Having on Meeting Service Users' Needs?

Budget reductions, with subsequent cutbacks in services, are having an impact on the extent to which service users are able to receive the services they need. For example, the 2010 standardised procedures for home care packages outline that where funding is not available, clients may not receive all of the supports they need, or may have to wait for them. This is very unsatisfactory for those who need the care but cannot access it. Although this report does not look specifically at access to, and payment for, care of older people, it is notable that access to all types of home care is an issue not addressed adequately yet by any of the quality standards, or indeed by legislation, which empowers the State to provide home care, but does not require it to do so. This means that older people have no entitlement to formal home care services.

A number of stakeholders interviewed for this research also noted that services already provided to older people were being cut, and, as a result, in some cases the older person was not receiving the care that they needed [R5, R4]. For example, at the workshop of key stakeholders, one private provider delivering care on behalf of the HSE outlined the impact of having strict time limits within which care had to be provided to a service user, as follows:

> The job was you must go in and you have a half-hour ... and the older lady asked, said – half an hour's not much, would you mind if the

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[46]   A HSE press release lists the names of these providers on the internet (see http://www.hse.ie/eng/services/News/Approvedhomecare.html, accessed 3 July 2012). The providers are also advertising that they are HSE-preferred home care providers on their websites and in their literature.

person comes for an hour and a half in the morning, because of the number of things to do? and the public health nurse said – no … [So] we went into that lady in the morning and … [the carer had to get her out of bed, [the client] had mobility problems but [the carer] eventually got her up, undressed her, helped her into the shower, dressed her and dried her hair, brought her downstairs, helped her downstairs, made her breakfast and helped feed her and medicate her and whatever – and she had a half an hour. [The carer] said … I told the lady, stand there – no you can't undress, I have to undress you, and I have to dress you and I have to shower you and I have to feed you. [The older lady said] – I can help, I can help. [But the carer had to say] – no, you don't have time to help, because if you try to help to put on the clothes yourself you'll take too long. [R4]

On the other hand, one public-sector stakeholder [R2] felt that in some cases private companies sought extra hours to provide care, even though that number of hours was not necessary. A solution to both problems could be greater management of the services by the older person themselves. Section 4.5.2 will outline evidence from Canada that allowing service users who do not directly employ the carer control over case management of their services (that is, control over decisions such as the type of service received, its timing, frequency and duration) led to lower increases in costs of home care compared to cases where the service user did not have such control. This, and other reports outlined in McWilliam *et al.,* (2007), suggest that involving clients in case management not only can reduce costs, but also yield improved outcomes for clients in terms of met needs, life satisfaction and health outcomes.

Complaints About Services Received

Several stakeholders [R1, R6] also felt that older people were loath to complain, in case their services might be reduced, as one explained:

> Older people are very slow to complain. They really won't. They are afraid to … that they'll lose the care or that they'll lose the carer. [R1]

All the draft standards and the tender stipulate that a complaints procedure must be in place, but support from advocates might be necessary to support older people to use this procedure more.

4.2.3   Do the Standards and Services Support What Older People Consider to be a Quality Home Care Service?

Patmore (2004) summarises UK research on what older people consider to be a quality home care service. Their priorities were service from familiar staff, reliable and punctual visiting, being kept informed about changes, and help with miscellaneous household tasks such as house cleaning, changing light bulbs, or identifying trustworthy tradesmen to carry out home maintenance. It is interesting to consider the extent to which the Irish standards cover these issues.

All the standards listed above, and the tender, outline that there should be as much continuity as possible in who provides care to an older person, with changes in carer avoided as far as possible, and limited to, for example, when the carer is on leave, or when a different type of care is needed, which the original carer is not able to provide. Nearly all the standards also stress the need for staff to be punctual and reliable. However, the issue of help with household maintenance is not covered by any of these standards, as home help and home care packages only cover personal and medical care and issues closely related to this, such as house cleaning. In 2012, the HSE has also decided to refocus its home help services 'to prioritise personal care ... and deprioritis[e] non-personal care' (HSE, 2012b: 7), which means that fewer household tasks will be carried out as part of home help services. There are, however, some schemes in place to support household maintenance – local authorities fund a Housing Aid for Older Persons scheme, which is a means-tested grant[47] to improve the housing conditions of older people; while Age Action, a voluntary body, provides a service that carries out minor household repairs.

Another issue that the various standards are beginning to address is measuring the service according to outcomes for the service user. Reviews have to be conducted with the service user, and one of the Minimum Required Specifications in the 2011 tender for home care packages was reported to be a requirement that there would be a system in place to continuously improve quality, based on outcomes for service users [R1].

The HSE has recently completed a pilot of a single assessment tool (called InterRAI[48]), which may be used on a nationwide basis to assess an older person and their need for care, whether that be in a hospital, a long-term care setting, or at home. The assessment process collects a minimum data set that can be used first for care planning, but also to measure outcomes for older people from different services, and so to monitor the quality of services. This would help assessment of care needs and outcomes in different care settings. If the tool is adopted nationally, it could provide good monitoring and learning data for the HSE, at both local and national level.

In the USA, such indicators are used by Medicaid to incentivise service providers who score above average on a range of service user outcomes, covering a range of Activities of Daily Living. This type of pay-for-performance system is not yet developed in Ireland, although it was reported that the tender to provide home care packages does include a provision that could allow such a system to be put in place [R1].

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[47] Those with household incomes of less than €30,000 can receive a grant to pay for 100 per cent of the cost of the repairs (up to a maximum of €10,500). This tapers to 30 per cent for those with annual household incomes of €54,001 to €65,000. See http://www.citizensinformation.ie/en/housing/housing_grants_and_schemes/housing_aid_for_older_persons_scheme.html accessed 16 April 2012.

[48] This tool is the result of international collaboration and application over the past two decades, and is currently used in 30 countries. See http://www.interrai.org/section/view/ for more detail, accessed 15 March 2012.

However, the Medicaid and InterRAI systems are both focused on the more medical aspects of home care. Surveys of clients have shown that they stress quality of life issues (see for example Patmore, 2004) to a greater extent than the more medical focus of many indicators developed by health care professionals (see for example, Hirdes *et al.*, 2004). As outlined in NESC (2012a forthcoming), ways to measure outcomes for service users, such as improved quality of life, and increased choice and control, have been developed internationally for disability services, and these could provide a model for measuring quality of life outcomes for users of home care services in future.

Private accreditation systems, such as the Q Mark and ISO, were reported by stakeholders to not be very focused on service users.[49]

> Standards in these personal sectors [such as home care] should be very much client-based, client-focused. [But] no, the ISO isn't client-focused, Q Mark isn't client-focused. [R1]

However, one aspect of the ISO health accreditation process did involve visits to clients, so from that point of view involves service users.

4.3   Learning

Learning mechanisms are incorporated into the various draft standards frameworks in different ways.

First, several of the standards include a requirement for the service provider to put learning mechanisms in place. For example, the *Minimum Required Specifications* in the 2011 tender for home care packages, and the draft home care standards, both require the service provider to have an effective system for continuous quality improvement in place. Both also require service providers to review the policies and procedures they have in place on a regular basis, to assure quality [R1].

In the private sector, as outlined in Section 3.1, the Home Care Association inspector, and the ISO and Q Mark accreditation processes also provide feedback to members, allowing them to learn from the inspection processes.

As noted in Section 3.1, a number of the draft standards require that the service provider will review the provision of home care with the clients. This provides another learning mechanism for the service provider on the quality of care provided.

Second, there has been an increased emphasis on data being fed back to the HSE. Although there is no provision on this in the draft home care standards, the 2011

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[49]   Possibly as they are accreditation systems that can be used in any sector.

tender for home care packages was reported to contain a number of specifications on data that must be supplied to the HSE by service providers, and to state that there would be monitoring and review of services [R1]. These requirements have the potential to enable learning on the service provided to feed back to the HSE, although how this will work in practice, and how the HSE might use such data, remains to be seen. Meanwhile, if the InterRAI assessment tool recently piloted is adopted on a national basis, it would have the potential to provide significant data on the cost and outcome of different home care (and other eldercare) services, including learning on these.

It was also reported that informal meetings take place between home care providers and the Department of Health [R1, R11]. This allows information on policy and practice in home care to circulate between these stakeholders.

Third, some of the standards systems are putting groups together to allow managers to leverage learning from practice. For example, the 2010 standardised procedures for home care packages outlined that a national best practice group will be established. It will consist of three senior home care package managers from each of the four HSE regions, and a HSE specialist in Services for Older People. This group will support implementation of the guidelines, share good practice, and consider and recommend any revisions or clarifications that might be required to the National Office for Services for Older People. The best practice group will meet monthly initially, and thereafter on a quarterly basis, and will be supported by a national specialist for Services for Older People. The Office of the Assistant National Director – Services for Older People in the HSE, will also 'take a lead role in the best practice group' (HSE, 2010: 11). This group has been established, and its continued existence will be reviewed in 2012, along with the procedures themselves.

These 2010 standardised procedures were themselves put in place following evaluations of how home care packages were being implemented, with one of these evaluations (PA Consulting Group, 2009a) strategically planned by the Working Group on Long Term Care when home care packages were first introduced, in order to assess their effectiveness after a number of years of operation. An NESF evaluation (NESF, 2009) found that there was no mechanism in place to ensure learning from local processes was captured at national level, and the establishment of the national best-practice group aims to counter that[50].

In addition, the establishment of the National Task Group on Home Care Packages and Home Help, which has representation of relevant staff from various different locations, disciplines and grades in the HSE, also provides a space for reflection and learning. It is progressing work undertaken by earlier HSE groups focusing on standards in home care, so again acting on learning from past work.

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[50]   It is not clear how the reconfiguration of the HSE under the Programme for Government commitment will affect the work of this group.

The 2011 tender for home care packages was also reported to outline that a management group of older persons' services nationwide will be established, to implement and govern the tender [R1].

However, one way in which the tender may reduce learning is that providers are in competition with each other to receive funding to provide services under it. According to one provider [R13], this was a reason for voluntary providers not coming together to share learning. On the other hand, monitoring and review by the HSE of the work of service providers under this tender could provide the HSE with knowledge on key quality issues arising and how to address them.

4.4   Devolution and Accountability

With provision of home care poorly regulated, accountability for the quality of home care services is very weak. The LRC reports (2009; 2011) are particularly concerned about this issue, noting that people receiving care at home are in a vulnerable position – they are vulnerable in the first place as they are unable to manage on their own and so need care, and if abuse occurs it is particularly difficult to identify it as it is not very visible.

Currently, some protection is provided by the various SLAs in place, by the HSE tender for home care packages, and by the Home Care Association standards. However SLAs, as outlined in Section 3.1.1, are variable, and monitoring of them is reported to be weak. The provisions in the tender for home care packages do 'raise the bar' by requiring more comprehensive, and nationally consistent, standards in terms of what is expected from home care providers by the HSE. However, the tender only covers some types of home care. It covers home care packages paid for by the State, but does not cover home care provided by the HSE through the home help system, or home care paid for by private individuals. Meanwhile, the Home Care Association standards do not cover home care provided by organisations who are not members of the Association – and their application is voluntary.

On a different aspect of accountability, the LRC paper (2009) notes that currently there is no legal protection for those who disclose a concern about abuse in home care, but who are not employees of a company. Those without legal protection include, for example, relatives, friends or neighbours who raise a concern, who could be civilly liable for making the disclosure. The LRC paper recommends that the Health Act 2004[51] be amended to provide such protection. This would provide another mechanism to help ensure good quality home care.

In terms of devolution, the picture is mixed. On the one hand, the development of several of the draft standards suggests that devolution is perhaps too great. Many

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[51]   This Act established the HSE.

of the drafts have been required to go through many layers of decision-makers (e.g. an advisory committee, a number of HSE layers, and the Department of Health) before they are approved; to date only three (the 2010 standardised procedures for home care packages, the tender to provide home care packages, and the Home Care Association standards) have been implemented. Although it is positive from one point of view that a range of key actors have been involved in drafting and agreeing the standards, more implementation would be useful at this stage. A key challenge is to balance broad consultation and engagement with decision-making, implementation, monitoring and review.

Meanwhile, with few requirements from the HSE on the practice of delivering home care, service providers are in some ways quite free to innovate and provide services as they wish. While such flexibility may be positive as it means that client wishes can be responded to in a flexible manner, an overarching framework is required to ensure that such flexibility does not benefit the service provider over the client (see Patmore, 2004). On the other hand, the decline in HSE resources available to purchase home care constrains the way in which home care can be delivered, as the example outlined above of the amount of home care that had to be provided in half an hour illustrated (see Section 4.2.2). In addition, the new tender is reported to stipulate that the time allocated to provide care can only be decided on or changed by the HSE, as the purchaser of services [R2]. However, such practice has been found in the UK to be associated with lower perception of home care quality by clients, as will be outlined in more detail in Section 4.5.4.

4.5   Addressing Costs While Improving Quality

Costs are a key issue for eldercare in the current Irish context, but little data exists on how to address costs while improving quality in home care. Internationally, there is also little research on this issue, but a number of studies were located, which provide suggestions on how quality can be maintained or improved, while reducing costs. The key suggestions relate to economies of scale, improved operational management, providing intensive short-term home care support after a period of illness, and contracting home care from private and voluntary providers. More detail will be provided on each of these issues in the following sections.

4.5.1   Economies of Scale

Davies & Drake (2007) looked at the issue of costs and quality in home care outsourced by six local authorities in England and Wales.[52] They argue that home care is a low-profit business, and as wages are a key part of costs, and already low,

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[52] Almost two-thirds of home care in England was contracted out by local authorities to independent providers in 2003; and 38 per cent in Wales (in 2002). Davies & Drake interviewed local authority personnel commissioning care, as well as public and private home care providers.

that providers have little opportunity to reduce them further. Due to this, they maintain that there are two key mechanisms available to help home care providers decrease costs without decreasing quality. These are increased economies of scale, and radical improvements in efficiency, often through use of ICT.

Economies of scale can be promoted through mergers and takeovers, as large private and voluntary sector providers have the necessary human and financial resources to compete on quality and costs. Such consolidation is already taking place in the UK, and is growing as State bodies increasingly commission large amounts of home care.

4.5.2   Improvements in Operations Management

Davies & Drake (2007) also argued that major improvements in operations management can reduce home care costs. Commissioning bodies can reduce costs through cutting out repeated assessment of a client's needs, and by sharing information between all the actors involved in the care of an older person (GP, hospital, private care providers, etc.). This can be done through use of electronic patient records and single assessment processes.

Other costs that can be reduced are those linked to invoicing, and to timetabling and monitoring time spent in clients' homes. Systems to roster and plan travel can be linked to ICT, which monitors the amount of time spent in a client's home, and this can be linked to billing, automatically sending bills to the organisation or individual paying for the home care.

The specific costs of some of the solutions proposed by Davies and Drake (2007) have been quantified in other studies. In Sweden, significant savings in the home care budget[53] have been made through use of a computer system called Laps Care. This system integrates staff scheduling with route planning in order to optimise both. Local managers input relevant information on employees, clients and client needs, home care visits to be made, and travel-time estimates. The Laps Care system then generates several work plan scenarios combining staff and routes. It is estimated to have increased operational efficiency by 10–15 per cent, with the costs of the investment covered by the first year of savings. For example, in one local authority, home care staff made 12 per cent more visits in the same number of working hours, and the matching of staff skills and client needs improved. In another, work-planning time reduced from 45 minutes to 18 per staff member per day.[54] Short-term sick leave also fell in several local authorities, which could be due to the work load now being more evenly distributed among all staff, and to the fact that travel times to and between clients are more realistic. In terms of quality, a number of areas reported a decline in the number of missed visits, as well as a

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[53]   In Sweden, the government spends €8.8bn per year on home care.

[54]   Home care scheduling is often planned using both a written base plan and a daily staff meeting to deal with last minute changes needed due to e.g. staff illness, and changes in client need.

decline in the number of staff members per client, something that older people appreciate. The authors note that for the system to work effectively, user training is critical, as is clarity around local operational priorities, and staff buy-in (Eveborn *et al.*, 2009).

Another study has quantified the savings generated through improved operations management in a home care company in the United States. There, Elberfeld *et al.,* (2007) looked at the experience of a home health care company that adopted the Six Sigma business improvement tool. Six Sigma is a process that 'seeks to improve the quality of process outputs by identifying and removing the causes of defects (errors) and minimising variability in manufacturing and business processes'.[55] The Six Sigma processes were adopted in this company to improve clinical quality, and to help the company be financially viable under a new Medicaid mechanism to reimburse costs for home health care. The process yielded significant savings, with the company moving from losses of $1m per year, to a financial gain of $1.2m, which was directly linked to improvements generated in the first year of the Six Sigma process.

To implement the process, the company set up an internal multi-disciplinary team, headed by a senior manager. The team then developed its initial objectives, and established key metrics for monitoring progress. Next, information was gathered on current processes used in the company, and causes identified for poor processes, or variation in the processes used. A pilot programme was then put in place to tackle the reasons for these problems. Some of the new processes included good standard operating procedures for care delivery, urgency in rescheduling cancelled visits, up-to-date information being made available to staff on a timely basis, easier-to-complete forms highlighting key documentation points, and a new computer system.

McWilliam *et al.* (2007) meanwhile have looked at the cost-effectiveness of different methods of case management of home care. They quote studies showing that where the client manages the services received (rather than a case manager alone managing these, or a case manager working with the client), there are lower costs – and improved outcomes for clients in terms of met needs, life satisfaction and health outcomes (see also Glendinning, (2012). McWilliam *et al.* studied 279 older people and people with disabilities receiving home care in Ontario over a period of two and a half years, comparing the costs where services were managed either by a case manager only, by the client with the case manager, or by the client only. In this study, the clients did not directly employ the carer, but had control over decisions such as the type of service received, its timing, frequency and duration. The researchers found that the overall average cost per month of services for clients in the three groups did not differ significantly over six or more months. However, where clients managed the services themselves, any increases in care costs were significantly lower than among those whose services were managed by a case manager, with intermediate cost increases where the services were managed

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[55]   See http://en.wikipedia.org/wiki/Six_Sigma, accessed 11 July 2012.

by a case manager and client together. This suggests that offering clients the choice of involvement in their case management not only provides clients with independence and control, but is also cost-effective.

4.5.3   Intensive, Short-Term Home Care

In the UK, home care 'reablement' services are becoming popular, and studies show that they reduce the need for subsequent home care. Reablement is defined as 'services to people with poor physical or mental health, to help them accommodate their illness by learning or re-learning skills necessary for daily living' (Glendinning & Newbronner, 2008: 33). Typically, the services provided are personal care, and help with mobility and other practical tasks for a time-limited period (usually six weeks), so that the users develop both the confidence and practical skills to carry out these activities themselves. Service provision usually involves occupational therapists and specialised equipment, as well as home care workers. The services are focused on either those who have been discharged from hospital, or those referred for home care services by primary health care workers. The vast majority of users are over 65.

There are few rigorous studies on the cost-effectiveness of reablement, but a small-scale evaluation of its use in Leicestershire[56] showed that after three months, between 58 and 62 per cent of those who had received reablement no longer received home care, compared to only 5 per cent of those who had not received reablement. In fact, 71 per cent of those who had not received reablement still had home care three months later, compared to between 10 and 17 per cent of those who had. The average reduction in hours of ongoing care required was 28 per cent (CSED, 2007: 4), although the reablement groups did have higher levels of service initially (see Glendinning & Newbronner, 2008). A larger study of four local authorities[57] showed that two years following reablement, only a minority of clients needed more home care than they were initially provided following reablement. This suggests that the skills and attitudes gained through reablement help sustain service users for a relatively long period (CSED, 2007). Unfortunately, these studies do not calculate whether savings are associated with reablement over the longer term, but the fact that reablement is associated with a reduction in long-term use of home care suggests that there could be savings.

4.5.4   Contracting Home Care From Private and Voluntary Providers

Home care in many countries has traditionally been provided by the public sector, but home care is increasingly contracted out to private or voluntary bodies, a route that has been found to cut costs. Drake & Davies (2006) outline a 2004 review of home care in Swansea, which noted that it cost £11 per hour for outsourced home care, compared to £18 for that provided in-house by the public sector. In 2003 in

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[56]   This study looked at 92 service users.

[57]   This study looked at 2,667 service users.

Bridgend, corresponding costs were £10.23 and £13.08. They cite Laing & Saper (1999), who reported that compared to the public sector, private providers offer less generous terms to care workers and this is a primary reason why they can deliver home care at lower cost. Additional savings for State bodies may be gained from the manner in which services are contracted out. For example, contracting out to a small number of providers decreases the complexity of communicating with and monitoring a high number of providers (Drake & Davies, 2006).[58] Similarly, establishing fixed price contracts can reduce the complexity of dealing with different costs paid to providers, depending on factors such as time of care delivery (day, evening or weekend). In Croydon, this practice led to 119 different costs that could be paid to providers (see Davies & Drake, 2007), complicating invoicing and payment systems. Local authorities that come together to commission home care from providers through one joint contract also have the ability to negotiate lower prices (Drake & Davies, 2007).

However, other studies (Netten *et al*., 2004; Netten *et al.,* 2007) indicate that clients receiving care from State providers were more satisfied than those receiving care from independent providers. Netten *et al.* (2007), in a study of 9,254 clients of 121 UK home care providers, have found that higher perceived levels of quality are associated with an older care workforce; a more highly trained workforce; more staff who had been employed by the provider for over five years; a higher proportion of staff with guaranteed working hours; higher female wage rates relative to local rates; and providers that allowed at least ten minutes for travel between clients. They found that virtually all of these workforce and organisational factors were associated with in-house rather than contracted-out provision. Their findings overall suggest that the nature of the workforce, in terms of age and experience, staff turnover, and allowance for travel time, was the most critical influence on service user experiences of service quality. Review of costs and quality in residential care for older people (see NESC, 2012c) has shown that low staff turnover not only helps maintain quality care but also reduces costs. It is likely that this would apply in home care also, which provides another argument for having employment practices that reduce staff turnover. Netten *et al.* (2007) also found that service quality was reported as higher where the provider had flexibility to vary the hours of care given, and the way hours were used, within agreed limits. Given that cost pressures mean that contracting out is unlikely to be reduced, the authors suggest that to ensure good quality care, commissioners of home care need to ensure a high quality workforce, adequate time for travel, and a trusting relationship that permits flexibility.

It is also relevant here to reconsider the arguments of Davies & Drake (2007) on the need for State organisations commissioning home care to ensure that their practices support an adequate number of flourishing providers. Financially weak

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[58]   Although the authors also note that contracting a small number of providers could shift the power in the marketplace too much towards these providers. In the Irish case, the high proportion of HSE-approved providers who are small companies operating under franchise may provide a good balance between the know-how and processes developed by large franchisor companies, and competition among smaller providers.

and ultimately unsustainable businesses cannot invest to deliver best value and continuous improvement. Commissioning care from too few private providers, while easier to manage in the short-term, could lead to fewer providers, a lack of competition, and a swing towards provider power in the longer term. Such a change might not be positive for the cost and quality of home care services.

4.5.5   Summary and Implications for Practice in Ireland

This review of research on costs and quality in home care indicates that a number of mechanisms can be used to decrease costs, while maintaining or improving quality. First, improvements in operational management can help. Such changes can include improving process management; cutting out repetition of needs assessment; providing client input to case management; and putting in place IT systems that optimise staff schedules and route planning, monitor time spent with clients, and automatically bill the commissioning body. Contracting out home care to private and voluntary providers also helps reduce costs, while providing short-term intensive reablement services can reduce the amount of home care subsequently needed by service users.

The InterRAI system recently piloted in Ireland could reduce repetition of needs assessment for clients. It could also increase the shared data collected, which could facilitate exchange of information between different professionals, and also allow monitoring of cost and quality. If InterRAi was linked to financial information provided by the service user, this could help reduce duplication of effort in means-testing for services (NESF [2009] reported that older people were often means-tested separately for home care, residential care and other services).

In relation to client management of services, the home care grant that allows service users to employ carers privately is being phased out by the HSE, but the fact that involving clients in case management of home care services can reduce costs suggests that Irish practice may benefit from allowing clients greater involvement in managing their services themselves, even if this does not extend to the client employing the care provider.

The successful use of Six Sigma to reduce costs in a US home care provider meanwhile suggests that optimising work processes could reduce costs while maintaining quality.

Several of the remaining factors that can reduce costs while ensuring quality care are linked to contracting out home care. The role of the HSE (or its successor) in future will be important in this regard, given that more home care is now being contracted out.[59] Experience from the UK suggests that it will be important that the contracting processes used by the HSE ensure good quality care, good employment

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[59]   The HSE annual reports for 2010 and 2011 show a decline between the two years in home help hours (which are less likely to be contracted out), and an increase in home care package hours (which are more likely to be contracted out) (HSE, 2011b; HSE 2012)..

conditions (to reduce turnover), a variety of good home care providers in the market (to ensure competition),[60] some flexibility (within agreed limits) for providers to alter services to suit client needs, as well as adequate data to monitor the quality and cost of care. It may also be useful for the HSE to support providers in putting IT systems in place, to promote optimum use of data, timetabling of staff, staff monitoring, automatic billing, etc., as not all providers may be in a position to support the investment that this requires, and it has been shown that it can reduce costs for both providers and commissioners of home care. It will also be important to ensure that contracting on a national rather than local scale continues under the HSE's successor, as this economy of scale can allow better negotiation on prices and reduce the need for local health service offices to 'reinvent the wheel'.

Increased contracting out of home care in the UK has led to increased monitoring of the care provided on behalf of the State by independent providers. Providers there must register with the Care Quality Commission, comply with sixteen core national quality and safety standards, and have regular inspections (announced and unannounced) (Glendinning, 2012). This suggests that there will be a greater need for adequate regulation and monitoring as more Irish home care is contracted out. The recommendations of the LRC (2011) provide a blueprint on how to do this.

4.5.6   What Costs are Likely to be Generated by Regulation of Irish Home Care?

It is difficult to assess the costs of actually implementing the various draft standards for home care in Ireland. Timonen & Doyle (2007: 13) consider that 'increased regulation [of home care in Ireland] ... would have substantial ramifications in the form of e.g. the costs of mandatory training and supervision'.   However, it is likely that these costs would differ for private, public and voluntary providers. A number of private home care providers already provide care in line with several of the draft standards, and so are unlikely to generate significant extra costs in meeting them. Other private providers would face higher costs, as they would have some work to do to meet the draft standards.   Meanwhile both private and public sector representatives interviewed for this research were of the opinion that the costs for the HSE of meeting the standards could be quite high [R1, R2, R7]. For example, the HSE has not traditionally required home care workers to have Fetac Level 5 training, while a number of private providers already require this. This means that the cost to the HSE of ensuring its existing staff meet that level of training would be higher. The relatively high costs for the HSE of meeting the draft standards may be one reason why contracting out of home care has been increasing.

One provider [R13] spoke of tradeoffs in relation to cost, feeling that it would be possible to provide very high quality care for a small number, or low quality care for

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[60]   Although an optimum balance in the number of providers would be needed, as commissioning care from a high number can take up a lot of management time in the commissioning organisation.

a lot of people, or somewhere in the middle – but that high quality care for all would be too expensive.

On the other hand, one stakeholder [R1] outlined how all 200 home care providers operating in Ireland could be audited twice a year by a team of ten auditors for less than a million euro per year, which would be a very low proportion of the third of a billion euro currently spent each year on home care. He argued that the relatively small amount of funding required to put such an inspection mechanism in place would provide very strong motivation to home care providers to improve the quality of their service, and was likely to lead a drive for improvement right across the sector, as had already occurred in residential care since the introduction of the HIQA standards.   So while the business costs of ensuring that standards are implemented may be high in the short term, in the longer term a better quality of care would ensue, which would provide much better value for the public monies spent. And as outlined earlier in this section, a variety of practices can be used to help reduce costs, while improving or maintaining quality. Implementing these could help offset any costs of regulating and inspecting home care. In the longer term, such approaches would enable many older people to remain in their homes, which is what many desire, with greater protection.

Chapter 5
Summary and Conclusion

5.1   Introduction

This final chapter summarises the home care standards frameworks drafted, and then how they are relevant to the five key themes of this NESC project, which are: responsive regulation; the role of the service user; learning; devolution and accountability; and addressing costs while improving quality. It then briefly considers the three questions posed in the Overview report (NESC, 2011) in relation to the draft home care standards. These are: how convincing is this regulatory and standards framework? To what extent does it (a) prevent the most serious harms, and (b) promote quality? And – are there things in this standards regime that need to change to ensure the provision of quality services?

5.2   Summary of the Development and Application of Standards and Initiatives to Improve Quality in Home Care

Following increasing calls for standards to ensure quality in home care, a number of standards have been drafted on behalf of the State since the mid-2000s. The first were the HSE draft home care standards (begun in 2005), and their requirements were subsequently incorporated into a number of the later standards frameworks developed. Currently, three of the six standards frameworks developed are being implemented. One is being implemented by member companies of the Home Care Association, for care delivered by these private home care operators; another is the HSE's standardised procedures for home care packages, which contain some provisions that promote quality in the home care packages provided by the HSE. However, the Home Care Association standards are entered into on a voluntary basis, and the standardised procedures for home care packages do not contain a large number of provisions on quality standards. In addition, these two standards frameworks do not apply to all types of home care. The third standards framework that is being implemented from 1 July 2012, the HSE tender for provision of home care packages, is a more comprehensive framework. It contains many provisions to ensure greater quality in home care packages that the HSE outsources. It is a different framework to promote standards than others being implemented in Irish residential care for older people. Rather than licensing providers who have been inspected to ensure that they provide a required standard of care (as happens in residential centres for older people), the tender only pays providers to deliver care

on behalf of the State once these providers have demonstrated that they have procedures in place to ensure a high standard of care. One person interviewed characterised the introduction of the tender as 'regulation by the back door'.

The Government also committed in 2011 to bringing in standards for home care, which would be inspected by HIQA. The recent LRC (2011) publication on regulation of professional home care includes specific guidance on how the Health Act 2007 can be amended to do this. This Government commitment is comprehensive, as it seems that it would cover all home care provision, whether it is commissioned privately or by the State.

In addition to these standards frameworks, a number of private home care providers have also been accredited with the Q Mark or ISO standards, and a number of voluntary home care providers apply continuous improvement methodologies, to ensure a level of quality in their service and management.

Progress to date on implementing the various standards frameworks that exist indicates that these are most likely to be applied to home care packages, and in home care that is not provided by the HSE. Applying standards to home help services (particularly those delivered directly by the HSE) is progressing more slowly.

5.3   Responsive Regulation

To date, self-regulation has been the key mechanism used to promote quality in home care. Sanctions to ensure implementation of the draft home care standards are weak, which is linked to the fact that few of the standards frameworks are being implemented or have legal backing. Currently, the tender to provide home care packages has the strongest enforcement mechanisms, although it remains to be seen how they will be monitored and enforced in practice. Adequate mechanisms to ensure implementation of standards (be they inspection, licensing, sanctions, and/or support) are essential. The LRC (2011) has provided a blueprint for such regulation in home care.

Meanwhile, supports to help service providers implement quality standards are quite limited. Private and voluntary sector home care operators who decide to seek standards accreditation receive support from accreditation inspectors. Under the 2011 tender for home care packages, providers must meet required standards themselves, without support, in order to compete for contracts from the HSE. Meanwhile, the HSE is providing some supports to its staff to ensure greater quality in provision of home care packages, such as standardised information booklets and assessment procedures, and training to relevant staff. However, these supports only apply to a small range of home care provision, and do not yet cover, for example, the home help services delivered directly by the HSE. In addition, as the HSE (or its successor) contracts out more home care provision, it will need to consider how it can support quality practices in these contracted-out services. To date, it has played a key role as a 'networking institution', bringing together a variety of different stakeholders to agree a standards framework that will have buy-in with all home

care operators. However, in future it may need to play a more supportive role in ensuring that the right conditions are in place for quality improvement standards to be implemented in a range of service providers.

5.4   Involvement of the Service User

The involvement of the service user is stressed in all the standards frameworks drafted to date, which state that they are to be involved in decisions on the care given to them. However, in practice it seems that reductions in HSE care budgets mean that the older person has less say in the type of care they would like to receive, with the time available increasingly determining the quantity, and quality, of care given. Nevertheless, providing the service user with greater scope to manage the services they receive has been associated with better outcomes and lower costs in Canada, which suggests that it might be useful to involve older people to a greater extent in future in Ireland. The ability of the older person to choose how to spend funding that they may be allocated for home care has also been reduced, as home care grants that could be used by an older person to directly employ a carer of their choice are being phased out. In contrast with other jurisdictions, the Irish State does not provide supports, such as the availability of an intermediary to take on employer responsibilities, i.e. to assist an older person directly employing a carer. A recent LRC report (2011) recommends that older people should have the option to contract for home care through intermediary bodies which take on employer responsibilities for them. Although the draft standards to promote quality in home care to date are very much modelled on care provided through a home care organisation, it would also be possible to monitor home care provided by individual home care workers, requiring, for example, registration of all home care workers, and monitoring their work through random audits. It would also be useful to keep on eye on developments in this in the UK, where use of personal budgeting and other schemes to allow service users more choice in the services received and from whom, are more advanced than in Ireland.

5.5   Learning

In terms of learning, the HSE has established a number of internal learning mechanisms, such as task groups and best practice groups, to take on board learning from implementing the various standards frameworks. The original draft home care standards, prepared by a group of stakeholders in 2005, have also been progressed by different working groups over time. For example, they have been incorporated into the later tender for home care packages, and into the draft guidelines for the home help service.

All of the draft standards frameworks reviewed here also require home care organisations to put procedures in place to regularly improve their service, and to

assess its quality, in conjunction with the service user. This mechanism should allow learning on the quality of the service to take place within organisations.

However, currently there is no co-ordinated learning mechanism to draw together the different approaches used to promote quality improvement, and to assess their effectiveness. Voluntary industry groupings, companies gaining accreditation, and HSE-led task groups do come together to share knowledge on the best ways to achieve quality services, but not all home care providers are involved in these. It seems also that there is not much sharing of knowledge on how to reach the draft home care standards that exist. As home care providers do not need to meet mandatory standards, there is less motivation for them to e.g. employ a private company that can advise on the best way to meet a standard, which a number of residential centres for older people do. In addition, the fact that tendering organisations are in competition with each other to gain business from the HSE to provide home care packages may mean that they are less likely to come together to share knowledge.

Nonetheless, it can be both cost-effective and useful to share learning on best practice. In future, it might be helpful for HIQA and the HSE (or its successor) to learn from the system of supports developed for those implementing standards devised by the Hospice Friendly Hospitals programme to implement quality end-of-life care standards in hospitals (outlined in NESC, 2012b). This programme provides many supports (including guidance on governance, training, and practical resources) to both management and frontline staff to implement new standards to improve the quality of care.

In terms of data to support learning, the tender for home care packages contains provisions that will allow the HSE (or its successor) receive data from service providers to help it monitor the quality of service provided. This, as well as the InterRAI project recently piloted by the HSE, could help more data be collected in future to help assess quality, costs and outcomes, and to compare these across different organisations.

5.6   Devolution and Accountability

The range of standards developed for home care to date shows the extent of devolution to local actors in this area. These different draft standards have allowed a range of possibilities for multiple routes to quality to be developed – from the voluntary inspection regime adopted by Home Care Association members, to the requirements for tendering organisations to meet these standards before they can be contracted by the HSE to deliver home care, and the work of voluntary home care organisations to devise ways to meet these standards and have them accredited by private accreditation bodies. These are three different approaches, all of which aim to implement similar quality goals.

However, the framework that exists to promote quality in home care is voluntary, with no mechanism currently in place to ensure that all home care providers meet

the goals of the draft quality standards. For the vast majority of home care provided in Ireland, there is no inspection or reporting regime to ensure that a certain quality standard is reached. Local units have too much discretion under this framework, so that more binding mechanisms to ensure that the framework is implemented are needed. Overall, there are elements of a quality improvement framework in place, but the home care area is missing a legislative underpinning to ensure that it is put into operation. The LRC's (2011) report outlines legal mechanisms that could be put in place to do this, which could be used to ensure that the Government's commitment to bring in national standards for home care services, subject to inspection by HIQA, is implemented. Wide scale mandatory implementation of the draft standards available, and inspection against these, is needed to ensure more consistently safe and quality home care. The organisation which succeeds the HSE will also need to continue to develop the work which it has done to date to progress standards in home care.

5.7   Addressing Costs While Improving Quality

Some stakeholders interviewed believe that the cost of bringing in standards for home care would be high, while others argue that a good standards and inspection regime would comprise a very small proportion of the entire budget spent by the State on home care, but would provide strong motivation to increase standards of care. Certainly, experience in other countries indicates that a variety of mechanisms can be used to maintain or improve quality in home care, while also reducing costs. These include improvements in operational management, such as cutting out repetition of needs assessment; providing client input to case management; putting in place IT systems that optimise staff schedules and route planning, monitor time spent with clients, and automatically bill the commissioning body; contracting out home care to private and voluntary providers; and providing short-term intensive reablement services to reduce the amount of home care subsequently needed by service users. Adoption of these mechanisms could help offset any costs that might be associated with implementation of the draft home care standards.

5.8   The Overall Effectiveness of Quality and Standards in Home Care

Finally, the three over-riding questions set in the Overview report of this series (NESC, 2011) are briefly addressed.

First, how convincing is this regulatory and standards framework? To answer, although draft standards for home care have been developed and are being progressed, and are helping to promote quality in home care provision, at the time of writing only the care provided through contracted-out home care packages must conform to one of these standards frameworks. The predominantly voluntary

nature of the standards frameworks that exist seriously compromises their ability to prevent abuse and serious harm in home care.

Second, to what extent does the standards framework (as it exists) prevent the most serious harms and promote quality? A number of private and voluntary providers of home care have taken initiatives to promote quality improvement through various accreditation mechanisms; and the tender for home care packages requires organisations awarded it to have continuous improvement mechanisms in place. In HSE services, the constant push to progress the 2008 draft standards for home care is a form of quality improvement. However, it would be much more effective if implementation of the various draft standards was mandatory, and monitored.

And finally, what needs to change in this standards regime to ensure provision of quality services? To date, progress has been made in applying standards to home care packages contracted to private and voluntary providers by the HSE, but the services provided directly by the HSE, especially home help care, need to apply the standards also, particularly as the majority of formal home care is provided through the HSE home help services. Care commissioned privately by individuals is also not covered by any of the draft standards. The key message is that the draft standards developed and unevenly applied need to be progressed further to implementation and inspection, and applied to all formal home care for older people, to ensure that this care is consistently safe and of high quality.

Appendix A
Institutions, Agencies and Frameworks Relevant to Quality and Standards in Care of Older People,
May 2011

This list outlines all of the national organisations and documents relevant to eldercare in Ireland, and is modelled on a framework to list such groups and documents developed by Carney *et al.*. (2011).

While reading it, bear in mind that some organisations and documents serve a number of purposes, so it can, for example, be difficult to decide whether a document should be categorised as a strategy or a framework, or a piece of research.

Organisations
Government departments
Department of Health

Executive offices in Government departments
Office for Older People (in Department of Health), est. 2008
Nursing Policy Division (in Department of Health)

State agencies
HIQA (Health Information and Quality Authority), est. 2007
HSE (Health Services Executive), est. 2005, due to be closed by current Government
Irish Health Services Accreditation Board (IHSAB), est. 2002, merged into HIQA in 2007
National Council for Ageing and Older People, est. 1997, dissolved in 2009
National Council for Professional Development of Nursing and Midwifery, est. 2001, dissolved in 2011
An Bord Altranais, est. 1950
Office of the Ombudsman

Offices in State agencies
Office of the Nursing and Midwifery Services Director (in HSE)
Nursing and Midwifery Professional Development Units (in HSE)
Office of Advocacy Services (in HSE)

Advisory groups (set up to advise on policy development)
Expert Advisory Group on Services for Older People (in HSE), est. 2005, closed *circa* 2009
Interagency group developing draft standards for home care services (under HSE, 2008)
Task Group on home help and home care standards (in HSE), est. 2010
Commission on Patient Safety and Quality Assurance
Law Reform Commission
Working Group on Long Term Care

Hospice Friendly Hospitals national steering committee
Hospice Friendly Hospitals advisory team

Multi-stakeholder alliances (set up to implement a policy)
National Advocacy Programme Alliance (NAPA)
Health and Social Care Regulatory Forum

Social partnership institutions/forums
N/A

Participatory forums: citizens
Forum on Services for Older People (HSE's Office of Advocacy Services)
Volunteer Panels (HIQA)

NGOs
Age Action
Alzheimer Society
Irish Senior Citizens' Parliament
Age & Opportunity
Irish Hospice Foundation/Hospice Friendly Hospitals programme

Older Women's Network
Third Age
Older & Bolder

Industry associations/lobby groups
Nursing Homes Ireland
Home Care Association

Documents
International agreements
Madrid International Plan of Action on Ageing, 2002

EU strategies
N/A

Legislation
Health Act 2004 (which established the HSE)
Health Act 2007 (which established HIQA), and its amendment
Health (Homes for Incapacitated Persons) Act 1964
Health (Nursing Homes) Act 1990

Regulations
SI No. 44/1966 – Homes for Incapacitated Persons Regulations, 1966
SI No. 317/1985 – Homes for Incapacitated Persons Regulations, 1985
SI No. 226/1993 – Nursing Homes (Care and Welfare) Regulations, 1993
SI No. 236/2009 – Health Act 2007 (Care and Welfare of Residents in Designated
        Centres for Older People) Regulations, 2009, and amendments
SI No. 245/2009 – Health Act 2007 (Registration of Designated Centres for Older
        People) Regulations, 2009, and amendments

Standards

National Quality Standards for residential care settings for older people in Ireland,
published 2009 (HIQA)

Draft National Quality Guidelines for Home Care Support Services (drafted in 2008)
(HSE)

National Guidelines and procedures for standardised implementation of the home
care packages scheme (2010) (HSE)

National Standards for the provision of home care support services (2010) (HSE)

Invitation to tender for the provision of high quality, enhanced home support and
personal care services for older people, to complement existing community
services (2011) (HSE)

Service-level agreements between HSE and funded organisations (HSE)

Tender document between HSE and providers of home care packages (HSE)

Quality standards for End-of-Life care in Acute Hospitals (no date) (Hospice Friendly
Hospitals programme)

Acute Care Accreditation Scheme: a framework for the continuous improvement of
the quality and safety of patient-client-centred care (IHSAB – now part of
HIQA

*Governmental Strategies, Policies & Plans (plans of action that determine decisions,
actions)*

The Care of the Aged (1968)

The Years Ahead: A Policy for the Elderly (1988)

Quality and Fairness: a health system for you (2001)

Report of the Working Group on Long Term Care (2008)

National Development Plan, 2000–2006

National Development Plan, 2007–2013

National Anti-Poverty Strategy

A review of practice development in nursing and midwifery in the Republic of
Ireland and the development of a strategic framework (DoHC, 2010)

Health Information Strategy, 2004

Partnership agreements

Sustaining Progress, 2003

Towards 2016, 2006

Non-governmental strategies and plans

Voluntary code of practice for nursing homes, 1995

Frameworks (conceptual frameworks that can be used to develop Strategies)

Building a Culture of Patient Safety (Report of the Commission on Patient Safety and
Quality Assurance)

Report of the Interdepartmental Working Group on Long Term Care, 2005

Framework for Public and Service User Involvement in Health and Social Care
Regulation in Ireland (by the Health and Social Care Regulatory Forum)

Reports/research/data
OECD: Long term care for Older People (2005)
NESF: Care for Older People (2005)
NESF: Implementation of the Home Care Package Scheme (2009)
Annual Output Statement, Health Group of Votes (annual)
Long Stay Activity reports (annual, Department of Health)
Report of the Commission of Investigation (Leas Cross Nursing Home)
Assessment of costs of national draft quality standards for residential care settings
    for older people in Ireland, 2009 (commissioned by Dept of Health and
    Children as part of a Regulatory Impact Assessment, from PA Consulting)
Assessment of costs of national draft quality standards for residential care settings
    for older people in Ireland: International benchmarking, 2008
    commissioned by Department of Health and Children as part of a
    Regulatory Impact Assessment, from PA Consulting
Nursing Home Standards Regulatory Impact Assessment (Dept of Health and
    Children, 2009)
Legal aspects of carers (consultation paper published by Law Reform Commission,
    2009)
Legal aspects of professional home care (final report published by Law Reform
    Commission, 2012)
National Audit of End-of-Life Care in Hospitals in Ireland, 2008/9 (Hospice Friendly
    Hospitals)
Who Cares? An investigation into the right to nursing home care in Ireland (2010)
    (Office of the Ombudsman)
The Implementation of a model of person-centred practice in older person settings:
    Final report (2010)
Enhancing care for older people: A guide to practice development processes to
    support and enhance care in residential settings (2010)
National Advocacy Programme for older people in residential care evaluation (2011)
High level review of the HIQA inspection process for residential care settings for
    older people (report commissioned by NHI)

Actions
Programmes/projects/initiatives/funding schemes
Fair Deal (Department of Health and Children)
Practice development (HSE/National Council for Professional Development of
    Nursing and Midwifery)
Volunteer advocacy programme
Myhomefromhome.ie
Teaghlach (HSE)
Nursing Homes Nursing Projects (private sector)
Hospital Friendly Hospitals supports to acute and community hospitals
National Treatment Purchase Fund

Monitoring mechanisms
HIQA inspection reports

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