

**Health and Social Care Committee
HSC(4)-12-12 paper 5
Inquiry into residential care for older people -
Paper by Prof Andrew Kerslake**

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**Evidence and analysis for the
Framework of Services for Older
People: A collection of papers for the
Welsh Assembly Government**

**Paper 4: Issues and interventions at
the health and social care interface.**

February 2011

Paper4: Part 1 Issues at the health and social care interface

1 Introduction

The following material is based on audits conducted by a range of organisations but chiefly from the Royal College of physicians. Where data is available for Wales that information has been identified and included.

2 Stroke¹

2.1 Location of stroke patients

Standard: All patients with suspected stroke should be admitted directly to a specialist acute stroke unit unless they need more intensive care, for example on an intensive care unit.

Key findings: The aim should be to admit all stroke patients directly to a stroke unit, but almost half of hospitals report the need to admit patients to non-specialist beds because of bed shortages.

Results: (a) In Wales, there are fewer numbers of beds in stroke units per hospital in 2010 than in England. There are also fewer stroke unit beds than there are stroke patients and far fewer hospitals with stroke units meet the five key characteristics², ie, markers of stroke unit organisation.

	All hospitals in the audit	Wales	England	Northern Ireland
Median number of stroke beds in stroke units per hospital in 2010	26	21	28	15
Ratio: Median number of stroke unit beds per stroke inpatient*	1.07	0.91	1.08	1.03
Hospitals with stroke units who meet all five Key Characteristics	38%	14%	42%	17%
* A value of 1 indicates that there are equal numbers of stroke patients and stroke unit beds on the day of the audit. If the number is less than 1, there are more stroke patients than stroke unit beds.				

(b) Wales has fewer beds pro rata than England for stroke patients. Given that the population of Wales is approximately 3 million and that of England is 51 million, England is approximately 17 times larger; England has 71 acute stroke

¹ Based on "Organisational Audit 2010", Public Report England, Wales and Northern Ireland, Clinical Effectiveness and Evaluation Unit, Royal College of Physicians of London, August 2010.

² The five key characteristics (markers of stroke unit organisation) are:

- Consultant physician with responsibility for stroke
- Formal links with patient and carer organisations
- Multidisciplinary meetings at least weekly to plan patient care
- Provision of information to patients about stroke
- Funding for external courses and uptake

units and using this estimate, Wales should have 4 acute stroke units. In fact it has only 2 acute stroke units.

Acute Stroke Units – beds dedicated solely for the first 72 hours after stroke	All hospitals: 75 units	Wales: 2 units	England: 71 units	Northern Ireland: 2 units
Median number of beds per Unit	6 beds	6 beds	8 beds	5 beds
Combined Stroke Units - beds used for both pre and post 72 hour care	All hospitals: 146 units	Wales: 12 units	England: 122 units	Northern Ireland: 11 units
Median number of beds per Unit	22 beds	19 beds	23 beds	14 beds

Key findings: Rapid transfer of stroke patients by ambulance: for acute care to be effective, patients need to be taken as quickly as possible to a unit that is equipped to provide acute stroke care.

Results: There remain some parts of the country, particularly in Wales, where systems are not in place with the ambulance service to identify acute stroke patients and transfer them rapidly to hospital.

	All hospitals in the audit	Wales	England	Northern Ireland
Percentage of hospitals with arrangements in place to transport patients with acute stroke symptoms rapidly to hospital	38%	67%	95%	92%

Key findings: Only a few stroke services providing care to patients in the first 72 hours meet all the seven quality criteria³ identified as being markers of high quality.

Results: Criteria used to measure acute quality of care for stroke patients in the first 72 hours after stroke in Wales compared with England and Northern Ireland:

Acute Stroke Units	All hospitals: 75 units	Wales: 2 units	England: 71 units	Northern Ireland: 2 units
Stroke unit beds with all 7 acute criteria	13%	0%	14%	0%
Stroke unit beds with 6 or more acute criteria	37%	0%	38%	50%
Combined Stroke Units	All hospitals: 146 units	Wales: 12 units	England: 122 units	Northern Ireland: 11 units
Stroke unit beds with all 7 acute criteria	3%	0%	4%	0%

³ The seven quality criteria are as follows:

- 1) Percentage of beds with Continuous physiological monitoring (ECG, oximetry, blood pressure)
- 2) Immediate access to brain scanning
- 3) Admission procedure to stroke unit
- 4) Specialist ward rounds at least 7 times a week
- 5) Acute stroke protocols/guidelines
- 6) Nurses on duty trained in swallow screening
- 7) Nurses on duty trained in stroke assessment and management

Stroke unit beds with 6 or more acute criteria	26%	0%	30%	18%
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2.2 Thrombolysis (clot busting treatment)

Standard: Patients seen within four and a half hours of developing symptoms should be considered for thrombolysis; when given to the right patients, at the right time, it can dramatically reduce the risk of long term disability.

Key findings: There has been a dramatic increase in the number of units providing a 24 hours per day, 7 days a week thrombolysis service for their population.

Results: Progress in Wales on delivering comprehensive acute stroke care including thrombolysis is slow:

Acute Stroke Units	All hospitals	Wales	England	Northern Ireland
Percentage of sites currently providing an on-site 24/7 thrombolysis service	28%	0%	33%	8%
Percentage of sites currently providing a 24/7 thrombolysis service, on-site only or in collaboration with neighbouring sites	50%	0%	57%	25%

2.3 Staffing

Key findings: Overall staffing levels in stroke units in Wales are somewhat lower than in England and Northern Ireland. Results: Median number of qualified staff, per 10 beds, are as follows:

Acute Stroke Units	All hospitals	Wales	England	Northern Ireland
Median number of qualified nurses/assistants on duty per 10 beds	3.2	2.9	3.2	3.3
Median number of junior doctor sessions per week per 10 beds	8.3	7.6	8.3	7.2

2.4 Early Supported Discharge Teams (ESD)

Standard: Community-based stroke-specialist rehabilitation teams, such as Early Supported Discharge (ESD) teams, can provide better and potentially more cost-effective outcomes than exclusively hospital-based rehabilitation for stroke patients with moderate disabilities.

Key findings: There are continued low levels of access to specialist stroke early supported discharge (ESD) with under half of the hospitals having such a team.

Results: Wales lags behind England and Northern Ireland in the provision of this service, as follows:

Access to:	All hospitals	Wales	England	Northern Ireland
Stroke/neurology specific early supported discharge multidisciplinary team	44%	7%	45%	83%

2.5 Management of Transient Ischaemic Attack (TIA) or mini-stroke

Standard: High-risk TIA patients should be seen, investigated and treatment initiated within 24 hours of onset of symptoms. For low-risk TIA patients the time frame is one week.

Key findings: High-risk patients are still not being seen quickly enough. A third of centres admit high-risk TIA patients in order to access specialist assessment. Almost half of centres admit low-risk TIAs, which is probably a wasteful use of resources.

2.6 Vocational Training for patients of working age

Standard: All people who wish to return to work (paid or unpaid employment) and have persisting problems after their stroke should be offered specialist advice, rehabilitation and support to get back to their work or to find an alternative job.

Key findings: Less than half of services specifically run a service that provides educational or vocational training for patients of working age although this should be regarded as a core element of all stroke services. This seems at variance with government policy (both present and previous) which stated the desire to encourage people off disability and sickness benefits and a focus on improvement in rehabilitation.

2.7 User Involvement and Information

Standard: Patient and carers should be provided with comprehensive information about the services they may need and how to access them on discharge from hospital, as well as on how to prevent further strokes.

Key findings: Over half of stroke services are still lacking comprehensive formal links with user groups of patients and carers that include areas of service provision, quality and planning. 40% of stroke patients are not given a personalised rehabilitation discharge plan and 29% still have no named point of contact on discharge.

3 Falls⁴

Key findings

- Risk assessments in A&E departments and Fracture services are inadequate.
- Services with Falls Coordinators and Fracture Liaison Nurses have systems in place to identify high risk fallers.
- Most trusts have developed inpatient falls policies, but only a third know their in-patient falls rates.
- Important public health information on fracture rates is inadequate or not collated.
- Only 39% of commissioning trusts report being compliant with the NICE technology appraisal on secondary prevention of osteoporotic fragility fractures.
- Only 24% of commissioning trusts have audited bone health prescribing in their local primary care and even less know their local fragility fracture rates.
- Patients with first fractures are not flagged up for secondary prevention.
- Many of the exercise programmes being provided are not evidence based.
- Too few services use patient-agreed treatment plans.
- Assessments for safety at home could be better. Home hazard assessment along with advice on safe and effective performance of activities of daily living is a proven component of falls reduction programmes, particularly if patients have experienced a recent change in health such as a hospital admission or injurious fall. But only 41% of sites include a validated approach to this aspect of falls prevention.
- Patient uptake and adherence to active interventions that include changes in health related behaviour does depend on information and explanation for patients. This is highlighted in the NSF, but only 35% of sites provide a written agreed intervention plan for their patients after an assessment.
- Half of trusts (52%) providing falls services did not provide any training to care homes or guidance on when residents should be referred to falls services; indeed a quarter (24%) provided no access to these services for care home residents.
- Too few services (51%) use patient's views to support and guide service improvement. The CEEU, in collaboration with Help the Aged, has piloted a patient experience questionnaire suitable for use, which will soon be available for any trust to use.

Results:

- Seven Welsh Trusts and Health Boards⁵ (27%) have a written local commissioning strategy regarding falls prevention; the information was not available from 15 Trusts (58%). Nationally, 66% of primary care

⁴ National Audit of the Organisation of Services for Falls and Bone Health of Older People, Healthcare Quality Improvement Partnership and Royal College of Physicians, March 2009

⁵ The structure of the health service in Wales changed after this audit. Therefore it is assumed that numbers refer to health boards and trust prior to re-organisation in October 2009.

organisations and 30% of Health and Social Care Trusts have a written strategy for falls prevention.

- Two Welsh Trusts and Health Boards (27%) have a written local commissioning strategy for bone health; the information was not available from 15 Trusts (58%). Nationally, 22% of primary care organisations and 30% of Health and Social Care Trusts have a written strategy for bone health.
- Eight Trusts and Health Boards (30%) have a local co-ordinated, integrated, multi-professional and multi-agency falls service. Nationally, 75% of primary care organisations, 50% of Health and Social Care Trusts, and 70% of Acute Trusts have this service.
- 15% of Welsh Trusts have a Fracture Liaison Nurse, compared nationally to 15% of primary care organisations, 60% of Health and Social Care Trusts, and 29% of Acute Trusts.
- 27% of Welsh Trusts provide written, agreed intervention plans which are given to patients, compared nationally to 44% of primary care organisations, 10% of Health and Social Care Trusts, and 28% of Acute Trusts.
- 35% of Welsh Trusts routinely screen older people who fall and attend A&E departments for risk of future falls. Nationally this figure is 33% of primary care organisations, 30% of Health and Social Care Trusts, and 50% of Acute Trusts.
- 32% of Welsh Trusts have a mechanism to record patients' views of the falls and bone health service. Nationally this figure is 58% of primary care organisations, 30% of Health and Social Care Trusts, and 50% of Acute Trusts.

4 Contenance⁶

4.1 Care

Key findings: Documentation of continence assessment and management for older people was described is poor even after a specialist assessment, There is a predominance of containment using pads and catheters which are frequently rationed.

Results: 58% of Welsh trusts⁷ have a written policy for the management of continence, compared with 86% of primary care providers nationally. Where bladder problems are an issue, 68% of primary care providers across England and Wales have a written continence care plan for patients aged 65 and over; in Wales this figure is approximately 32%. 64% of primary care patients aged 65 and over with bowel problems have a documented care plan; this figure is only 38% in Wales.

Sixty six percent of primary care sites impose a limit on provision. Half of Welsh trusts state that they have a written policy indicating that products are supplied

⁶ Based on National Audit of Continence Care – combined organisational and clinical report, Healthcare Quality Improvement Partnership and Royal College of Physicians, September 2010

⁷ The structure of the health service in Wales changed before this audit. Therefore it is assumed that use of the word 'Trust' here refers to the 7 new Health Boards.

on the basis of patient need; 42% did not answer this question. 84% of primary care providers nationally answered similarly.

4.2 Management and organisation

Key findings: There are clearly established protocols for integrated continence services yet they do not seem to be being followed.

Results: 50% of Welsh trusts have access to an integrated continence service, compared with 11% of primary care providers nationally. Across England and Wales only 4 services across the country fulfill all of the requirements set out in 'Good Practice in Continence Services (2000)' (DH) and reiterated in the National Service Framework for Older People. 50% of Welsh trusts have a structured programme of staff training for promoting continence, compared with 86% of primary care providers in nationally.

In each service there should be a Director of Continence Services or designated lead with responsibility for organisational change towards an integrated service. In acute hospitals, only 48% of self-reported integrated services have a designated lead or director. In primary care, only 40% of services meet this standard. Only 25% of Welsh trusts have a Director of integrated services, compared with 38% of primary care providers. 50% of Welsh trusts have Continence nurse specialists, compared with 99% of primary care providers nationally.

In hospitals, mental health care and care homes, staff with the requisite skills to perform a continence assessment are not always available to do so despite sites reporting that such staff are available. Structured training in continence care only occurs in 49% of acute hospitals and 39% of mental health care sites.

4.3 User involvement

Key findings: There is little evidence of users being involved in planning or evaluation of services.

Results: Only 16% of Welsh Trusts state that they have a user group for the continence service, compared to 24% of primary care providers across England and Wales. Only one Welsh Trust (8%) state that they elicit patient views, compared to 30% of primary care providers nationally.

5 Dementia⁸

Key findings:

95% of hospitals do not have mandatory training in dementia awareness for all staff whose work is likely to bring them into contact with patients with dementia.

About one-third of patients with dementia did not have a nutritional assessment recorded during their admission.

Fewer than half of patients received a formal mental status test upon admission to hospital or were formally tested for the presence of depression.

Less than a fifth of patients were referred to in-hospital psychiatry services. Less than half of those referred were seen within 48 hours. Over one third had not been seen after 96 hours.

Fewer than one in ten hospital executive boards regularly review re-admission data for patients with dementia, and only one in five regularly review information on delayed patient transfers.

A minority of hospitals said that they had a formal system in place for gathering information relevant to caring for person with dementia.

A minority of patient case-notes contained a section dedicated to collecting information from the carer, next of kin or a person who knows the patient well.

Few hospitals said that they had in place a system to ensure that staff on the ward were aware that a person had dementia and how it affected them, and that necessary information was imparted to other staff with whom the person came into contact.

⁸ Based on National Audit of Dementia (Care in General Hospitals) - Preliminary Findings of the Core Audit, Healthcare Quality Improvement Partnership and Royal College of Physicians, December 2010. Results for Wales are not disaggregated. This is also an interim report which summarises the key findings from an analysis of aggregated hospital-level data collected as part of the 'core audit' of the National Audit of Dementia. The final report will be published in late 2011 and will include findings from a more in-depth evaluation and site-specific results. This short interim report is published to avoid delay in making preliminary findings public.)

Paper 4: Part 2 Interventions at the health and social care interface

6 Introduction

The following table draws on a number of research sources in order to develop indications of best practice in the areas outlined in Part. However, it also brings in some of the wider factors at the interface and at the impact that some factors will have on others, ie often older people may have an interrelatedness of falls, strokes and dementia rather than single and separate conditions. It is often the inter-relatedness of these conditions that the health service seems to find hardest to address.

Intervention	Evidence
Interconnection of problems and social isolation	
Check for inter-connectedness.	<p>A lack of mobility may increase the likelihood of someone being incontinent because they cannot reach the toilet quickly enough. ⁹ Equally falls may occur because someone gets up in the night to go to the toilet.</p> <p>Older people who have had strokes will frequently have ongoing issues with mobility, maybe continence and sometimes dementia.</p> <p>People who fall and have a hip fracture may leave hospital with a continence problem they previously did not have.</p> <p>Support to carers of people who have had a stroke in terms of rehabilitation, benefits advice, lifting and handling may improve both the carers capacity to maintain someone in the community as well as maintain their own health.</p>
Home check for repairs need to make house secure and habitable. Use care and repair services where necessary. Take immediate action where home may increase the likelihood of falls. Check where falls have previously occurred and why the service user thinks this is happening.	<p>Concern over housing repairs can be a source of anxiety and a motivator towards care home admissions. They may increase isolation if people are ashamed of where they live and home circumstances may be a hazard for falls.</p> <p>Older women, especially those living alone struggle with maintaining homes as they get older in terms of DIY and require assistance with this¹⁰.</p>

⁹ Slack. M. et al (2008) FAST FACTS: BLADDER DISORDERS. Oxford: Health Press.

¹⁰ Care Services Efficiency Delivery (CSED) – Anticipating Future Needs (2007)

Intervention	Evidence
<p>If person is reluctant to go out due to continence issues look at mechanism and approaches for getting around this, eg, assisting service users to have an outdoor bag with ready supplies, helping service users plan a route out where there will be public toilets.</p>	<p>Improvements in continence can lessen social isolation as people gain greater confidence in going out.¹¹</p>
<p>Support worker to develop a 'before' and 'after' activity schedule, ie explore what the person used to do, where they used to go, why that has stopped and what maybe done to overcome potential fears and anxieties. Support worker to facilitate re-engagement with community life.</p>	<p>Higher levels of loneliness have been found to increase the likelihood of nursing home admission and to decrease the time until such an admission. The influence of extremely high loneliness on nursing home admission remained statistically significant after controlling for other variables, such as age, education, income, mental status, physical health, morale, and social contact, that were also predictive of nursing home admission¹².</p>
Mobility	
<p>Where people have had a previous fall(s) carry out a range of assessments such as ADL, mobility and home environment assessment (also cognitive tests if appropriate) carried out by occupational therapist.</p>	<p>Home Hazard assessment along with advice on safe and effective performance of activities of daily living is a proven component of falls reduction programmes, particularly if patients have experienced a recent change in health such as a hospital admission or injurious fall.¹³</p>
<p>Put in place adaptations work where necessary. Check that adaptations will actively encourage independence rather than increase dependence. In the past research has suggested that service users have had to wait unacceptable amounts of time for equipment that is needed to support independent and comfortable living at home¹⁴</p>	<p>Research also indicates that having appropriate adaptations in place increases people's feelings of safety and improvement in mental health by 70%¹⁵. Adaptations are effective and promote physical as well as good mental health¹⁶.</p>

¹¹ Help The Aged Taking Control of Incontinence, Exploring the links with social isolation (Jan 2007)

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

¹³ National Audit of the Organisation of Services for Falls and Bone Health of Older People (Royal College of Physicians)

¹⁴ <http://www.dhcarenetworks.org.uk/csed/Solutions/homeCareReablement/>

¹⁵ Dolan P, Torgerson DJ, The Cost of treating osteoporotic fractures in the UK female population. Osteoporosis International 1998 8: 6-11-17

Intervention	Evidence
Put in place a detailed falls prevention programme. Need to make sure it is of sufficient time duration to deliver lasting results ¹⁷ .	<p>An effective comprehensive exercise programme should include interventions to address:</p> <ul style="list-style-type: none"> • Low muscle strength • Poor Balance • Gait deficiencies • Addressing fear of falls. <p>FaME programme is a practical approach that can be set by Physios and individualised to the service user¹⁸</p> <p>These programmes can be delivered in the home as well as outside the home by a Physiotherapist.^{19 20 21}</p> <p>OTAGO exercises also effective and established approaches to falls reduction/ prevention²²</p>
Training for carers of people with dementia	
Construct training programme.	<p>It is widely recognised that providing support for carers of people with dementia may delay care home admission^{23 24}. Brodaty et al found that training carers of people with dementia delays admission to a nursing home by an average of 20 months²⁵.</p> <p>Prince Henry Hospital in Sydney, Australia developed a training and support for carers of people with dementia. The interventions included a</p>

¹⁶ Poor G, Jacobsen, SJ Melton LJ. Mortality after hip fracture. *Facts, Research in Geratology*. 7: 91-109

¹⁷ Skelton D and Dinan M Exercise for Falls management: Rationale for an exercise programme aimed at reducing postural instability

¹⁸ Tailored group exercise (Falls Management Exercise – FaME) reduces falls in community-dwelling older frequent fallers (an RCT)

¹⁹ Royal College of Physicians, (2009), National Audit of the Organisation of Services for Falls and Bone Health of Older People

²⁰ Lundin-Olsson L, Nyberg L, Gustafson Y 1997 'Stops walking when talking' as a predictor of falls in elderly people. *Lancet* 349: 617

²¹ Lundin-Olsson L, Nyberg L, Gustafson Y 1998 Attention, frailty and falls: The effect of a manual task on basic mobility.

²² (ibid)

²³ Coon, D. W., Gallagher-Thompson, D., Thompson, L. W., (eds) (2003), *Innovative Interventions to Reduce Dementia Caregiver Distress*. Springer Publishing Company Inc.: New York.

²⁴ Association of Public Health Observatories, (2008), *Indications of Health in the English Regions: 9: Older People*. www.apho.org.uk/apho/indications.htm

²⁵ Brodaty H, Gresham M, Luscombe G.(1997) The Prince Henry Hospital dementia caregivers' training programme. *Int J Geriatr Psychiatry* 1997 Feb;12:183-92

Intervention	Evidence
	structured, residential, intensive 10-day training programme, boosted by follow ups and telephone conferences over 12 months. The research found that even if it did not avoid admission then carer training programmes can demonstrably delay placement into care ²⁶ .
Health improvement (Podiatry, medication, dental care, nutrition, dehydration).	
Older people are offered a sight check. Transport delivered by support worker. Vision is assessed and reviewed.	Causes of falling can be in part related to vision ²⁷ .
Feet are checked and assessed for fungal infections, poor toe nail cutting, growths etc. Podiatry offered ²⁸ .	Help the aged estimated in 2005 that 1 in 4 people aged over 65 needed foot care that they were not receiving ²⁹ .
Dental check offered and carried out. Transport delivered by support worker.	Many older people do not have dental checks and hence have tooth decay, gum diseases or poorly fitting dentures ^{30 31} .
<p>Support workers should take an initial weight check and regularly weigh until desired weight is sustained.</p> <p>Consideration should be given to vitamin D supplements for people who rarely go outside. If deficiencies are found, energy, calcium, iron and zinc content of meals should reach 40% of the Dietary Reference Values, and the</p>	<p>As activity lessens, calorie requirements fall. However, if insufficient food is eaten, the level of nutrients in the diet can become dangerously low, leading to a vicious circle of muscle loss, even less activity, and even lower appetite.</p> <p>Mouth problems and swallowing difficulties may also lead to low food intake.</p> <p>There are more underweight than overweight older people and, in old age, being underweight poses far greater</p>

²⁶ Brodaty, H., Gresham, M., Luscombe, G., (1997), The Prince Henry Hospital Dementia Caregivers' Training Programme. International Journal of Geriatric Psychiatry, Vol 12: 182-192.

²⁷ National Institute for Clinical Excellence (2004) Clinical practice guideline for the assessment and prevention of falls in older people. National Collaborating Centre for Nursing and Supportive Care

²⁸ See Feet for purpose, Age Concern 2007, for good practice examples.

²⁹ Best foot forward: Older people and foot care, Help the Aged 2005.

³⁰ The orodental status of a group of elderly in-patients, McNally, Gosney, Dopherty, Field, Gerontology Volume 16 December 1999

³¹ Pearson NK, Gibson BJ, Davis DM, Gelbier S, Robinson PG, The effect of a domiciliary dental service on oral health related quality of life: a randomized control trial, British Dental Journal 2007, 2003.E3

Intervention	Evidence
<p>folate and vitamin C content to 50%³².</p> <p>Where there is evidence of malnutrition or of dehydration then a plan for addressing this should be developed and put in place.</p>	<p>risks to health than being overweight. Good guidelines exist for the nutritional intake required by older people³³.</p> <p>Buckinghamshire in 2005 estimated that 30% of older people referred to accident and emergency services had a dehydrated related condition³⁴.</p>
<p>Medication is reviewed and systems in place for safe administering of medication.</p>	<p>Evidence shows that some medication can increase the risk of falls³⁵.</p> <p>Adjusted medication regimes can be effective in reducing falls. For example gradual and assisted withdrawal from some types of drugs for sleep deprivation, anxiety and depression has been shown to reduce incidence of falls³⁶.</p>
<p>For stroke survivors support workers to motivate, prompt and instruct exercises set by a Physiotherapist to improve limb function or tasks.</p>	<p>Low intensity home-based therapy can improve lower limb function more than one year after a stroke³⁸</p> <p>Evidence that these approaches can improve rehabilitative outcomes³⁹.</p> <p>Some studies have shown significant gains through occupational therapy intervention resulting in reduced hospital</p>

³² The Dietary Reference Values prepared by COMA (the Committee on the Medical Aspects of Food Policy) in 1991 should be used as the basis for the nutritional guidelines for food prepared for older people.

³³ Eating well for Older People: The Expert Group Report The Caroline Walker Trust, 1995 revised 2004.

³⁴ Just add water, Community Care October 2005.

³⁵ Interventions for preventing falls in older people living in the community; Gillespie LD, Robertson MC, Gillespie WJ, Lamb SE, Gates S, Cumming RG, Rowe BH (Online publication 2009)

³⁶ National Institute for Clinical Excellence (2004) Clinical practice guideline for the assessment and prevention of falls in older people. National Collaborating Centre for Nursing and Supportive Care

³⁷ Kerse, N., Flicker, L., Pfaff, J.J., Draper, B., (2008), Falls, Depression and Antidepressants in Later Life: A Large Primary Care Appraisal. Public Library of Science. June 2008 Volume 3 Issue 6

³⁸ Lin, J.H., Hsieh, C.L., Lo, S.K., Chai, H.M., Liao, L.R., (2004), Preliminary study of the effective of low-intensity home-based physical therapy in chronic stroke patients. Kaohsiung Journal of Medical Science. 2004; 20:18-23

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

Intervention	Evidence
	admission and more appropriate aids and adaptations ⁴⁰ .
For stroke survivors, develop an action plan for support workers so that they can recognise and respond to TIAs or further strokes.	
Consider whether psychological support may be necessary for stroke survivors and if so ensure its delivery.	Evidence that there is high prevalence of depression following a Stroke but that this can be averted and is not an inevitable long term side effect if treated ⁴¹ .
Continence	
Ensure particularly where person displays signs of incontinence or is in a high risk category, eg, women who have had multiple births that full continence assessment is completed, together with diagnosis and full treatment plan.	A diagnosis following comprehensive assessment increases likelihood that incontinence will be <i>pro-actively</i> treated ^{42 43} .
Supporting service users through the continence assessment process with bladder diaries, urinalysis to aid assessment process and information and support re: potential medical interventions. Ensuring service users are assisted and engaged in any continence plan increases the likelihood of successful outcome ⁴⁴ .	Older people benefit from taking control of their incontinence ⁴⁵ .
If appropriate assist to motivate,	Evidence that Pelvic floor exercises can

⁴⁰ Occupational therapy for stroke patients after hospital discharge — a randomized controlled trial (Corr and Bayer 1995)

⁴¹ Kneebone, I. & Dunmore, E. (2000). Psychological management of post-stroke depression. *British Journal of Clinical Psychology*, 39, 53–66.

⁴² Department of Health (DH)(2000) Good practice in continence services' and National Service Framework for Older People Outlines good practice in relation to managing incontinence

⁴³ National Audit of Continence Care For Older People – Royal College of Physicians

Peters. Tim J;et al.; (2004) Health and Social Care in the Community 12 (1), 53 – 62. Factors associated with variations in older peoples use of community-based continence services

⁴⁴ DH Good Practice in Continence Services (2001)

⁴⁵ (ibid)

Intervention	Evidence
prompt and instruct exercises set by a Physiotherapist to improve continence.	reduce both stress urinary incontinence (SUI) Urge Urinary Incontinence (UI) and faecal incontinence ^{46 47 48 49 50 51 52} . Postural and breathing exercises help with some incontinence issues ⁵³ . Correct toilet positions help with some incontinence issues ⁵⁴
Where peoples are incontinent, regular cleaning may help to ensure home is free from odour.	
Skin integrity needs to be checked as part of daily routine of care.	
Assistance to wash and dress and assist with helping service users to wear and feel comfortable in adapted clothing if required.	
Improve access to lighting at night. Good positioning of commodes may also help.	

⁴⁶ Tan TL (2003) Urinary incontinence in older persons: a simple approach to a complex problem

⁴⁷ Hay-Smith EJ Bo Berghmans LC Hendricks HJ de Bie RA Vab Waalwijk van Doorn ES (2003) Pelvic floor muscle training for urinary incontinence in women Cochrane Database of Systematic reviews issue1

⁴⁸ Berghmans L Hendricks H Bie RD Doorn EVWV Bo K Kerrebroeck PV (2000) Conservative treatment of urge incontinence in women: A systematic review. British Journal of Urology International

⁴⁹ Solomon MJ, Pager C, Rex J, Manning J, Roberts R. Randomised, controlled trial of biofeedback using anal manometry, transanal ultrasound or pelvic floor retraining with digital guidance alone in the treatment of mild to moderate fecal incontinence. *Diseases of the Colon & Rectum* 2003; 46: 703 – 710

⁵⁰ Newman D. *Managing and treating urinary incontinence*. Baltimore, MD: Health Professions Press; 2002

⁵¹ Bowel and Bladder Foundation website

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