



SOUTHERN
COUNCIL

intermediate care

***Users' Views of Services
in the Southern Area***

December 2004



Southern Health
& Social Services
Board

Intermediate Care

Users' Views and Experiences of Services in the Southern Area

Karen McCoy: Researcher Officer
& Karen Wells: Research Assistant:

Southern Health and Social Services Council
Quaker Buildings
High Street
Lurgan
BT66 8BB

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1. INTRODUCTION

The Southern Health and Social Services Council (the Council) is one of 4 independent statutory watchdog bodies for health and social services. It has a statutory remit to represent the views and interests of users of health and social services in the Southern Board's area; to keep under review the operation of all health and personal social services and to make recommendations for improvement where it thinks fit.

In February 2003 the Southern Health and Social Services Board (the Board) requested the Council's assistance in an evaluation of intermediate care services. The evaluation process comprised 4 main elements including: -

1. An assessment of the level of staff activity involved in delivering the intermediate care service in each Trust area.
2. A measurement of the extent to which patients benefited from the care in terms of improvements to various functions such as self-care, mobility, communication, psychosocial and cognition.
3. Research into users' experiences and views of the quality of care provided by the schemes.
4. An assessment of the level of GP involvement in providing support to the delivery of intermediate care.

The Council agreed to undertake Part 3 of this evaluation - research into users' experiences and views of the intermediate care provided in the Southern Board's area. Consulting patients on their views of services, particularly new services, is increasingly viewed as an essential component of any evaluation (Campbell et al, 2000¹). This makes sense as it is the patient who is most affected by the quality of a service (Kelson, 1997²).

WHAT IS INTERMEDIATE CARE?

Intermediate care is a relatively new concept. As such there are various definitions which have been used and developed over recent years.

Steiner (1997)³ defined intermediate care as 'a range of services aimed at meeting the needs of those who are physiologically stable but who could improve the quality of their

¹ Campbell M, Fitzpatrick R, Haines A et al (2000). Framework for design and evaluation of complex interventions to improve health. *BMJ* 321: 694-696.

² Kelson M (1997). *User Involvement: A guide to developing effective user involvement strategies in the NHS*. College of Health, London.

³ Steiner A (1997). *Intermediate care: A conceptual framework and review of the literature*. King's Fund, London.

lives, increase their ability to live independently and minimise their longer term dependence on health care services through timely, intensive therapeutic input'.

Vaughn & Lathlean (2000)⁴ defined intermediate care as 'those services which will help to divert admission to an acute care setting through timely therapeutic interventions which aim to divert a physiological crisis or offer recuperative services at or near a persons own home'.

Stevenson & Spencer (2002)⁵ defined it as 'short term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or admission to hospital or residential care which could be avoided. The care is person-centred, focused on rehabilitation and delivered by a combination of professional groups'.

The Southern Board in preparing its Intermediate Care Development Plan held a number of workshops at which the various definitions of intermediate care were considered. One of the outcomes of these workshops was that the Southern Board's vision for intermediate care was agreed as: -

'to provide a range of locally tailored integrated services that promote faster recovery from illness, prevent unnecessary acute hospital admission, support timely discharge and maximise independent living. The care is person-centred and focused on rehabilitation and delivered by a combination of professional groups'⁶.

MODELS OF INTERMEDIATE CARE

Intermediate care can take many different forms. However, it is frequently broadly classified as either 'step-down' or 'step-up'. 'Step-down' refers to care provided to assist the rehabilitation of an individual after a period of hospitalisation. 'Step-up' refers to care provided to prevent an individual being admitted to hospital. Specific models of intermediate care have been outlined by the Southern Board in its Intermediate Care Development Plan. These are outlined below.

- **Rapid Response Team**

This is a service that reacts to an event that could result in attendance at A&E or admission to hospital. It aims to prevent the need for admission to hospital by providing

⁴ Vaughn B & Lathlean J (2000) Intermediate care: Models in Practice. King's Fund, London.

⁵ Stevenson J & Spencer L (2002). Briefing paper in Developing Intermediate Care: A guide for health and social care professionals. King's Fund, London.

⁶ SHSSB (September 2003). Intermediate Care Development Plan.

assessment, diagnosis and immediate treatment in the patient's own home or usual place of residence.

- **Hospital-at-Home**

This service provides treatment by healthcare professionals in the patient's own home or usual place of residence for a condition that would otherwise require them to be admitted to hospital. This service is provided for a limited period of time.

- **Supported Discharge**

This facilitates discharge for patients who are medically stable and able to complete their recovery at home. It typically includes support at home such as nursing care and therapeutic input as well as personal care.

- **Home-from-Hospital**

This is used to facilitate the transition from hospital to home and to build up the confidence of both the patient and the carer. It is time limited and usually involves low-level interventions and does not necessarily involve healthcare professionals but is often supported by a voluntary sector organisation.

- **In-patient Rehabilitation and Recovery Beds**

This service is designed to help people who have been in hospital to make a quick but sustained transition back to their own home or usual place of residence.

- **Residential Rehabilitation Unit**

This usually consists of the provision of intensive therapy in a residential facility for a period of up to 6 weeks. This service is different to 'long stay', 'continuing care' or 'respite beds' which do not usually offer intensive rehabilitation.

- **Day Rehabilitation Units**

These units provide rehabilitation services that do not involve an overnight stay. They are usually based in a day hospital or day centre and provide short-term therapeutic support and can also provide a one-stop rapid response service with both specialist and multidisciplinary input.

INTERMEDIATE CARE IN THE SOUTHERN BOARD'S AREA

The models used to deliver intermediate care across the Southern Board's area vary from Trust to Trust. Each scheme is different and is locally tailored, however there are some similarities between them in terms of the models adopted. The following gives a brief overview of each scheme included in this evaluation.

- **Armagh and Dungannon**

One intermediate care scheme operates in Armagh and Dungannon. It was established in 1998 as an early discharge scheme for patients who could be discharged from hospital but required a period of rehabilitation. It now operates as a 'step-down' and 'step-up' scheme with step-up referrals generated from the community.

The scheme operates in two ways - either through the 6 dedicated beds in Roxborough House residential home and/or the provision of additional services in a domiciliary setting. The average length of stay on the scheme is 21 days.

The scheme is managed by a co-ordinator and team members include; a physiotherapist, occupational therapist, nurse and social worker. Homehelp is an additional element of care which is available to patients on the scheme. Additionally, district nursing services provide a nursing assessment to each client.

The criteria for admission to the scheme states that patients should: -

1. Be 65 years or over.
2. Require an input from at least two disciplines (nursing, physiotherapy, occupational therapy and social work).
3. Be medically fit to be at home.
4. Would benefit from a period of rehabilitation.

- **Craigavon and Banbridge**

The scheme operating in Craigavon and Banbridge Trust commenced in April 2000 as a 'step-down' scheme. Similar to the Armagh and Dungannon scheme it targeted patients who could be discharged from hospital but required a period of rehabilitation. Since April 2001 the scheme also provided 'step-up' intermediate care. Patients are admitted to the scheme who require either: -

1. An intensive nursing package to facilitate discharge.
2. Further rehabilitation.
3. An intensive social support package.

The criteria for the scheme includes that the patient must be:-

1. Over 65 years.
2. Living in Craigavon and Banbridge Community Trust Area.
3. Requiring two or more professionals (nurse, social worker, physiotherapist, occupational therapist, speech and language therapist)
4. Medically/Surgically stable.

5. Have the potential to improve functional/physical ability.

Unlike the other 2 schemes in the Southern Board's area, it does not exclude patients with dementia. It is delivered in either the patient's own home or in specifically allocated beds in Crozier House residential home in Banbridge and this scheme on assessment may offer up to a maximum of 6 weeks intervention.

The scheme is managed by a co-ordinator and team members include; an occupational therapist, physiotherapist, speech therapist, social work assistant, daycare worker, nurse, homecare worker and care assistant.

- **Newry and Mourne**

The intermediate care scheme in operation in Newry and Mourne Trust is a multidisciplinary community rehabilitation scheme. This is mainly provided in a daycare setting at Archway Rehabilitation Centre and there are 16 places available at any one time. However, approximately 1/5 of the scheme is provided in a domiciliary setting. Patients in the Kilkeel area receive the service at home because of the distance they would have to travel. The scheme accepts referrals from both the hospital and the community although most referrals come from the community.

The criteria for admission to the scheme states that patients should: -

1. Be 65 years or over.
2. Require no more than assistance of 2 people to mobilise.
3. Be medically stable.
4. Have the potential for rehabilitation.
5. Previously have had a good level of functional ability.
6. Have recently acquired a physical disability (within previous 6 months).

Patients attend Archway Rehabilitation Centre twice a week for a maximum of 8 weeks and most remain on the scheme for the maximum length of time. Patients in the Kilkeel area tend to remain on the scheme for longer as they are only seen once a week. In February 2003 the option of 2 nursing home beds was also incorporated into the Trust's scheme.

There is no intermediate care co-ordinator in Newry and Mourne. The team is comprised of; an occupational therapist, physiotherapist, speech therapist, rehabilitation worker, care manager, podiatrist, dietician, daycare worker and daycare assistant. Homehelp is an additional element of care which is available to patients on the scheme.

In addition to the community rehabilitation scheme, Newry and Mourne Trust operates

a 'home from hospital' scheme which is provided by social services. At the time this evaluation was undertaken, the Trust planned to add an Allied Health Professionals element to this scheme which would then become a 'from hospital to home' scheme. As these changes had not yet been implemented, only the community rehabilitation scheme was included within the current evaluation.

2. METHODOLOGY

AIM

The focus of the research was to examine the views and experiences of patients who received care from one of the intermediate care schemes in the Southern Board's area between 1 April 2003 and 30 June 2003. This included an examination of various aspects of care such as; admission to the scheme, quality of care and treatment, staff, information, involvement in decision-making, discharge and the benefits gained.

SAMPLE

All patients admitted to one of the 3 specified intermediate care schemes in the Southern Board's area within the evaluation time period of 1 April - 30 June 2003 were included in the sample. It was estimated that this would total approximately 126 patients.

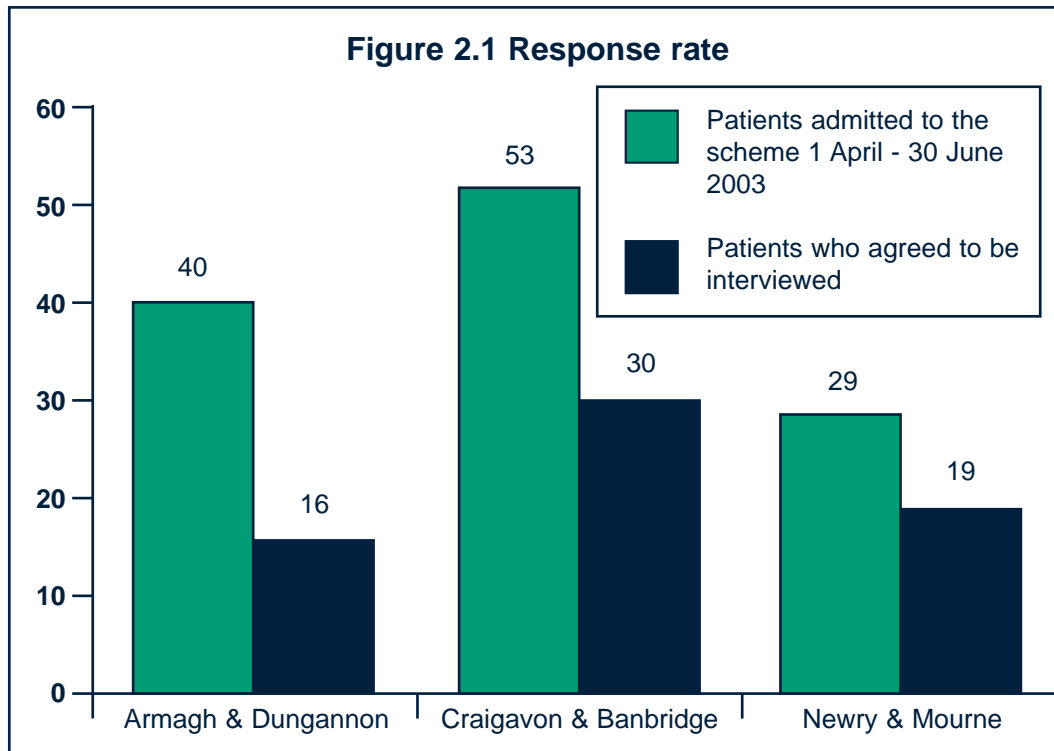
RESPONSE RATE

In total 122 patients were admitted to the 3 schemes during the evaluation period 1 April 2003 to 30 June 2003. This included 53 patients in Craigavon and Banbridge, 29 patients in Newry and Mourne and 40 patients in Armagh and Dungannon. Out of the total 122 patients admitted to one of the schemes:-

- 70 patients (or their relatives)⁷ were interested in taking part in an interview and consented for their names and addresses to be passed to the Southern Health and Social Services Council. Of these:-
 - ◆ 65 interviews were conducted.
 - ◆ 4 patients decided not to take part when contacted by the Council.
 - ◆ one patient had died.

The response rates varied in each Trust area. The highest response was from patients in the Newry and Mourne Trust area, 19 of the 29 patients (65%) who were admitted to the scheme during the evaluation timeframe took part in an interview. In Craigavon and Banbridge, 30 of the 53 patients (57%) admitted to the scheme took part and in Armagh and Dungannon the proportion was lower, 16 of the 40 patients (40%) took part in an interview.

⁷ The relative could take part either instead of the patient or as well as the patient if this was desired.



PROCEDURE

Patients' views and experiences of the care provided by the 3 intermediate care schemes included in the evaluation, were collected by personal interview using a structured interview schedule.

All patients admitted to the intermediate care schemes between 1 April and 30 June 2003 were informed about the ongoing evaluation at the time of their admission to the scheme. The intermediate care co-ordinator provided this information verbally to patients.

The main points conveyed to patients at this stage included:-

1. The Southern Board was carrying out an evaluation of intermediate care services throughout the Board's area and one aspect of this was to find out what patients thought about the services they received.
2. The evaluation included all patients admitted onto the scheme between 1 April 2003 and 30 June 2003.
3. The patient did not need to do anything at this stage, they would be provided with further information later and invited to take part.

Then, when patients were discharged from the scheme they were given a **Patient Information Leaflet** which contained further information about this part of the

evaluation (See Appendix 1). They were invited to take part and assured that their participation was completely voluntary, that they did not have to take part if they did not wish to and that their decision would not in any way impact upon future care. If they wished to participate, they were asked to sign a consent form permitting the Trust to pass their name and contact details to the Council so that an interview could be arranged (see Appendix 2). In some cases a relative provided consent for their contact details to be passed to the Council. This occurred in instances where the patient had communication difficulties or lived with the relative. In total 59 patients and 6 relatives provided consent for their contact details to be passed to the Council.

Table 2.1 Provision of consent

	Patient	Relative	TOTAL
Armagh and Dungannon	15	1	16
Craigavon and Banbridge	25	5	30
Newry and Mourne	19	-	19
TOTAL	59	6	65

The Council then contacted the patient or relative after the patient was discharged and arranged a suitable time for the interview to take place in the patient's or relative's own home.

The primary interview where possible was sought with the patient however, the option of having a carer or relative present during the interview was offered to all participants and in some cases relatives took part instead of the patient. Participants were asked for their consent to tape-record the interview, 60 participants consented and 5 chose not to have it recorded. Where interviews were recorded, the tapes were later transcribed and where participants opted not have the interview recorded, detailed notes were taken during and immediately after the interview.

Of the 65 interviews conducted, 41 were with the patient only, for 22 interviews both the patient and the relative were present and took part. The level of participation varied from the patient being the predominant participant and the relative only occasionally contributing to the relative being the predominant participant and the patient only contributing occasionally. Two interviews were conducted with the relative only, for one of these, the patient was present but did not take part.

Table 2.2 Interview participants

	Patient only	Patient and relative	Relative only*	TOTAL
Armagh and Dungannon	9	7	0	16
Craigavon and Banbridge	19	9	2	30
Newry and Mourne	13	6	0	19
TOTAL	41	22	2	65

*as proxy - Information gathered related to the patient however any expression of views was the relative's own

In total, the patient was present in all but one interview.

3. RESULTS

BACKGROUND INFORMATION

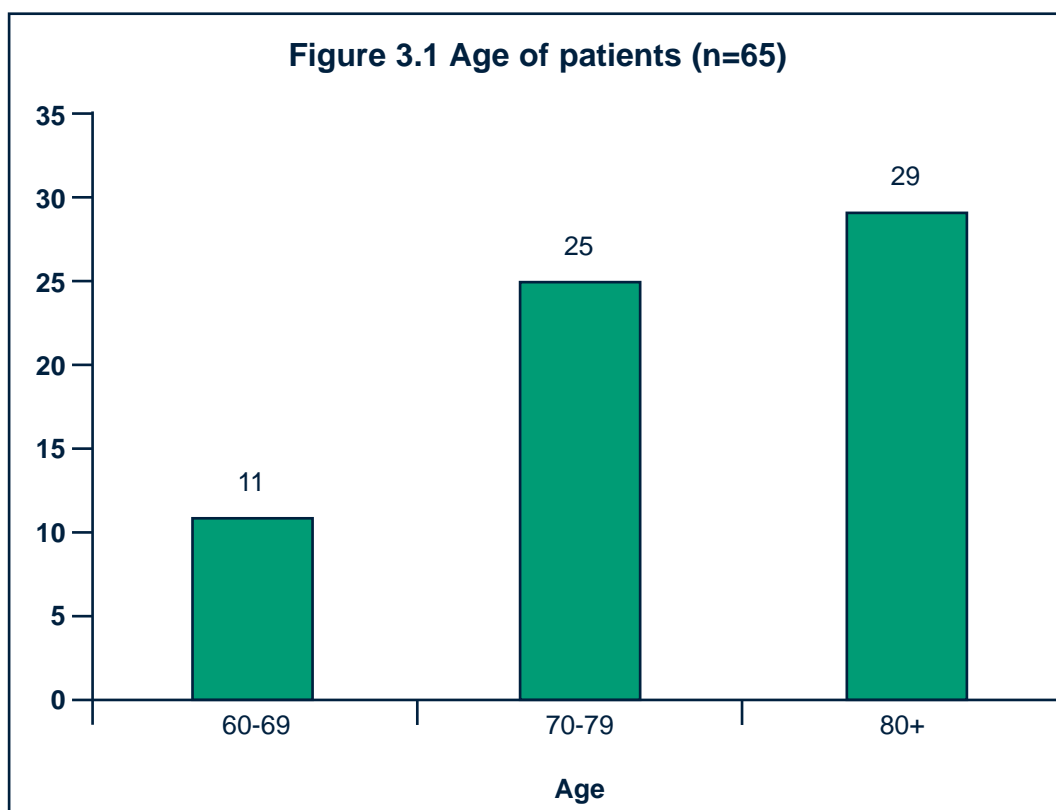
- About the Patients**

More information on female patients than male patients was collected during the interviews - the information related to 43 women and 22 men.

Table 3.1 Sex of patients (n=65)

Male patients	22
Female patients	43

The majority of patients (54) were over the age of 70 years, however 11 were aged 60-69 years. The largest age group were those aged 80 years or older (29).



Nineteen of the 43 female patients were over 80 years of age, 11 of whom lived alone. Sixteen were aged 70-79 years and 8 were aged 60-69 years. Of the 22 male patients,

nearly half (10) were aged 80 years or older, 9 were aged 70-79 years and 3 were under the age of 69 years.

Table 3.2 Age of patients by sex (n=65)

	60-69	70-79	80+	TOTAL
Male	3	9	10	22
Female	8	16	19	43
TOTAL	11	25	29	65

Nearly half (32) of the 65 patients lived alone, and 33 lived with either their husband/wife or another family member. Fifteen patients who lived alone were over 80 years of age.

Table 3.3 Age of patients living alone (n=65)

	Yes	No
60-69	6	5
70-79	11	14
80+	15	14
Total	32	33

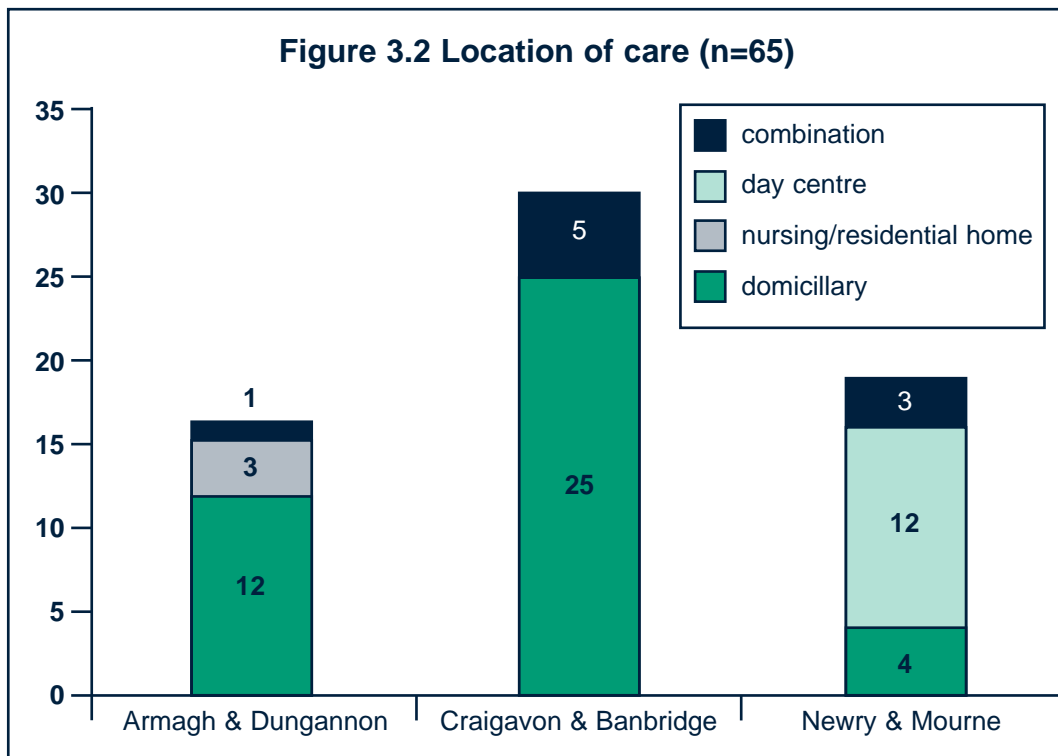
• About the Schemes

The location where the intermediate care was delivered varied to some extent across the 3 Trusts. Most participants in Armagh and Dungannon (12) and Craigavon and Banbridge (25) received the care in their own homes whereas in Newry and Mourne 12⁸ participants (68%) attended Archway Rehabilitation Centre⁹ and only 4 participants received domiciliary care. Smaller numbers of participants received their care in a nursing or residential home. In Newry and Mourne 3 participants received their care in both a nursing/residential home and Archway Rehabilitation Centre. In Craigavon and Banbridge 5 participants received a combination of both domiciliary and

⁸ Two of the participants who attended Archway Rehabilitation Centre also received homhelp.

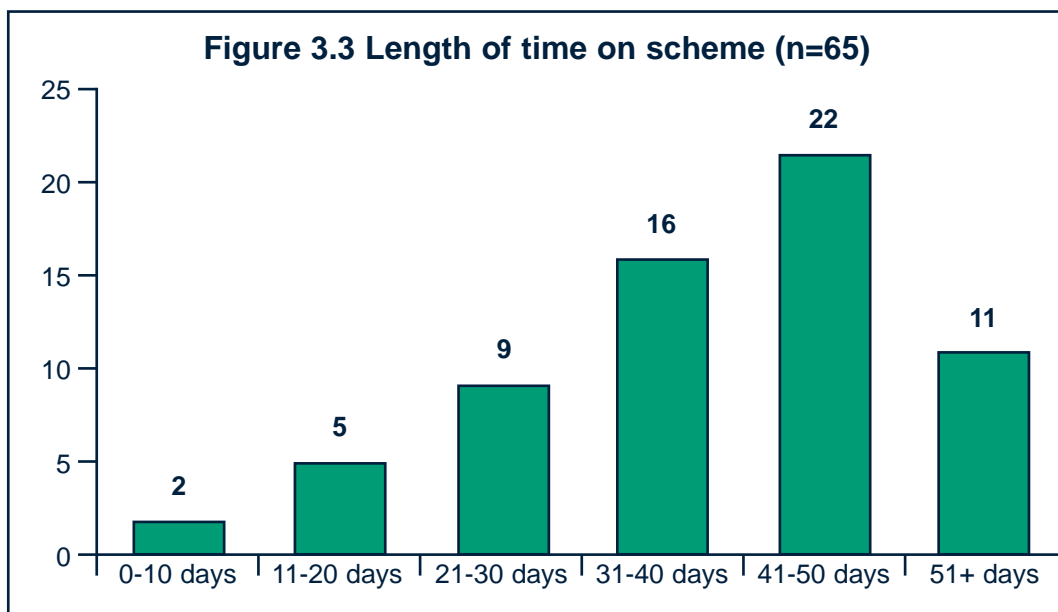
⁹ Archway Rehabilitation Centre. Newry & Mourne is the only Trust which includes attendance at a rehabilitation centre as the main site for the delivery of its Intermediate care.

nursing/residential care. Three participants in Armagh and Dungannon were in a nursing/residential home and one participant had a combination of care.

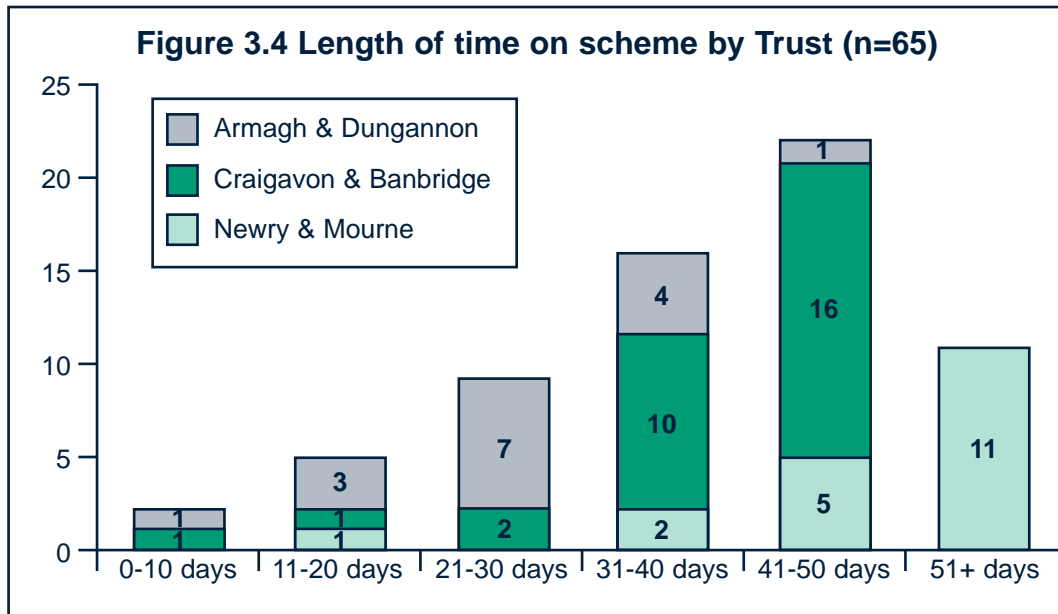


Length of Time on Scheme.

The length of time participants were on the scheme varied from less than 10 days to 51+ days. The majority of participants (47) were on the scheme for between 21-50 days. Two participants were on the scheme for 10 days or less and 11 participants were on the scheme for longer than 51 days.



The length of time participants were on the intermediate care schemes varied across the 3 Trust areas. Participants on the Armagh and Dungannon scheme tended to stay for the shortest length of time, only five participants from this area were on the scheme for more than 30 days. The majority of participants from Craigavon and Banbridge were on the scheme for between 31 and 50 days. Participants on the Newry and Mourne scheme stayed for the longest periods of time. The majority were on the scheme for over 41 days and 11 participants were on the scheme for 51+ days.

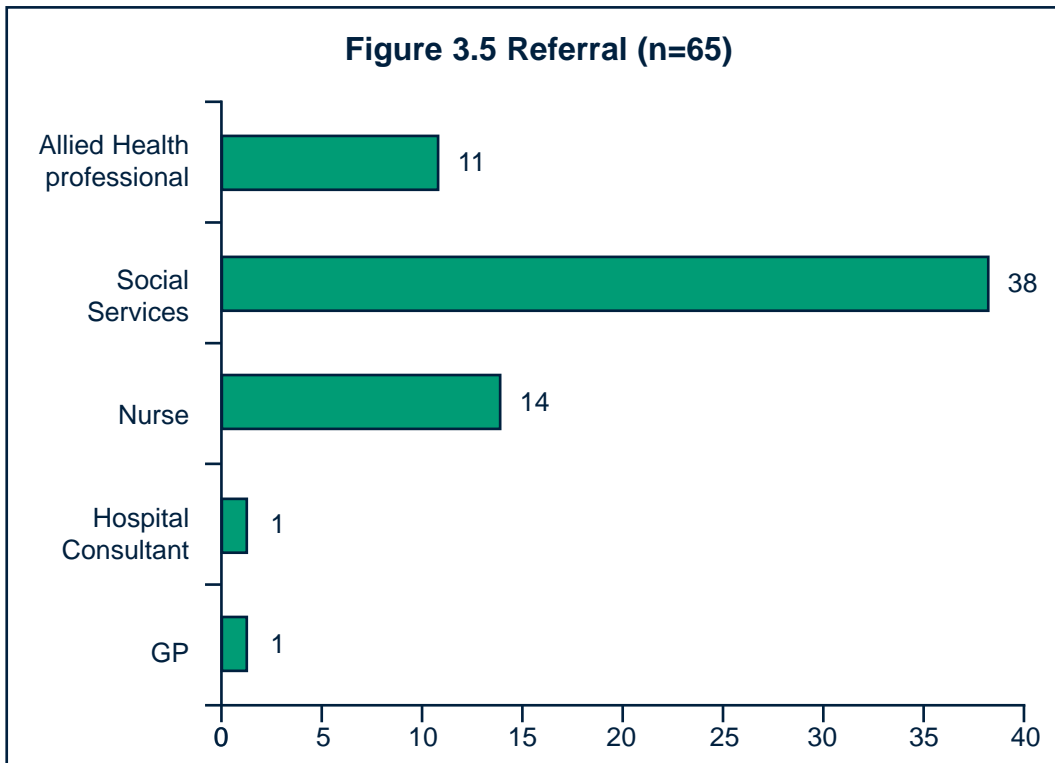


ADMISSION TO THE SCHEME

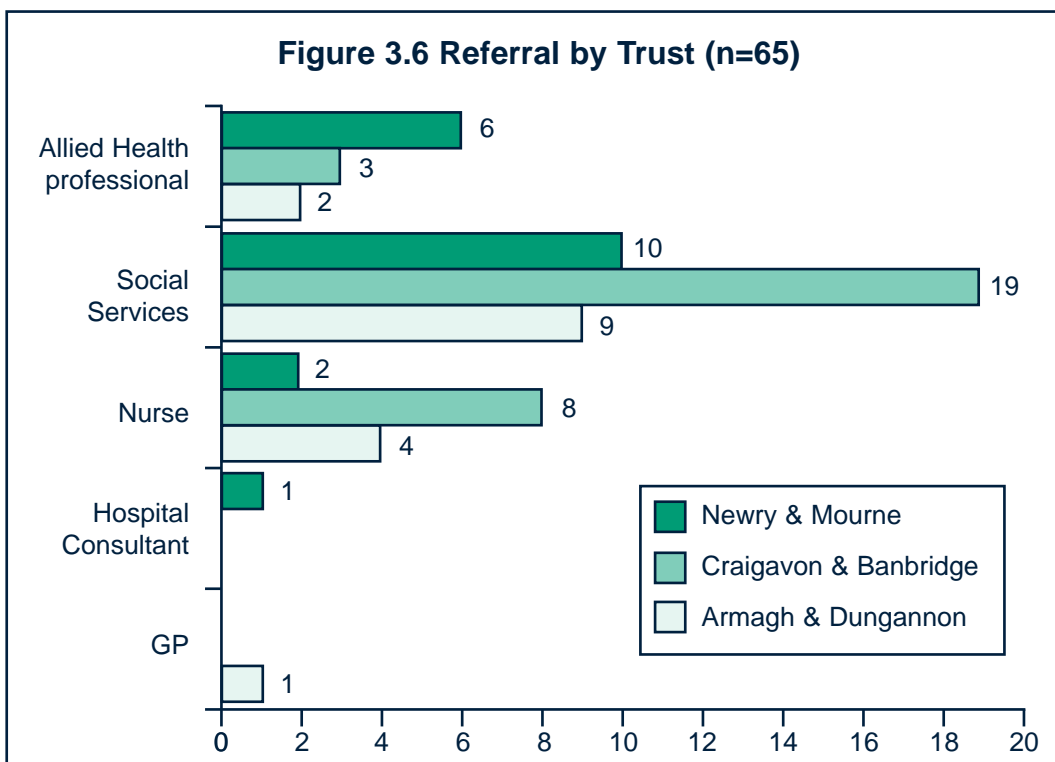
- Source of Referral**

There were various sources of referral to the intermediate care scheme across the 3 Trusts¹⁰. Most participants (38) were referred to the intermediate care scheme by social services. Fourteen participants said they were referred to the scheme by a nurse. Eleven participants said they were referred by an allied health professional (occupational therapist or physiotherapist). The least number of referrals came from GPs (1) and hospital consultants (1).

¹⁰ This information was provided by the Trusts and not from the participant interview.

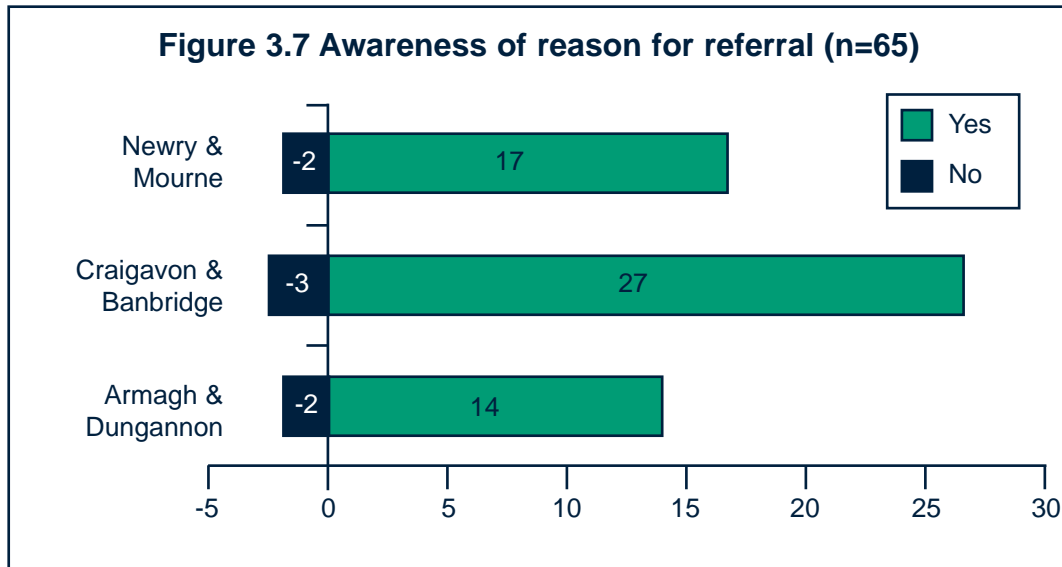


Nineteen referrals to the Craigavon and Banbridge scheme, 9 to the Armagh and Dungannon and 10 to the Newry and Mourne schemes were from social services. In Craigavon and Banbridge (8) and Armagh and Dungannon (4), the next most common source of referral was a nurse whereas in Newry and Mourne it was an allied health professional (6), (occupational therapist or physiotherapist). The only Trust which received a GP referral was Armagh and Dungannon.



Nine participants (6 in Craigavon and Banbridge, 2 in Newry and Mourne and one in Armagh and Dungannon) said they (or their family) initiated the referral by either asking to be referred to the intermediate care team or for some sort of extra help and support.

The proportion of participants who didn't know why they were referred to the scheme was similar across all three Trust areas. Two participants in both Armagh and Dungannon and Newry and Mourne and 3 participants in Craigavon and Banbridge did not know why they were referred to the intermediate care scheme.



The majority of participants (58) did however know why they were referred to the intermediate care scheme. The reasons they understood for their referral fell into 5 main areas, these included:-

- general ill health or frailty;
- had just undergone surgery;
- mobility problems;
- to receive specific therapies and
- felt they couldn't cope any longer.

A large proportion of participants understood they had been referred to the scheme because of their ill health or frailty. As such they identified that they needed help with general everyday tasks such as washing, dressing and preparing food.

“Well I was taking awful light heads and couldn't see and . . . I couldn't cook my own dinner because I had an awful sore back. I couldn't stand and one day I passed out.”

“Because I wasn't fit . . . I was fit to do nothing myself.”

“Because he was very frail and he was ill, so he was and they thought that he was going to need the care”. (Relative)

“She wasn’t just quite able to manage things . . . and they felt that a wee bit of extra care would be better for her”. (Relative)

Another commonly mentioned reason was that they had recently undergone surgery, with the most common surgery being a hip or knee replacement.

“I just had gone through a hip operation, a hip replacement and they said I would need care, you see, because I am a diabetic as well”.

“Well I had got the hip, I had a hip done years ago and I was getting it done over again . . . a major operation. I don’t know whether it was through that or not like, but when they came out . . . they said you could have this for 6 weeks”.

“I thought it was because I had this knee operation, knee replacement and that they thought I would need physio and all the rest of it”.

Several participants said they were referred because of problems with their mobility. Their mobility had deteriorated and many had difficulties getting up and down stairs, in and out of bed and walking.

“. . . because they wouldn’t let me go up the stairs on my own . . . They said I had to go to Crozier house or some place for a week or two”.

“Couldn’t walk too well at the beginning upstairs”.

“Well I think it was because I couldn’t walk too well”.

“Because I can’t do really much now, I had a fall in the ice and I hurt my back and I haven’t been able to do much since then, I can’t walk very well, that is why I was referred to get the help”.

“. . . you were getting back on your feet and they were teaching you to walk on the zimmer frame . . . they felt that coming home that she would benefit from having a physio or somebody coming in to see how she was progressing and advising her”. (Relative)

Many of the participants said they had been referred to the intermediate care scheme to receive, one or more specific therapies or elements of care.

“Well they told me that I would have an OT”.

“. . . for the speech therapist to come and the occupational therapist came here for most of 6 weeks”. (Relative)

“They wanted to give me physiotherapy so they did and I got the physiotherapy and I got a thing home with me for to do the exercises in the house”.

“For to get physiotherapy, I had a knee replacement. When I came out of the hospital I needed the physiotherapy so that was the place to go”.

A smaller number of participants felt they were referred to the scheme because they were not able to cope. Some lived alone but others identified that their relative needed extra help in order to enable them to continue caring.

“Because there would be no one at home to look after me”.

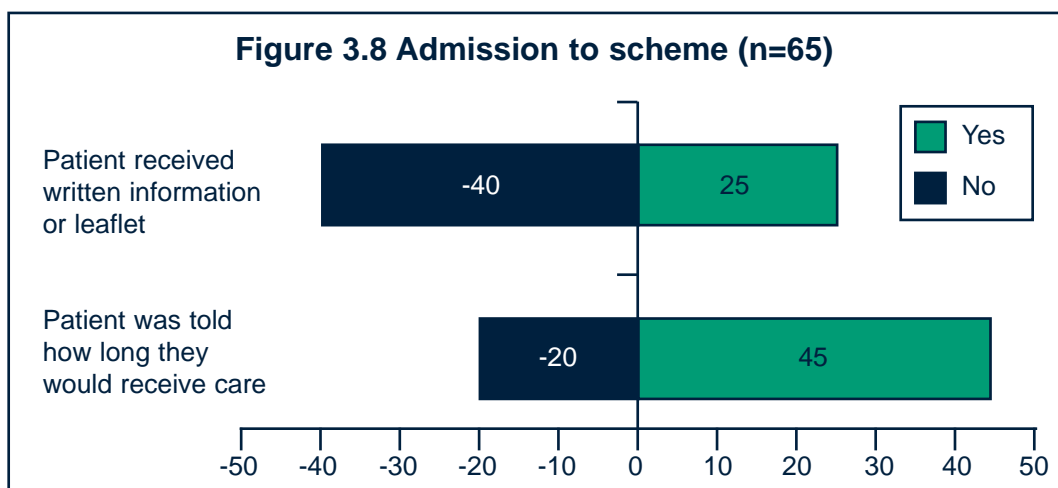
“Well the problem was my wife wasn’t able to cope during day and night with me because I was very helpless and couldn’t do anything for myself”.

“The wife had pains you see and I knew she wouldn’t been able to look after me, so the doctors and us, made the suggestion that I would go into some home for a while”.

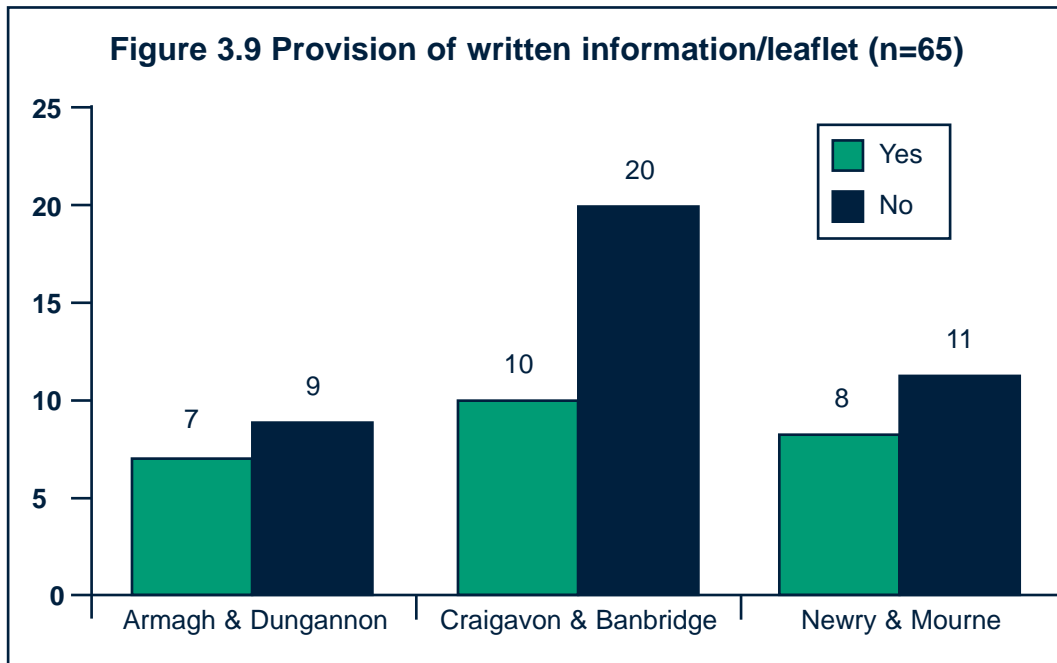
“Well probably because she knew the circumstances, we needed the help because we were not capable of carrying on, on our own”.

Information

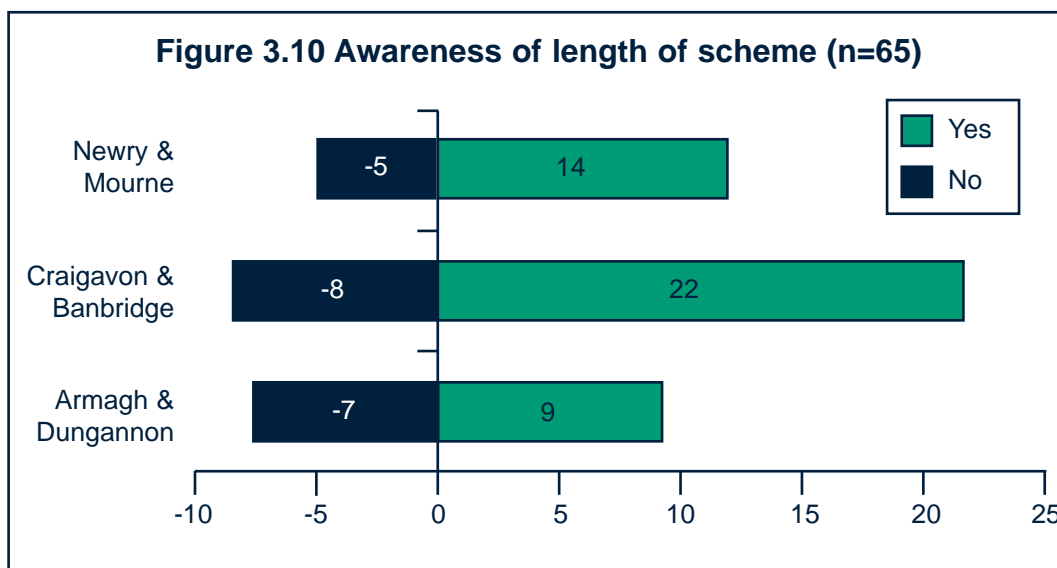
Overall 40 participants said that they didn’t receive any written information when they were admitted to the scheme and 20 participants stated they were not told how long they would receive the care for.



Twenty-four participants over the age of 80 years said that they did not receive any written information or a leaflet at admission. Two thirds (20) of participants in Craigavon and Banbridge stated that they did not receive written information when admitted to the scheme. Just over half of participants in Newry and Mourne (11) and in Armagh and Dungannon (9) also said they didn't receive any written information.



A higher proportion of participants in the Armagh and Dungannon area said they were not told for how long they would receive the care. Seven participants (44%) were not told for how long they would receive the care. In Newry and Mourne (26%) and Craigavon and Banbridge (27%) the proportions were slightly less.

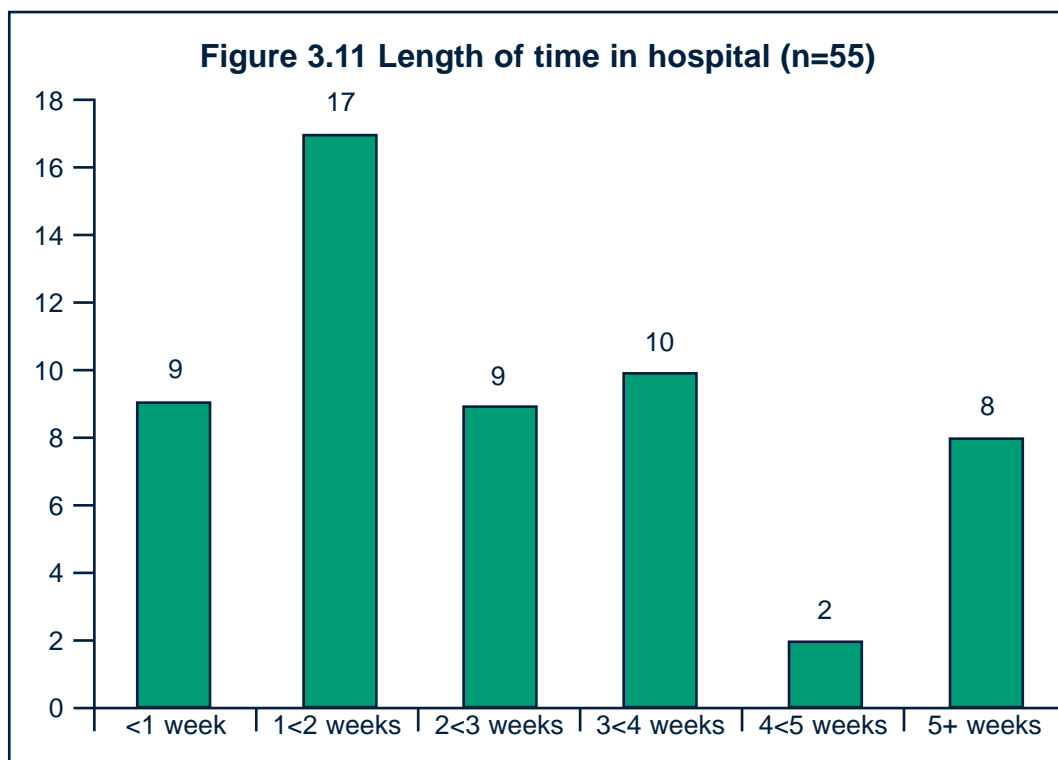


In addition one person said they would have liked to have known in advance for how long the care would be provided.

“Would liked to have known at the start how long it was going to last for, somebody said four weeks somebody said 6 weeks and we really didn't know how long it was going to last for”.

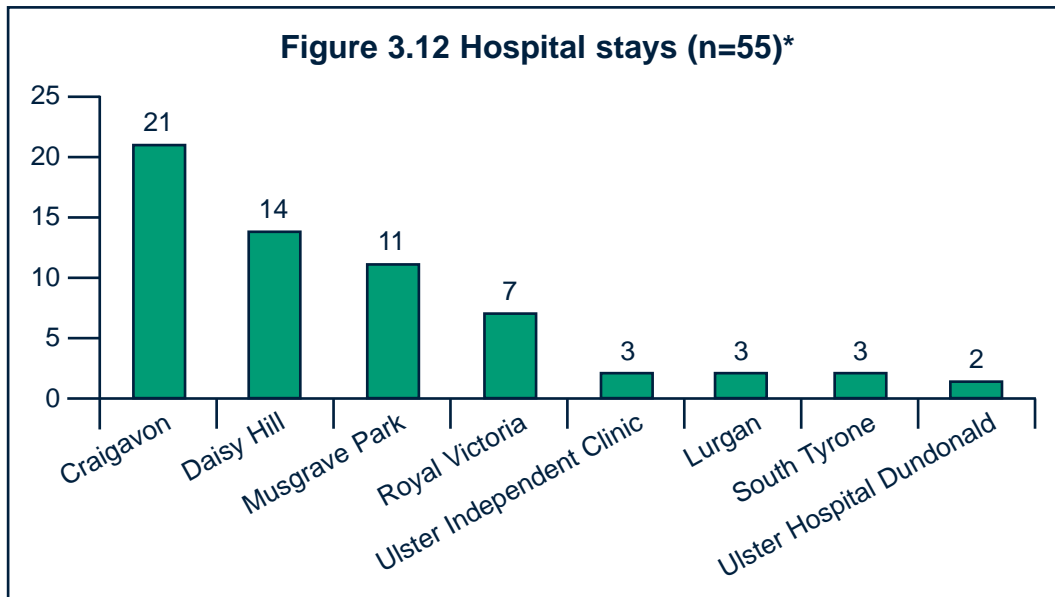
- Hospital Stay Prior to Admission**

Fifty-five patients were in hospital prior to their admission to the intermediate care scheme¹¹. The length of time patients stayed varied from 1 week or less to 5 weeks or more. The majority were in hospital for less than 3 weeks (35) with the largest number (17) in hospital for between 1 - 2 weeks. Eight patients were in the hospital for 5 weeks or longer.



Most had been in-patients in either Craigavon Area Hospital (21) or Daisy Hill Hospital (14). Twenty-three were in hospitals outside the Southern Board's area including; Musgrave Park Hospital (11), the Royal Victoria Hospital (7) and the Ulster Independent Clinic (3). Three participants had been inpatients in Lurgan Hospital and South Tyrone Hospital.

¹¹ An additional analysis of the Trusts' classification of 'step-up' and 'step-down' is included in Appendix 3.



*Out of the 55 patients who were in hospital prior to admission to the intermediate care schemes, 9 were in more than one hospital.

All 16 participants in Armagh and Dungannon had stayed in hospital prior to being admitted onto the intermediate care scheme. Most had been in Craigavon Area Hospital (11), 3 had been in South Tyrone Hospital, 2 had been in Musgrave Park Hospital and the Royal Victoria Hospital. One patient had been in the Ulster Hospital Dundonald.

Twenty-six of the 30 participants who were interviewed in Craigavon and Banbridge had been in hospital prior to their admission to the intermediate care scheme. The largest number of patients had stayed in Craigavon Area Hospital (10) however, 6 had been in Musgrave Park Hospital, 4 in Daisy Hill Hospital, 4 were in the Royal Victoria Hospital, 3 in Lurgan Hospital and 2 in the Ulster Independent Clinic.

Thirteen of the 19 participants in Newry and Mourne had been in hospital prior to their admission onto the intermediate care scheme. The majority of these participants had been in Daisy Hill Hospital (10). Three participants had been in Musgrave Park Hospital, one participant had stayed in the Royal Victoria Hospital, another had been in the Ulster Independent Clinic and another one had been in the Ulster Hospital Dundonald.

Table 3.4 Hospital Stays by Trust (n=55)

	Armagh and Dunagannon	Craigavon and Banbridge	Newry and Mourne	Total
Craigavon Area Hospital	11	10		21
Daisy Hill Hospital		4	10	14
Musgrave Park Hospital	2	6	3	11
The Royal Victoria Hospital	2	4	1	7
Ulster Independent Clinic		2	1	3
Lurgan Hospital		3		3
South Tyrone Hospital	3			3
Ulster Hospital Dundonald	1		1	2
Total	19	29	16	64

*Out of the nine patients who were in more than one hospital, 3 were from Armagh & Dungannon, 3 were from Craigavon & Banbridge and 3 were from Newry & Mourne.

Participants were asked how they felt about coming out of hospital to receive this type of care. They generally tended to have one of 2 reactions. The vast majority were very happy with this arrangement. They appreciated the provision of services as they acknowledged that they needed help and couldn't manage without it. The practical aspect of the care in terms of the help provided, the psychological impact of feeling reassured that support was available and the social aspect in relation to the company the care offered were all highlighted as elements which were viewed positively.

“Well I was quite happy about it . . . because I wasn't completely able to do for myself that it would help me on, I was happy to receive it”.

“I actually felt good about it because I was in such a state that I knew I couldn't look after myself so I was quite sensible enough to know that I was going to be looked after”.

“I was thankful because it is always someone to speak to and someone to do a wee turn for you”.

"She felt more reassured that there was somebody coming in and out, it was reassuring for you, wasn't it, because you were nervous about coming home. She was worried about how she was going to manage on her own". (Relative)

"I thought it was great and the company was . . . great".

However, some participants had less positive reactions. This ranged from those who were slightly apprehensive or reluctant initially, to others who felt a loss of dignity at having staff look after their personal care needs. Another person felt depressed because he/she was not able to manage independently.

"Initially you were a bit reluctant I think weren't you and you got to like it". (Relative)

"I felt dead on but then when they said that there was people coming to wash and dress me and all I didn't fancy it much . . . although I didn't tell them to go away".

"He just lost his dignity with people washing him and things, he would have felt". (Relative)

". . . now they would have helped me with hygiene or washing but its embarrassing".

"I was just crying all the time, I was so depressed because I never was used to anybody doing anything for me and because I couldn't do it myself I got awful depressed and down. It near killed me".

In terms of having an option whether or not to receive the intermediate care some participants did not remember this being discussed with them.

"No if there was we didn't know them".

"No just that I had to have it, that was all I can remember".

"I don't think so I never asked I was just glad to get it".

"Well I knew it was the right thing to do. There was no other option".

Others however, said they were told that it was their choice as to whether or not they received the service.

". . . they asked if you wanted it, you didn't have to take it, it wasn't forced on you but it was an option. I had the social worker down . . . this is what she suggested and

mummy was happy with that, it give her a chance to get back to her own home". (Relative)

". . . explained everything and she said it was totally voluntary and if we didn't want they weren't imposing themselves . . . but the scheme was there for 6 weeks".

Some others said it was discussed and also they could choose which specific elements of care to receive.

"They said I could go to some home or some rest place, but I wanted to come home".

"Well you got the preference of going into a nursing home for 6 weeks or coming home, so . . . wanted to come home". (Relative)

Well there was home help which was available that was an option but I didn't want that help I could carry on myself". (Relative)

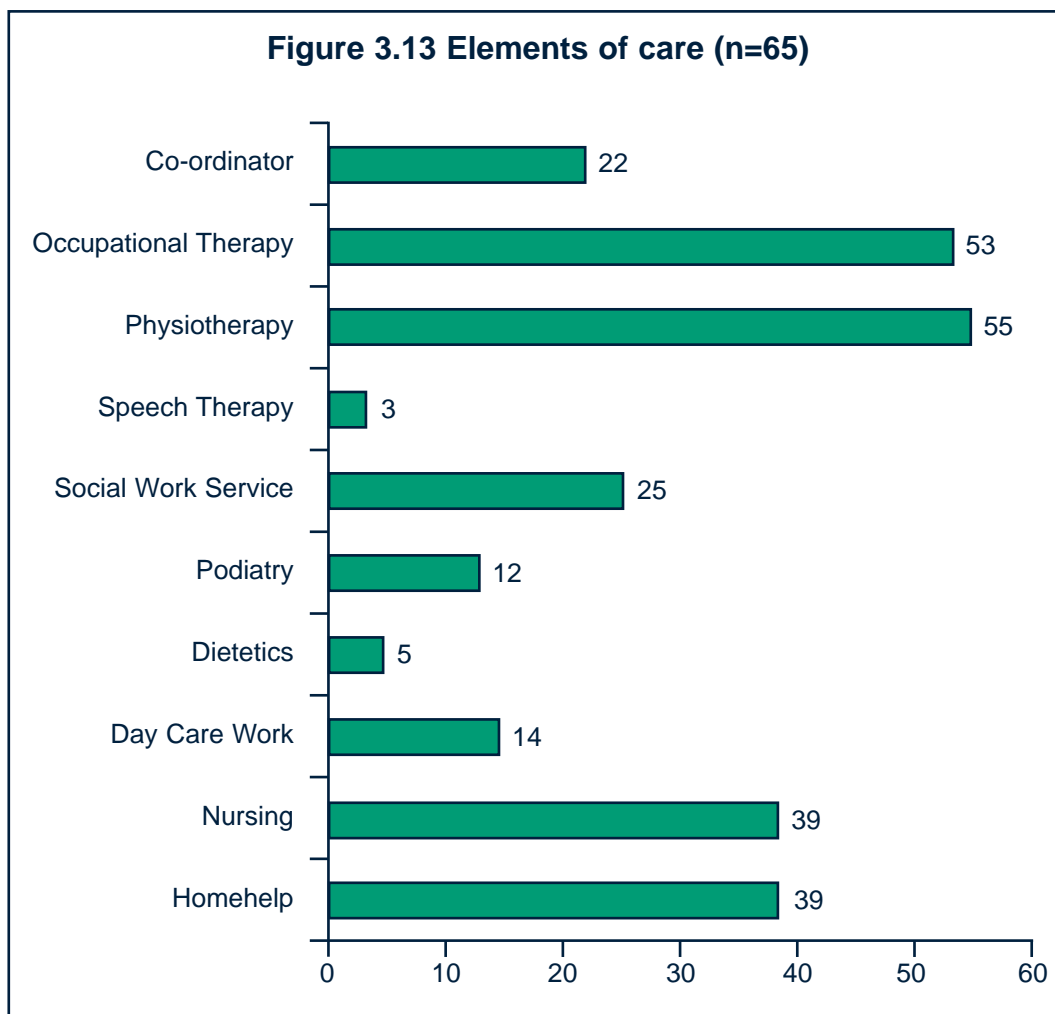
"No they wanted to know did I want anybody help me to dress and anything like that . . . I said no I was able to manage that myself".

CARE PROVIDED

Figure 3.13 below outlines the elements of care received by participants while on the intermediate care scheme. The services which participants were most likely to have received were; physiotherapy (55) and occupational therapy (53). However the majority also mentioned nursing (39) and home-help (39). Twenty-two participants recounted having contact with the intermediate care co-ordinator and 25 a social work service¹². Lower levels of service were reported for daycare¹³ (14), podiatry (12), dietetics (5), and speech therapy (3).

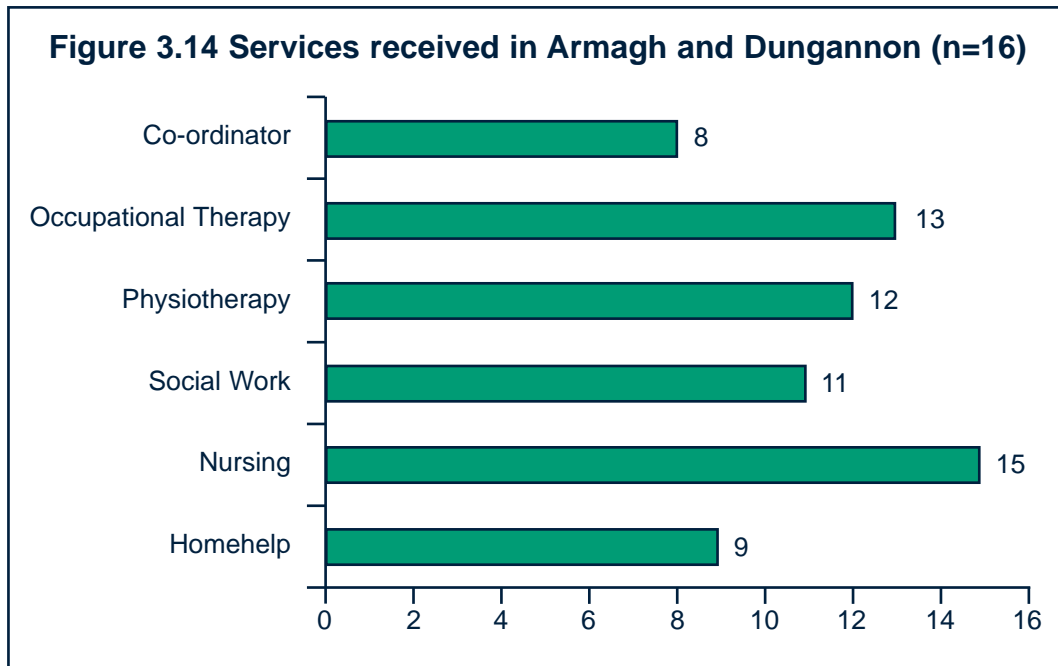
¹² Social work service includes social work and social work assistance.

¹³ Day care work includes both a service form the day care worker and the day care assistant.



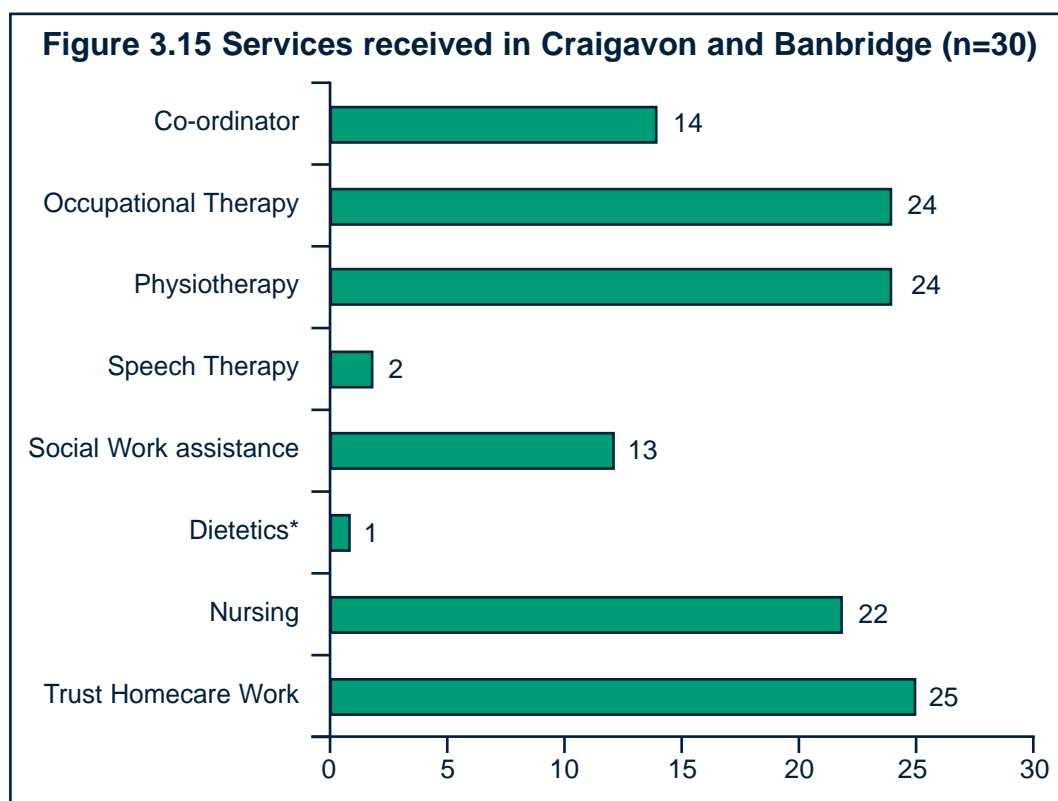
- Armagh and Dungannon**

Figure 3.14 below illustrates the various elements of care which were part of the intermediate care scheme in Armagh and Dungannon. It also illustrates the number of participants who received each of these elements of care. Participants from this area seemed to have had most contact with nursing (15), occupational therapy (13) and physiotherapy (12). Eleven participants received a social work service, 9 homehelp and 8 recollected contact with the co-ordinator.



• **Craigavon and Banbridge**

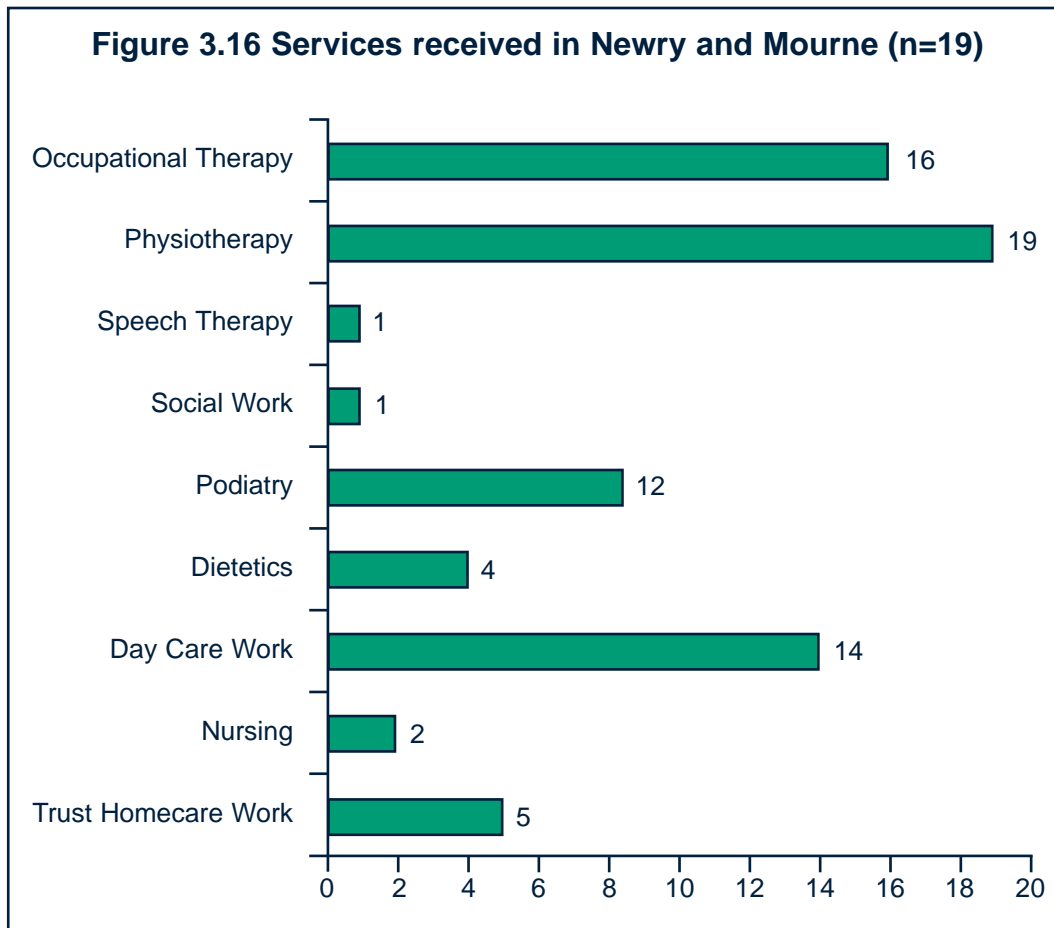
Figure 3.15 illustrates the various elements of care which were part of the intermediate care scheme in Craigavon and Banbridge. A high proportion of the participants received a homehelp service (25), occupational therapy (24), physiotherapy (24) and nursing care (22). Services which were less frequently received included speech therapy (2) and dietetics (1).



*This is not part of the intermediate care scheme but one participant said they received this service.

- Newry and Mourne**

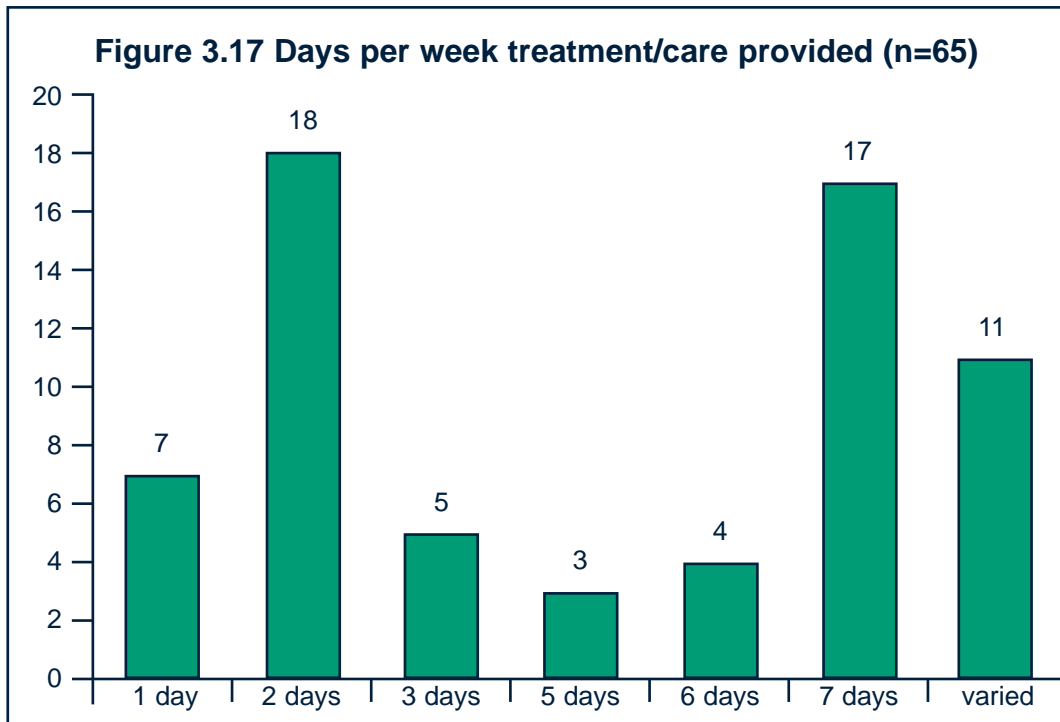
Figure 3.16 illustrates the various elements of care which were part of the intermediate care scheme in Newry and Mourne. All the participants interviewed (19) received physiotherapy as part of their intermediate care. High numbers also received occupational therapy (16) day care (14) and a podiatry service¹⁴ (12). Fewer participants said they received speech therapy (1), social work (1) and nursing care (2).



- Frequency**

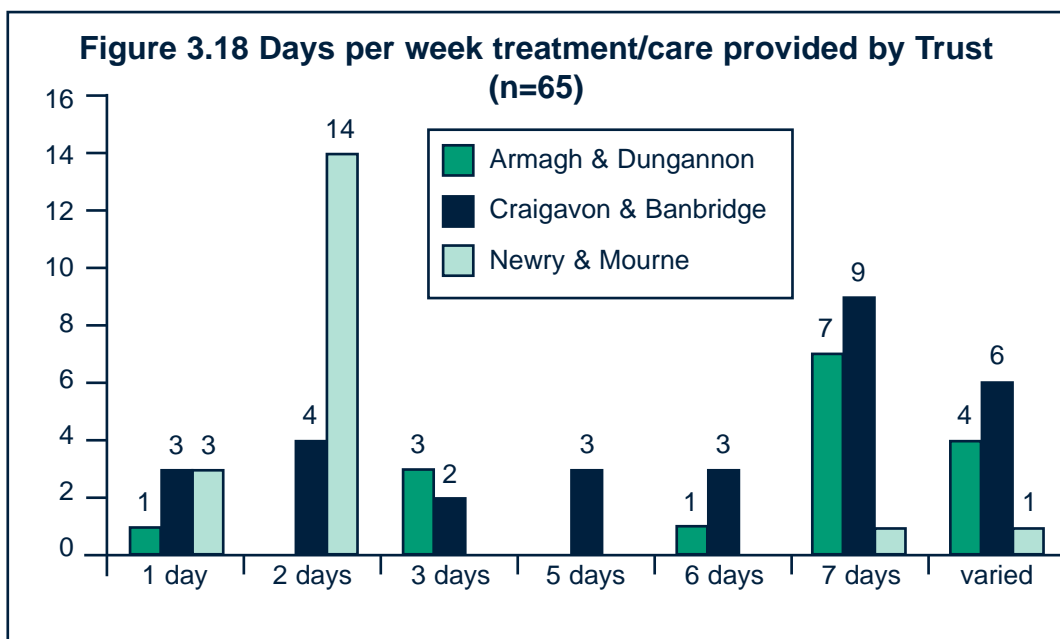
The number of days participants received the various elements of care from the intermediate care team varied from 1 day per week to 7 days per week. Seventeen of the 65 participants received treatment/care every day. These people either tended to receive a homehelp service or were in a nursing/residential home. Eighteen participants said they received care twice a week. Seven participants said they received treatment/care just one day a week.

¹⁴ Newry & Mourne was the only Trust area to have a podiatry service available for participants.



Eleven participants received a varied amount of care, this included participants who either had their care decreased over the period they were on the scheme or the number of days they received care varied from week to week.

The majority of participants in Newry and Mourne received care 2 days per week (14, 74%). Twenty-one participants (70%) in Craigavon and Banbridge received care 5 days a week or more. Half (50%) of the participants from Armagh and Dungannon received care 6 or 7 days per week. One participant in Newry and Mourne received care 7 days per week, this participant did not attend Archway Rehabilitation Centre but received domiciliary care.

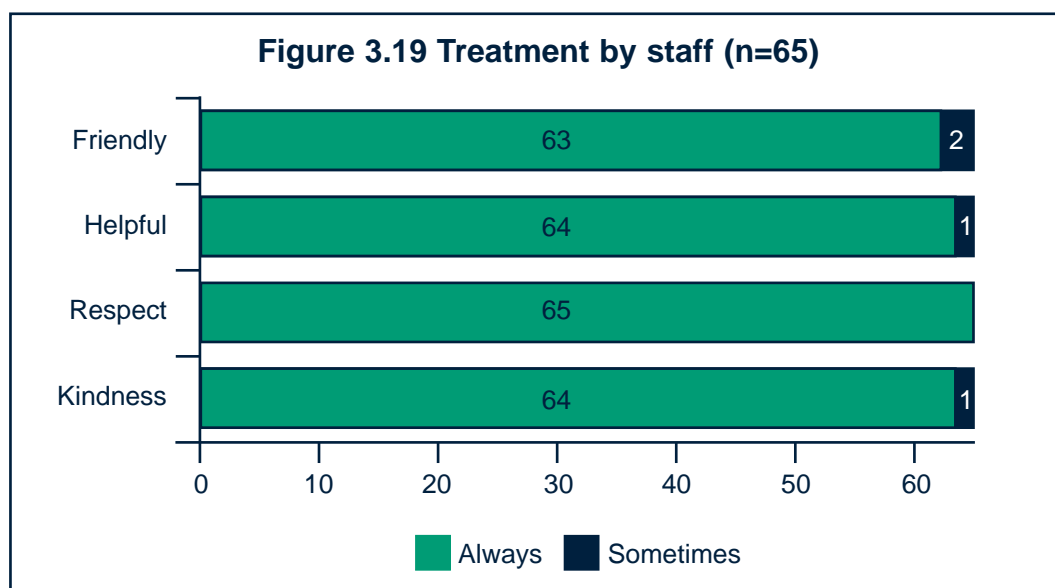


In terms of whether participants felt they received an adequate amount of the various elements of care, 8 participants across the Board area said they would have liked more physiotherapy, 5 in Craigavon and Banbridge, 2 in Newry and Mourne and one in Armagh and Dungannon. Six participants said they would have liked more occupational therapy, 4 in Newry and Mourne, and 2 in Craigavon and Banbridge. Six participants also said they would have liked more homehelp, 4 in Craigavon and Banbridge, 1 participant in both Newry and Mourne and Armagh and Dungannon. One participant said they would have liked more social work involvement.

STAFF

- Treatment by Staff**

Overall participants were satisfied with how they were treated by staff. The vast majority said staff were always friendly (63) and helpful (64) and treated them with respect (65) and kindness (64).



The reasons why participants considered the staff friendly, helpful, kind and respectful are illustrated below.

“ . . . very good and very friendly, it was help to have somebody come around because if there’s anything bothering you, you could have asked them”.

“ . . . I don’t think you could have got any better, it was really great, they were so helpful to you. And helping you to do things along with them they were showing you what to do and then saying ‘you do it’, it was very good what with the trolley and all, it was great like, and showed you what to do”.

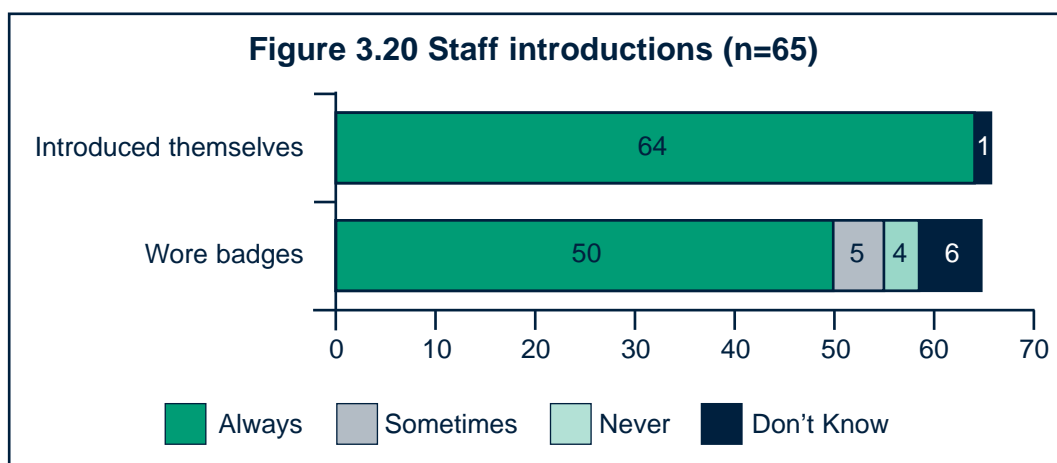
“Yes absolutely, well they were very helpful and very kind, efficient, not intrusive at all”.

“I think the most of it was kindness, you know, when you are vulnerable and you are down and you . . . have kids of your own and they are not here, and someone coming in and listening was the best medicine, really, they were very, very good and very kind”.

“Well the way you were treated and the things that they done and they were homely, you could have got on very well with them”.

“Well I felt I could talk to them about my leg and my complaint and they were sympathetic with me and tried to help me as best they could”.

The majority of participants also said that staff always introduced themselves (64) and wore name badges (50). However 9 participants said that staff either sometimes or never wore name badges. Six of the participants who said that staff sometimes or never wore name badges were from the Craigavon and Banbridge area, 2 were from Newry and Mourne and 1 participant was from Armagh and Dungannon.



All participants interviewed felt that the arrangements were convenient for them. This was the case regardless of the location of the delivery of care at Archway Rehabilitation centre, at home or in a nursing/residential home.

Participants from the Newry and Mourne area who attended Archway Rehabilitation Centre felt that the provision of care in this way was convenient. Two main reasons for this were highlighted - that the care was provided locally and transport was provided.

“It was handy for me so, it’s only a mile and a half up the road maybe not that . . . it seemed to be all right, the taxi man came”.

"It was very convenient and it's only out the road, it's not that far".

"Well when somebody came and took me it was alright. They took me there and then came back for me".

"Yes they come in the morning with the car and lifted me, they took me into Newry".

"Well it was handy there, it was in Newry, so it was, so it wasn't too far away and it was convenient and the car lifted me and took me in and all, they were very nice too".

A high proportion of participants commonly mentioned that it was convenient as they were not fit to go out and receive the help elsewhere or they were not able to do things for themselves so it suited to have someone to come in. Other reasons as to why they found this convenient included their preference to be in their own home and the convenience this provided for family members.

"It was because I wasn't able to go out anywhere for a few weeks and so it suited me that they came and at night when one of the girls came to take off my shoes and tights . . . it didn't matter to me if they came at 8.15 or 8.30 because I couldn't go anywhere anyway".

"Much better, you felt much more secure especially when I wasn't well I hadn't to travel or go anywhere, they came here".

". . . well I think you know your own surroundings, don't you like, definitely, you can futter about or get up and sit down when you want to or lie down, you know, I thought it was really good".

". . . well it is just that I was here in my own house and I could do what I feel like - getting up and getting an apple or an orange or something to eat . . . I would rather have been in my own house".

"Because I like to be in my own home and get back into a routine at home".

". . . it suited better coming than having to go anywhere and she preferred to be in her own home. That was about all really it was convenient for us". (Relative)

"Yes very much so, well first of all probably my son felt it more convenient that I was here".

In addition some participants said it was convenient because staff would have telephoned before coming out to visit them to check that the arrangements were suitable.

“Oh it was very, everything was very nice. I couldn’t have asked for better. Because they would always call before to see was it ok at that time, or did I have another time or whatever”.

“Yes the arrangement was convenient because they telephoned and asked us . . . they contacted before they came out and every time and said does it suit you”.

“Oh it did, well they always arranged it now and rung up and asked me would it be suitable . . . they did yes. And if it didn’t suit me they always made it some other day that would suit me”.

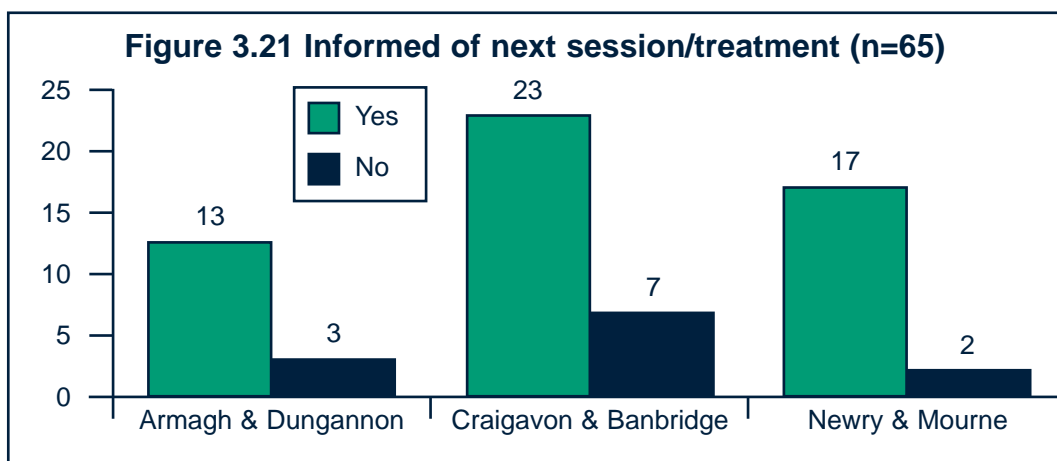
Those who had received the intermediate care in a nursing or residential home also found this arrangement convenient.

“It was convenient because we hadn’t facilities here for the condition I was in . . . wasn’t really able to come home at that time because my feet were also swollen up and the arm”.

“Well it was very convenient, because you were there and everybody was so helpful to you, there never a dull moment in Crozier house for me”.

- Informed of next treatment/session**

The majority of participants (53) were informed in advance of when their next session or treatment would be. Twenty-three participants in Craigavon and Banbridge, 17 in Newry and Mourne and 13 in Armagh and Dungannon were told when their next session or treatment would be. The numbers who were not told varied from 7 in Craigavon and Banbridge to 3 in Armagh and Dungannon and 2 in Newry and Mourne.



Sometimes arrangements for the next treatment or session were changed but generally participants said this did not cause any problems as they were notified in advance.

“Once . . . couldn't come because a meeting, there was some urgent meeting but she rang that morning”. (Relative)

“. . . or if they couldn't come they would phone up and said it would be the afternoon is that all right type of thing. But they would have phoned and said if they were going to be late”.

“. . . had to cancel but he had been to the place and then he made an appointment for another day and he got in touch by the phone”.

“They would have rang”.

“No if they didn't come there was somebody else sent”.

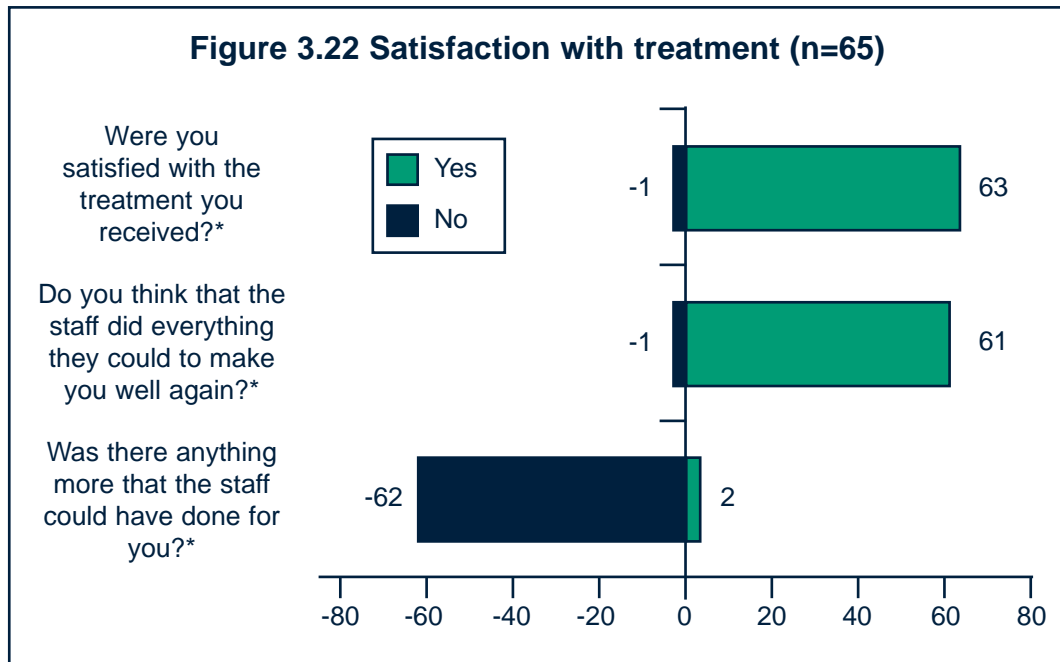
However 2 participants highlighted instances where care was not provided when it was expected. One was in Newry and Mourne and was due to the transport pick-up being late. The second case occurred in Craigavon and Banbridge.

“I think there was only one when . . . had to go to the Mourne one and everything was a bit late that day or I could have been in late. . . . sometimes they would have collected me about 10.00am and . . . one day it was 12.00pm. So then she hadn't time to give it, I was too late in”.

“Well there was one time there was something happened that you didn't have anybody come one night and you had no word, I don't know what happened. It was coming towards where they knew that she was managing”. (Relative)

- **Satisfaction with Treatment**

The vast majority of participants were satisfied with the treatment and care they received (63). The majority (61) said that they thought the staff did everything they could to make them well again and 62 participants did not think that the staff could have done anything more for them. One participant said they were not satisfied with the treatment they received because they felt staff had too short a time period available.



* Numbers did not add up to 65 due to participants not expressing a definite opinion.

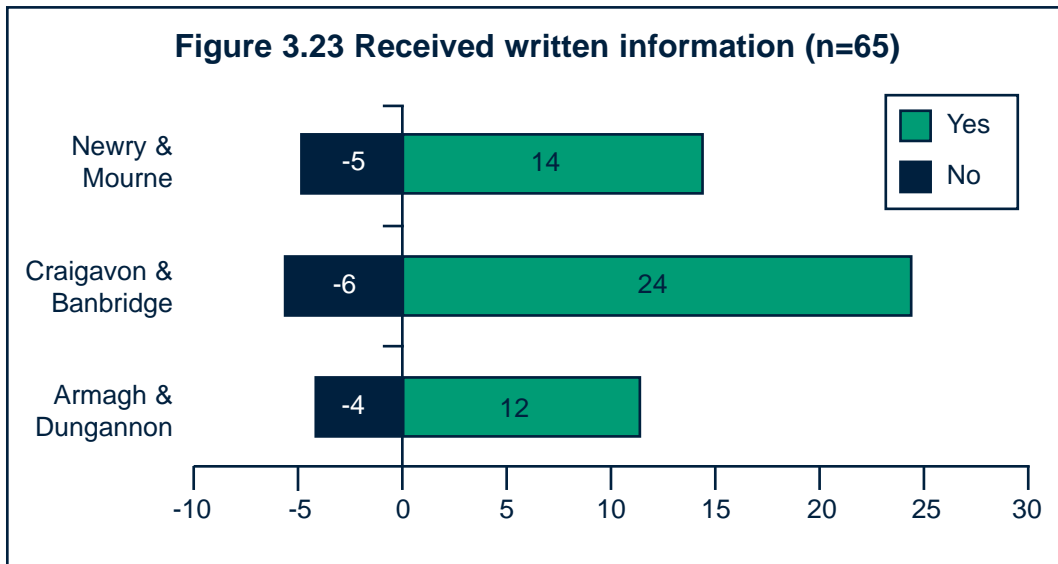
Two participants said that they felt that the staff could have done something more for them, this included being told they would receive physiotherapy but not receiving it and wanting help with tasks such as making the bed or hanging out clothes. One participant thought that staff could have done something further to make them well again.

INFORMATION AND COMMUNICATION

- Written Information**

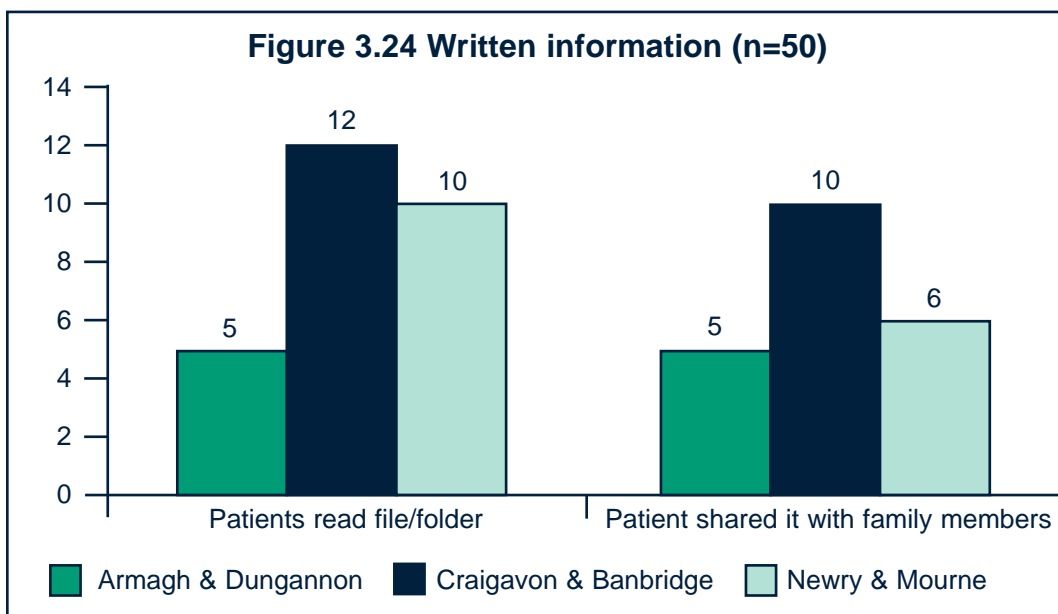
In advance of the evaluation, each of the Trusts shared a sample of the written information provided to patients. The schemes in Craigavon and Banbridge and Armagh and Dungannon provided the patients with their own 'Patient held file' in which information was provided about the scheme and staff made notes on the patient's treatment and progress. Newry and Mourne provided a leaflet about the scheme.

While the majority (50) of participants said they saw written information about their care and treatment, 15 did not, 5 in Newry and Mourne, 6 in Craigavon and Banbridge and 4 in Armagh and Dungannon. Six of the participants would have liked to have seen this information, 3 from Newry and Mourne, 2 from Craigavon and Banbridge and 1 from Armagh and Dungannon.



Of the 50 participants who said they received written information 27 read it and 26 understood it. Twenty-one participants said the information was shared with family members.

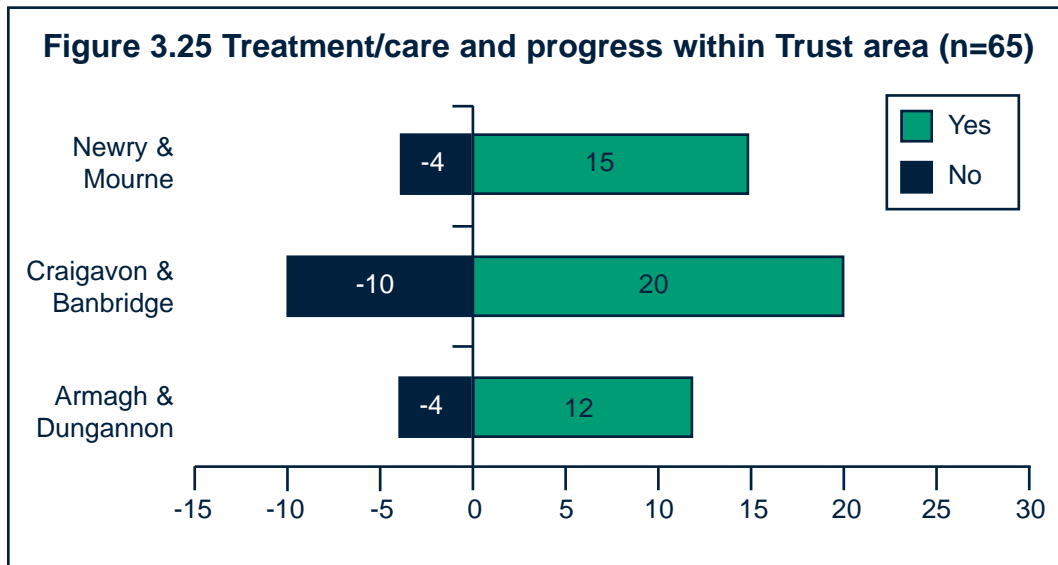
Twelve participants in Craigavon and Banbridge said that they read the information, 10 in Newry and Mourne and 5 in Armagh and Dungannon. Ten participants in Craigavon and Banbridge said they shared it with family members, 6 in Newry and Mourne and 5 in Armagh and Dungannon.



Information Discussed

In total 47 participants said that staff had discussed their care, treatment and progress with them while they were on the scheme. Ten participants in the Craigavon and

Banbridge area said that staff did not discuss their care, treatment and progress with them, 4 in Newry and Mourne and 4 in Armagh and Dungannon.



The types of issues discussed with participants varied. A large proportion said that staff discussed their progress with them. This included getting information about their condition and the therapy as well as being asked about and receiving feedback as to their level of improvements.

“Now . . . and . . . would have went into quite a bit about strokes and things and how you might come on”.

“They told me what I was going down there to get to have done and they would ask me each time I’d go down did my leg feel any better and did I do the exercise that they told me to do at home. And I would tell them yes, which I would do”.

“She couldn’t believe the way I was coming on that I was able to, not just right away, but in a few weeks, get my leg up into bed and get out of bed and she said it was great because when she came I couldn’t done neither”.

“. . . you would be told how you were going on”.

“She would say ‘you done very well today, now you did that yourself today.”

“I can remember just the morning carers saying ‘oh you’re walking well, you’re doing well, you’re getting up and all well’. They were encouragement all the time”.

A small number of participants said staff gave them advice and staff discussed

exercises with them that they could carry out at home.

“. . . they would say to me how could I sit on the passenger side of the car and they told me to try sometime to see how I could cope with getting into the steering side of the car, which I did and done it successfully”.

“She told me what to do at home . . . the exercises, not to do them if I was on my own”.

“. . . the therapist would leave exercises to do and checked up each time they came back had you done your exercises and checked like that and put you through them and see if you had made progress or not. They would discuss that with you and set a target next week and you would do”.

“. . . they would tell you what to do and how it would help you and try and do it, practice yourself. And they would tell you through time . . . I would be coming well”.

Another issue commonly discussed was in relation to how the participant was coping in the home environment and whether any additional help was required.

“Well the occupational therapist would have discussed about the bath, you know, what was suitable for the bath”. (Relative)

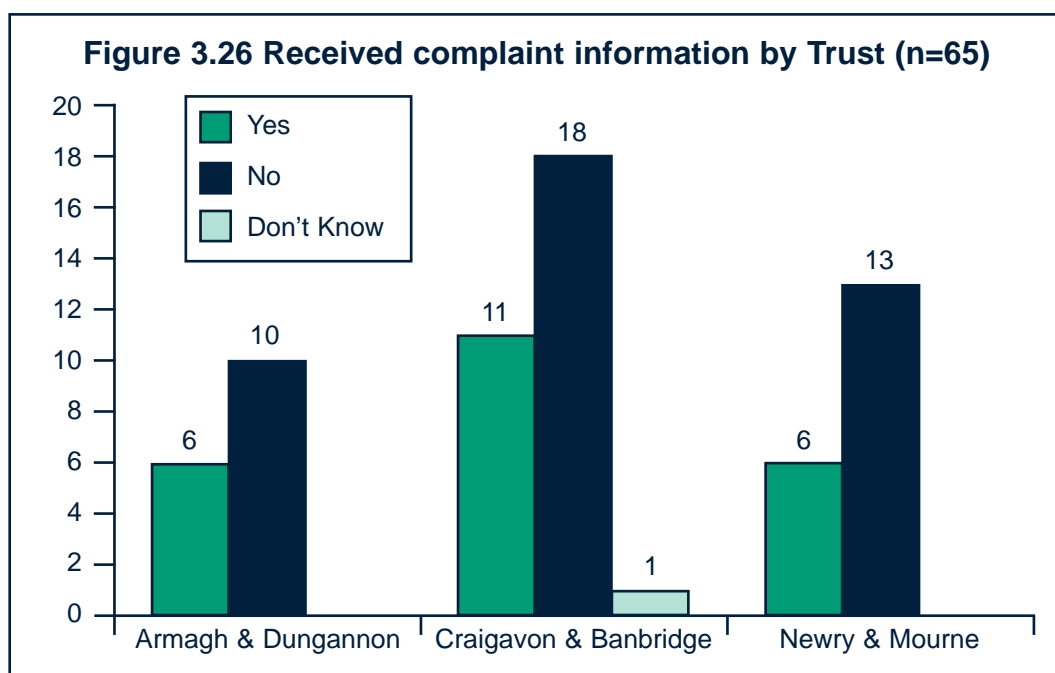
“We would have discussed what my home conditions were here. I told them of course that our toilet and all was upstairs”.

“Oh yes they would come in and any time they would come in they wanted to know how things were going and did I think I needed anything else. They would ask me things and sit and talk, how I felt today, did I think I was progressing a little more”.

“Yes they would have talked about my care and treatment and they asked me did I need different things, you know, they were very thoughtful”.

- **Complaints**

A large number of the participants (41) said they did not receive any information on how they could make a complaint if they were not happy about some aspect of their care, 13 were from Newry & Mourne, 10 from Armagh & Dungannon and 18 from Craigavon & Banbridge.



Half (20) of the 41 participants who said they did not receive any information on how to make a complaint were aged 80 years or older.

Table 3.5 Information received on complaints (n=65)

	Age			TOTAL
	60-69	70-79	80+	
Yes	3	11	9	23
No	8	13	20	41
Don't Know	0	1	0	1
TOTAL	11	25	29	65

When participants were asked what they would do if they were not happy with any aspect of the care they received and wanted to make a complaint, a number of themes emerged. The majority of participants said they would not make a complaint, either because they didn't know what to do or they had no reason to complain or even if they had, they would be reluctant to do so.

"I don't know I would be the last one to be complaining anyway".

“Don’t know, I wouldn’t make a complaint”.

“I would say nothing at all”.

“I wouldn’t complain to anybody, no indeed I wouldn’t not, I had no reason to complain, because them girls were good to me”.

“I didn’t think that there was anything I could do about it”.

Some participants said that if they had a complaint they would speak to a member of staff, either to the person about whom they had a complaint or another team member. The social worker was frequently mentioned as the staff member that participants would approach regarding a complaint.

“Well I would have just said to them, to whoever that I thought wasn’t right, I would have said to them ‘well I don’t like that’ or ‘I don’t think you should do that’.”

“I would make the complaint to the person I thought it was against anyway”.

“Well it depends who the complaint was about it. If it was the carer or anything like that I would tell the social worker. I don’t know who I would contact for the physio. I would just have rung into Gilford, you know, the head office and said if there was anything”.

“I wouldn’t know what I would do unless get in touch with the social worker”.

“Ring up some of those social workers”.

“I would get on to somebody, I don’t know what I would do, ring somebody up and let them take it from there, social worker or somebody there is bound to be somebody, I never thought about that to tell you the truth, it didn’t enter my head”.

A small number of participants however, remembered receiving some information which contained telephone numbers they could contact.

“There was a number to ring but that was if you wanted something, ring this number if you need anyone”.

“Well now, what she told me to, say the carer didn’t come at night . . . and if they don’t come and she give me a mobile number they are on call and somebody is on call, you see, and you ring them”.

"I suppose I would have rung up whichever one of these people it applied to because I had the phone numbers in the book".

"Well I would follow the rules in the book".

Some participants specified other people they would raise the issue with if they had a complaint. Family members were highlighted and two participants in Newry and Mourne said they were encouraged by staff to identify any problems to the researcher during the interview.

"I would just get on the phone to my daughter and say could you come up".

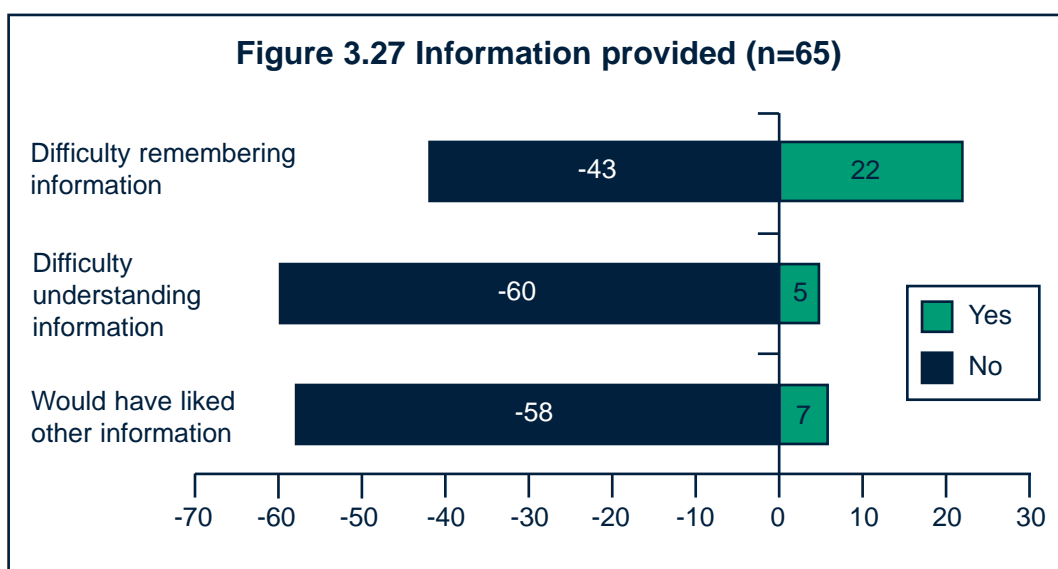
"I would just ring up and tell". (Relative)

"They told me I could make a complaint if I wanted to and that I would give it to you, they told me you would be coming out to see me".

"They said if there was any complaint I had I was to tell you. Speak up and speak out anything I thought".

- Accessibility of Information**

While the majority were able to understand the information provided to them by staff (60), 22 participants had difficulty in remembering this information. A number of participants (7) would have liked more information than they received.



*One participant said they didn't know.

Most of the participants who had difficulty with either understanding or remembering

information attributed the reason for this to themselves, either a poor memory or their age. However, others said they had difficulty because the information was either too complicated or they got too much.

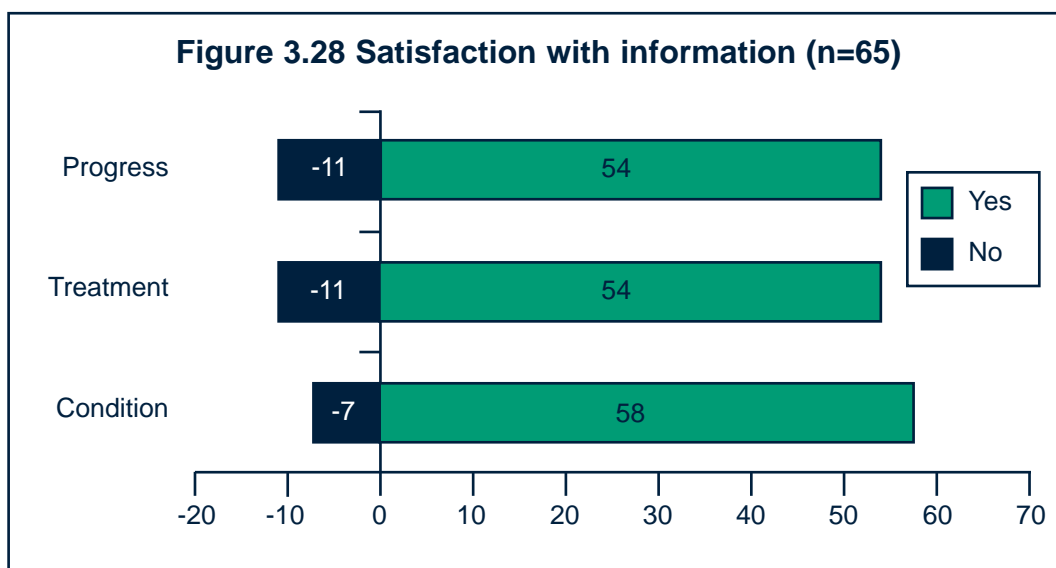
“At first I couldn’t understand it and then the nurse spoke to me and explained things to me. Just when you see things written down it is different to somebody telling you”.

“Most people could have understood, it but it was just my dad was never used to being told how to get in and out of bed. And then when they are not there ‘I do it my way’.” (Relative)

“Well if anybody gives me too much information . . . if I’m not interested, I just switch off and think of something else”.

• Adequacy of Information

The majority of participants were satisfied with the information they received about their condition (58), treatment (54) and progress (54). However some were not, 11 were not satisfied with the information received about their progress, 11 were not happy in relation to treatment and 7 with respect to information about their condition. Out of the 11 participants who were not happy with the information given to them on their treatment 5 were also not happy with information given to them on their condition.



The issues about which participants felt that they would have liked more information included their condition and health promotion advice as to how they could maintain or continue progress.

“More information on my condition especially from the hospital”.

“Time to explain to me more about my condition and what way it was, I thought they could have explained it better to me. As I said they never seemed to have time, you see”.

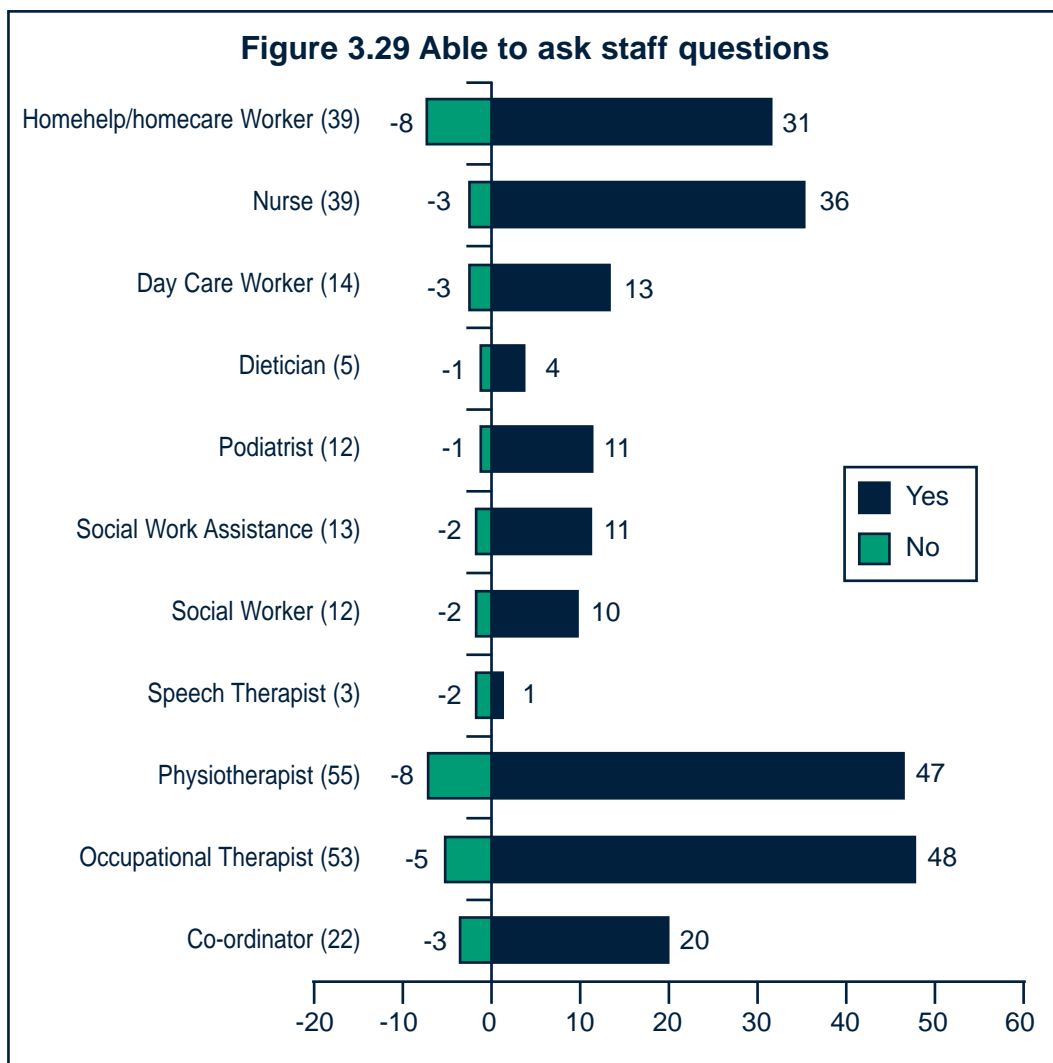
“What I would like to know is what kind of exercise is helpful. I’m still not sure whether she should be stretching”. (Relative)

“. . . a wee bit more information on what exercises I could do, further along the line, you know. I’m at the stage now were I could be doing, I’m walking a good bit more now . . . but I would have liked a few more leg exercises things to do”.

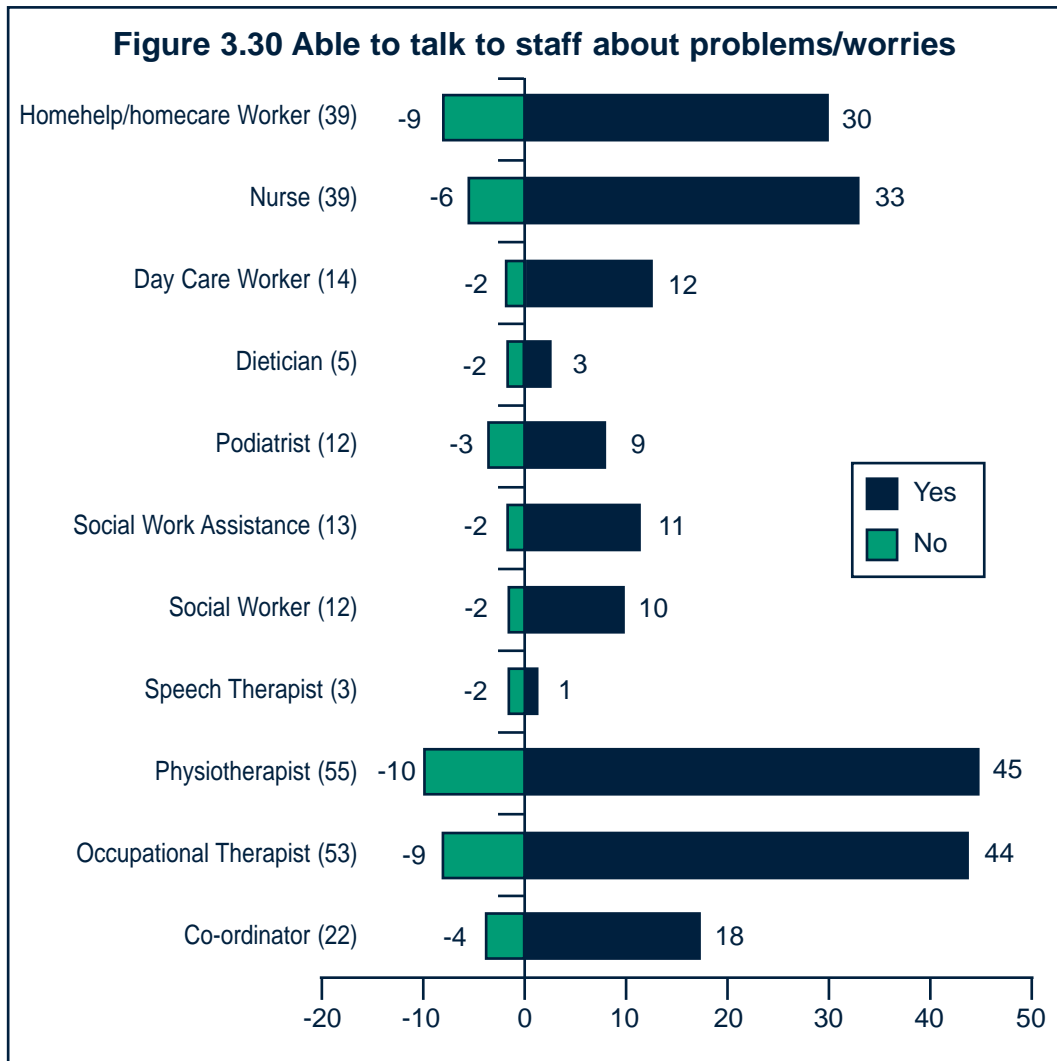
“I would like to have known what not to do. I would have liked to have a leaflet on that sort of thing, you know, that you could have referred to”.

“It would have been nice actually if mummy had been given a list of things she could do to help her hand, so like even if mummy was given it, I could do a few things with her. Or perhaps even if I was brought up, say on the last day, and say ‘oh your mother is doing very well, these are some of the exercises perhaps you could help her’. A wee list because I mean, I don’t know what I can do with mummy to help her”. (Relative)

The majority of participants felt that if they had any questions they could have asked the staff. However there were a number of people who felt they couldn't - this included 8 participants who did not think they could ask questions of the physiotherapist and the homehelp/Trust homecare worker and 5 participants who didn't feel able to ask the occupational therapist questions. While the majority of participants identified at least one member of staff they could have asked questions to, 3 didn't.



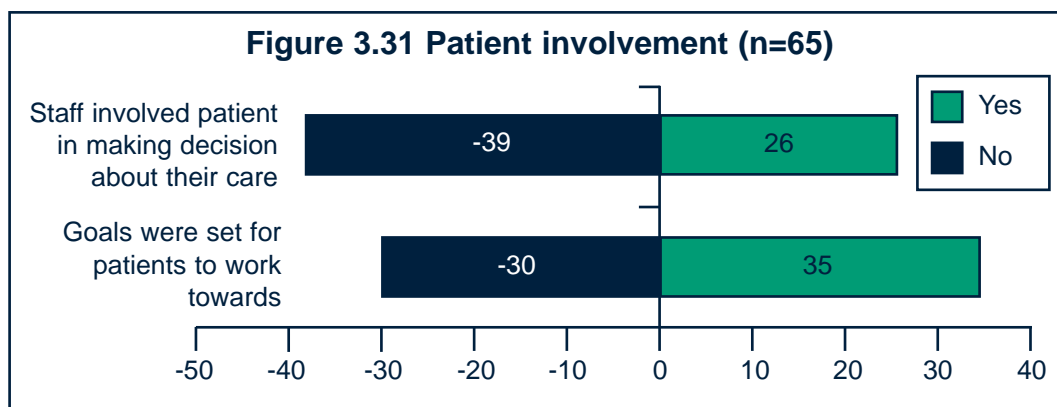
The majority of participants felt that they were able to talk to the staff if they had any problems or worries. However between 9-10 participants indicated that they did not feel able to talk to the physiotherapist, occupational therapist and the homehelp/Trust homecare worker about any problems or worries. While the majority of participants identified at least one member of staff they were able to talk to about any problems or worries they had, 6 didn't.



INVOLVEMENT IN DECISION MAKING

- Patient Involvement**

Over half the participants interviewed (39), stated that staff did not involve them in making decisions about their care and 30 said that staff did not set goals for them to work towards.



However 35 participants said staff had set goals for them to work towards. Goals were set progressively. Once a certain level was achieved then the goal increased. Achievements of the goal often meant the participant had to practice on their own.

“They said I need to practice the exercises here at home and then the next week we would do something else . . .”

“She would explain to me that we are going to go a bit further tomorrow . . . and we are going to try something different, so she always talked it through with me. They gave me things at home to do, exercises to sit here at night, pages and pages all printed out with exercises”.

“I definitely did, yes, it was up to me to try to meet that goal by the next time he came back.”

“Oh yes . . . the physio came out one time and next time we come out we will be doing this that and the other. That was an advancement and I found that alright”.

Participants understood that the aim of setting goals and working towards them was to help them regain as much independence as possible while they were on the intermediate care scheme.

“. . . the aim was to get as much usage of your hand back again and so on and . . . goal would have been so you could wash and try and get as much of that done by yourself”. (Relative)

“. . . it was, well to get me back to what I was before I went into the hospital. And then the district nurse says it will all come, it takes time don't rush things, that is the advice she gave me”.

“Well, yes. Like, they told me to do and I done it and that was my ambition, to get it back and get it going. I would hate to not be able to walk again”.

“. . . we just hoped he would get back to it and that's what they were trying, to get him back to what we had told him he used to be able to do”. (Relative)

Participants in the Newry and Mourne and Craigavon and Banbridge areas were more likely than those in Armagh and Dungannon not to have felt involved in making decisions about their care. Thirteen participants in Newry and Mourne said they were not involved in making decisions about their care and treatment, 18 in Craigavon and Banbridge and 8 in Armagh and Dungannon.

Table 3.6 Participant felt involved in decisions about their care (n=65)

	Yes	No
Armagh and Dungannon	8	8
Craigavon and Banbridge	12	18
Newry and Mourne	6	13
Total	26	39

However, participants did not express dissatisfaction with this arrangement. When asked about not being involved, they said they didn't need to be involved and were happy to leave the decisions to staff.

The 26 participants who said staff had involved them in making decisions about their care and treatment were asked in what ways they had been involved. Two main ways were highlighted in which staff had involved them. This included being provided with information, having the exercises explained and also being advised on what exercises to do.

“They would have talked to you, it was usually when you were getting . . . your physio or before your physio . . . would talk to you about it”.

“They would have talked about it . . . occupational therapist when she told and explained to . . . when she would be coming back the next day, she wanted her to make a meal and she wanted to be here and supervise her and see if she was happy enough and that was she told us what would be happening in the day ahead”. (Relative)

“They would have explained why they would have wanted mummy to do it and the benefits of it . . .”. (Relative)

“Well they would advise you what you should be doing and all this . . . and tell you, ‘you’re improving’ or ‘do something else’ or ‘you’re not walking straight’ or something”.

“They involved me all the time, yes, and told me what they were doing”.

“They sort of said what they were going to do, and explained what they were going to do and was that alright with her, you know”. (Relative)

The second way in which participants felt involved was in providing feedback. Staff asked them what they thought of their treatment and participants felt that they had control over the treatment.

“They would have asked me what I thought of it and all that”.

“Well they would have talked to you about what was happening to you and then it was up to you whether you wanted to do it or not. You had the final say”. (Relative)

“They involved me as well, yes. Well they would ask me about the facilities that they brought, was the chair ok, was the zimmer ok, am I able to do my exercises myself or would I need any further assistance”.

“They did, the staff would ask you are you happy to do this x, y and z, we seem to be very positive about it, but we are, the truth is they are a good team”.

“Well they came and asked what I would need, you know, and if I wanted somebody to come more often than they were coming”.

- **Family Involvement**

Just under half (31) participants said their family members were involved in discussions with the staff about their care and treatment. They highlighted various ways in which this occurred. Some participants indicated that the family were involved in discussions at the initiation of the intermediate care or that they were asked during the course of the care about the needs of the patients or the family.

“I was here when . . . came first and she discussed everything and she explained the whole scheme and what it was about, she was fabulous”. (Relative)

“Well it was actually me, I was here, I was the one who answered the phone, . . . it was before granny was coming out to see whether we felt it was intermediate care whether, that would be acceptable for her and whether that would be the right support and what she would need prior to her coming out of hospital”. (Relative)

“. . . everything that they wanted to do they would have rang and asked us first before they would have done it”. (Relative)

“Was there anything that my mum needed and you know was I happy with the things they were doing . . . came out about 2.00 we were just home about half an hour and she stayed until after 4.00 and got her sorted and explained everything”. (Relative)

Others said that relatives were involved in discussions on an ongoing basis they were kept informed of progress and had the opportunity to ask questions. Some indicated that relatives were involved on an ongoing basis because they had a role to play in the rehabilitation process.

“A couple of my daughters were talking to . . . they would ring her up on the phone about . . . , how I was going on and what was needed to be got for me when I came home”.

“Well the nurse always discussed the blood pressure, that he had taken his tablets and all those things and was he sleeping and the bowels working and all that”. (Relative)

“. . . she went to them and asked them all the questions of the day and they told her”.

“Myself and my sister . . . would have been in with . . . and would have been speaking to her . . . took cards and that home with her, you know, to try and do them at home in between, to boost her on”. (Relative)

“. . . just what was available and what he needed and what they felt that would be helpful to him and helpful to me as well . . . showed me how to do the exercises with him . . .”. (Relative)

“. . . about watching that he didn't fall and as a diabetic that his blood sugar was kept right. That would have been the health visitor and about if he wasn't able to get out of bed, how to avoid bed sores and things like that, just practical things”. (Relative)

TRANSPORT

This section only includes the 15 participants who attended Archway Rehabilitation Centre in Newry and Mourne Trust. Only one participant used their own means of transport and the other 14 participants were taken from their home to Archway Rehabilitation Centre via taxis organised by Archway Rehabilitation Centre.

The majority of the participants said that they found the taxi coming to their home and collecting them very convenient, and that they might not have been able to go to Archway Rehabilitation Centre had this not been the case.

“I think the transport was the main thing, if you hadn't had transport you wouldn't have been able to go, you had nobody to take you”.

“Sure it couldn't have been handier, a car coming to the door for you and taking you there. It was great, like, there was nobody in the house here to bother, there was no trouble”.

“At that time I wasn't driving, somebody collected me and took me out and left me back and that was great”.

“The drivers came and they helped me into the car and helped me out of it at the far end”.

Generally participants shared the taxi with other participants attending Archway Rehabilitation Centre. Most said this was the case but didn't seem to mind.

“There wasn't usually many in the mornings, there might have been one would have been lifted before they came here”.

“Usually there would have been about two in the car before I'd be collected”.

“Well sometimes they would have collected me first and I would have to go round Mayobridge and that and other time they would have collected Mayobridge and then come to me and picked me up”.

“It wasn't that long, just lifted one woman”.

Arrival at the participants' homes for collection seemed to vary. Generally participants felt happy knowing that they were going to be collected and even if the taxis were late, participants said they knew they were coming and as they were voluntary drivers they allowed for this. There was one occasion when the taxi didn't turn up.

“Sometimes he was a bit early but that was neither here nor there, he was doing it voluntary and I suppose you can't expect, he came within the specified time, it was good”.

“It could have been a bit late, you see sometimes they would have collected me about 10.00am and . . . one day it was 12.00pm”.

“They come between 10.00am and 11.00am, apart from that one day, it was 12.00pm”.

“They came at all different times but I was usually ready for them”.

“I had to ring up once because there was no transport but they came eventually”.

“When people are doing it on a voluntary basis you don't mind if they are a wee bit late”.

One theme which emerged which caused dissatisfaction with the transport was in

relation to getting home in the afternoon. Participants were eager to get home once their session at Archway Rehabilitation Centre was finished and having to wait for the taxi to return in the afternoons caused some dissatisfaction.

“Well you were ready for home but there was no car for you until 4.00pm maybe 4.30pm so you sat there and waited and that was terrible. I would have rather have been going home . . . you can’t blame the taxi men, they are doing other jobs doing schools and they couldn’t get back but that’s the trouble and everyone that was there felt the same”.

“Three hours that’s a long time. I didn’t like it . . . I thought it was a bit long and boring”.

“They were good enough only for you didn’t get home in time you were there 2 or 3 hours . . . a waste of time”.

“That was the only trouble we had - sitting there too long in the evening come to 4.00pm/4.30pm you get fed up”.

Some participants were not happy with the transport for other reasons, including the mode of transport.

“What I didn’t like was they had a radio and some of the people who were driving and I was sitting in the back and you were blasted”.

“The second was kind of a mini bus thing which wasn’t so good, it was harder to get into, but he only came when something happened to the other man that he couldn’t come, they got this man on short notice”.

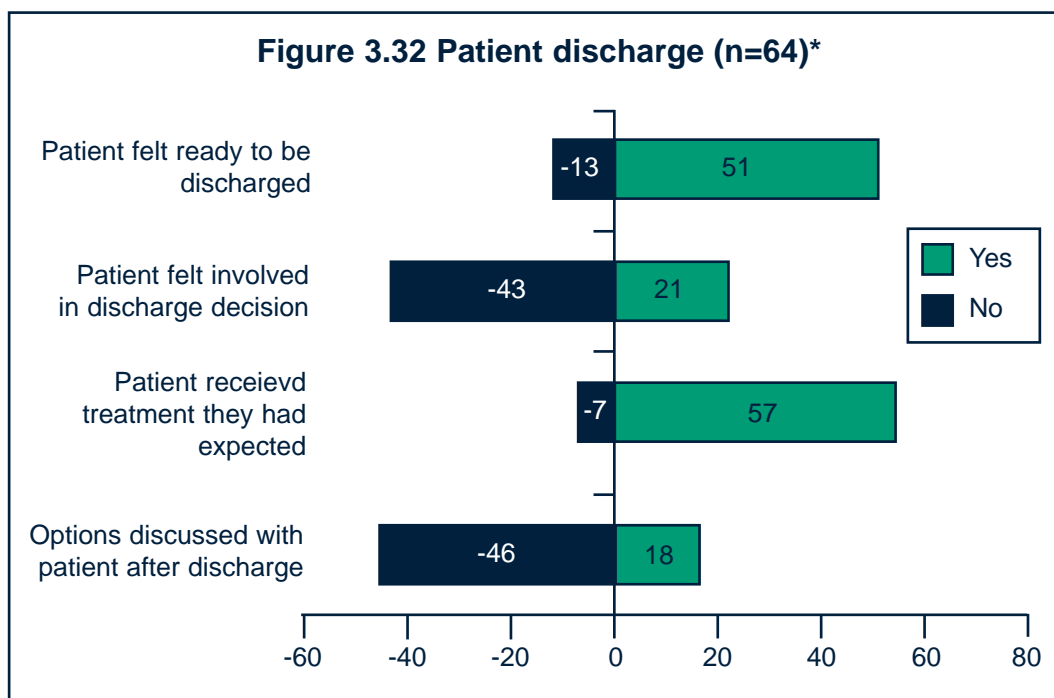
“I suppose a different type of person wouldn’t have found it difficult to get up into it but the other patient who was in it, he had his knee done and I had had my hip done so both . . . it was hard to get up into the bigger vehicle”.

“Well there was this one day that was . . . meant to be a taxi and they sent this man with a van and I had nowhere to hold onto and he was late and he was jumping all over the show, it was so uncomfortable”.

DISCHARGE

Overall 51 participants said they felt ready to be discharged from the scheme when they were and the majority (57) said they had received the treatment they had expected. However, 13 did not feel ready to be discharged and 43 did not feel involved in making

the decision to be discharged. Forty-six participants said their options after discharge were not discussed with them.



*One person did not complete the Interview

• Timing

Participants were asked why they did or did not feel ready to be discharged from the scheme. The 51 participants who were happy with the timing of their discharge identified a number of factors why they felt ready at this time. A large number of participants felt ready for discharge because they were better able to manage than they had been. This included improved mobility, being able to attend to their personal care needs, reduced pain and improved confidence in their ability to manage independently.

“Well I felt like I was ready because I was going out and I was doing the exercises and they weren’t hurting me or anything else and I was walking better”.

“Yes, because my leg was stronger and I felt that I could go to bed and sleep and I had no pain and I kept doing exercises that they were showing me down there, moving my leg in different ways and all that”.

“When I was leaving here, I left with just a walking stick, because my physiotherapist came on the Wednesday and she checked the walking again and she give me a walking stick”.

“. . . well you know I thought I was doing well and I was getting round and getting about and went out in the car . . . I thought well I am feeling a lot better than I was so they had to pull out . . .”.

“ . . . my back ache had left me and I had a bit more confidence”.

“I did, because I felt fit enough to make my own meals and wash my dishes and all that sort of thing”.

Some participants said they felt ready for their discharge at this time either because there was nothing further to be gained or simply because the allocated time had expired.

“I did, well I knew everything about it, I knew what I had to do and they explained everything to me, that’s all you needed”.

“I just says to myself well sure they can’t do anything more for me and I think it was time I was stopped, . . . once my time was up I was contented”.

“I did, yes I thought they had done all they could for us in Roxsborough”.

“I don’t think they could have done anything more for him really”. (Relative)

“ . . . she had done her turn she is only allowed six weeks . . .”.

Some participants only felt ready to be discharged from the intermediate care scheme because this was followed with additional care.

“Well I think she probably wouldn’t have thought that if she hadn’t have been referred to the day hospital . . . because she was referred on, there wasn’t a problem”. (Relative)

“ . . . said that was their 6 weeks over but she said ‘I’ll guarantee you tomorrow morning the same thing will go on’ and it did”. (Relative)

The 13 participants, who didn’t feel ready to be discharged from the scheme when they were, indicated 2 reasons for this. One reason was that they did not feel fit enough to be discharged, either because of pain or their previous level of functioning was not restored.

“I would have loved to have stayed on and on, you know. To get more power into my left hand”.

“Because I was still the same pains and aches”.

“Because I wasn’t able to do anything for myself”.

“Well I just wasn’t what you call fit, I couldn’t get on my inside clothes and my stockings I just couldn’t manage them”.

The other reason was that they would have liked to have more time on the scheme because of the social aspects of it.

“We would have liked mummy to have more time there because she enjoyed it and it was good and you felt that mummy was still getting something”. (Relative)

“You would have liked to been in longer, you got used to them coming”.

“It wasn’t that she needed them, she missed the company of them coming in”. (Relative)

“. . . I missed the company of them coming in”.

Looking at the breakdown of whether participants felt ready to be discharged from the schemes when they were, across the 3 Trusts, 25 participants from Craigavon and Banbridge felt they were ready to be discharged, 14 from Newry and Mourne and 12 from Armagh and Dungannon. However 4 participants from both Armagh and Dungannon and Newry and Mourne and 5 from Craigavon and Banbridge felt they were not ready to be discharged. Six of the 13 participants who did not feel ready to be discharge were over the age of 80 years.

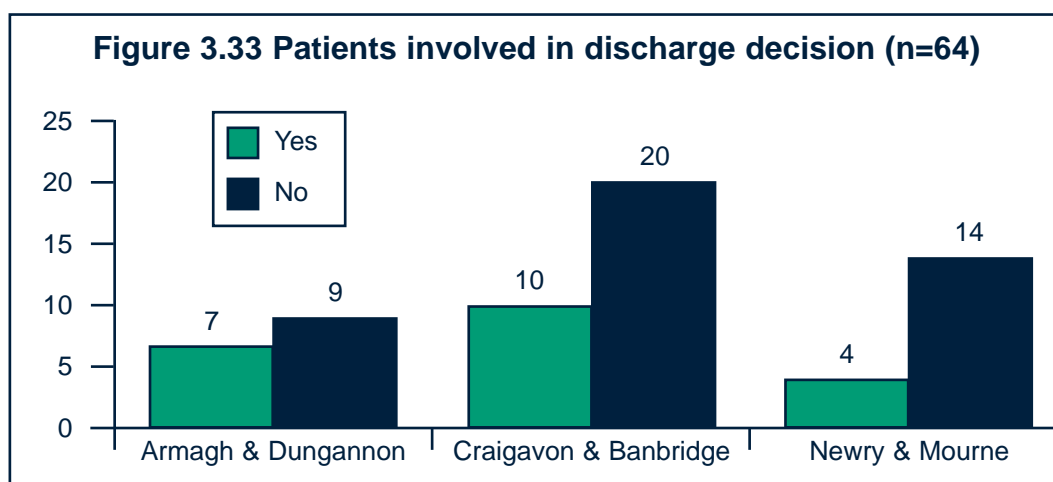
Table 3.7 Participants felt ready to be discharged (n=64)

	Yes	No
Armagh and Dungannon	12	4
Craigavon and Banbridge	25	5
Newry and Mourne	14	4
Total	51	13

- Involvement in discharge decision**

More participants in each Trust area felt they were not involved in making the decision to be discharged than felt they were. Fourteen participants in Newry and Mourne said

that they were not involved in making the decision about their discharge, 9 in Armagh and Dungannon and 20 in Craigavon and Banbridge.



Patients who initiated the decision or were asked by staff whether they were ready for discharge, felt they had been involved in making the decision for discharge.

“ . . . I said to . . . I think I could go home. I was confident enough”.

“I told them I wasn’t coming down anymore, if that’s what you meant”.

“She asked me would I be able to go but would I be in agreeance . . . and yes I did say that’s fine, that’s great I’ll be prepared to go whenever”.

“Well because they sort of asked me did I think I was alright now, or did I feel I needed them to come back any further, . . . They were very nice about it, they sort of let you make the decision”.

“She was asked was she happy enough to try it on her own and there was the option that if you couldn’t manage, all you had to do was to ring and there would be somebody out to you”. (Relative)

Those who were not asked tended not to have felt involved in making the decision. They said that staff decided they were ready for discharge or it simply came to the end of the allotted time.

“ . . . she come out here at 9.00am in the morning and the washer woman came at that time too, it was them made the decision, it wasn’t me”.

"I would say the individual people reported, back that I was x, y, and z".

"It's the occupational therapist, she puts in a report she comes out and sees you trying to walk and do things like that and then she puts that report into social services".

"All them girls in there are all involved in it".

"No, they just said they were stopping and that was that . . . said it was only for 3 weeks".

"They had so long to do it . . . I mean we were told at the beginning it was 6 weeks".

"Just the 6 weeks was up, the time was up, . . . , she just sat down beside me and give me a paper over there and she said . . . 'you're finished on Wednesday'."

- **Expectations met on discharge**

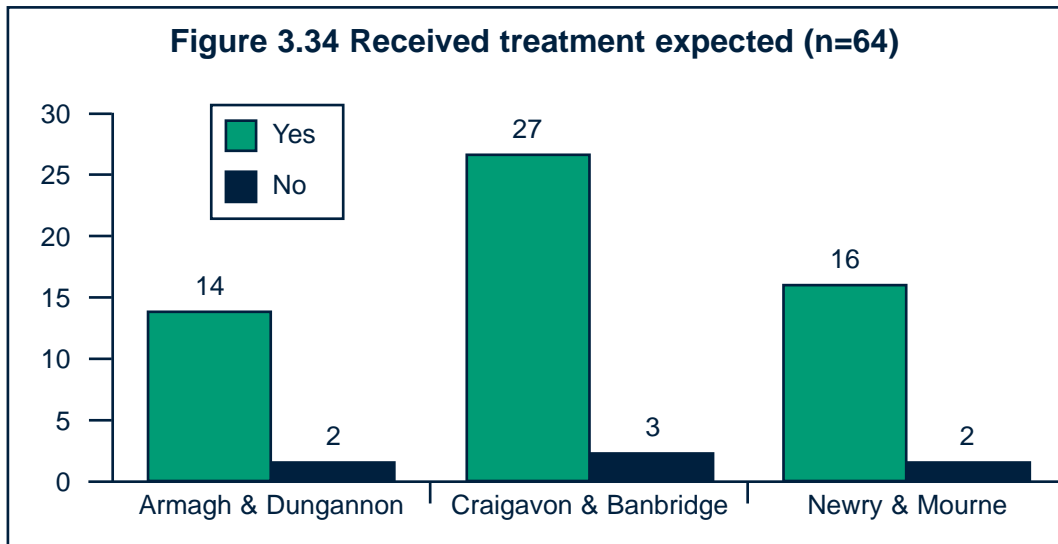
Looking at the extent to which expectations were met on discharge across the various age groups Table 3.8 illustrates that all 11 participants in the 60-69 age group said they had received the treatment they had expected. The highest number of participants (5) who said they had not received the treatment they had expected were in the 80+ years age group.

Table 3.8 Participants received treatment they had expected (n=64)

	Yes	No
60-90	11	0
70-79	22	2
80+	24	5
Total	57	7

All 12 participants who had received treatment at Archway Rehabilitation Centre said they had received the treatment they had expected.

Some participants in each Trust area had not received the care and treatment they had expected when discharged from the scheme. Three participants were from Craigavon and Banbridge and 2 from both Armagh and Dungannon and Newry and Mourne.



The reasons why participants did not receive the treatment expected are outlined below.

“No, because there was nobody done anything for me”.

“It’s an awful hotch potch of a scheme I think because there is not continuity you don’t know who is coming. All the time we were not told anything about who’s coming”. (Relative)

“I didn’t get much treatment, you know, just the same everyday, they came out”.

“No, I don’t think I did . . . (staff member) didn’t give me much exercises overall”. (Relative continued) “I think . . . went home when . . . left here. I was very disappointed in them”.

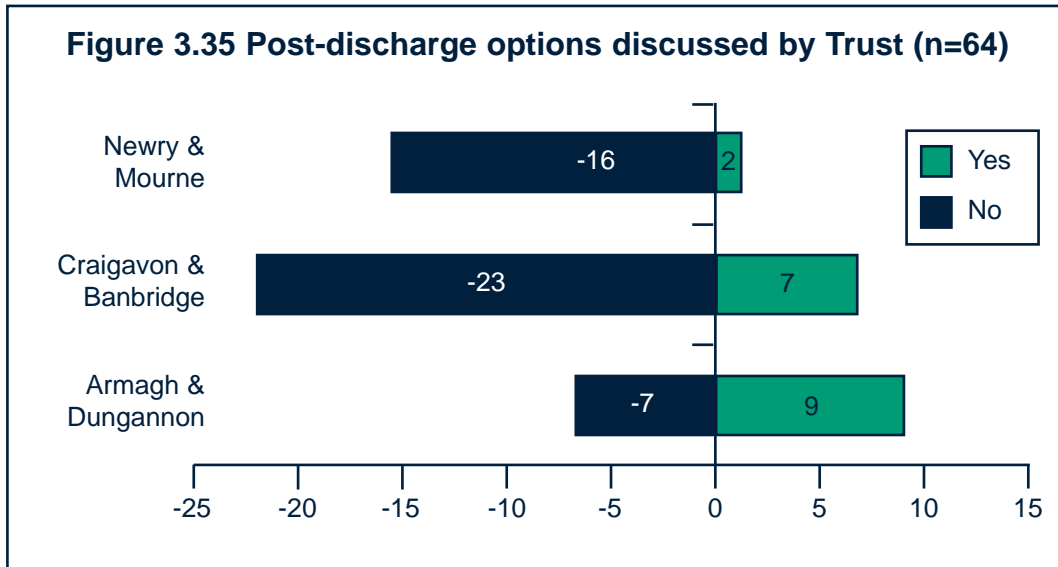
• Future options

Only 18 participants said options after their discharge were discussed with them. Twenty-four of the 46 participants who had no options discussed with them after their discharge were in the 80+ years age group.

Table 3.9 Post discharge options discussed (n=64)

	Yes	No
60-90	4	7
70-79	9	15
80+	5	24

More patients in both the Newry and Mourne and Craigavon and Banbridge Trust areas said that their options after discharge had not been discussed, than said they had. Twenty three participants in Craigavon and Banbridge said that they had no options discussed with them after their discharge and 16 in Newry and Mourne. Nine participants in Armagh and Dungannon said their options after discharge were discussed with them and 7 said this hadn't occurred.



The 18 participants who said options after their discharge were discussed with them highlighted different choices. Some were offered the opportunity to go to a day hospital, others were offered physiotherapy and some told they could contact the services again in the future.

“Well they said I could go to a care centre and I elected to go to Cloughreagh which is in the same garden area I only went once”.

“They asked you did you want to attend for physio once a week”.

“They just said I would get rest over in the Meadows and there was company and I wouldn't be as depressed as I was”.

“They just said will you go to Banbridge, when they finished with me if that was alright with me to go to Crozier Lodge and they asked me would I like to do it and I said of course”.

“I have to keep in touch with them and let them know how I am getting on and if I feel at any time that the awful pain is back again to come back out again”.

"I know they said that if there was anything needed at anytime . . . to get in contact, not to be afraid to contact them at anytime". (Relative)

BENEFITS

The majority of participants interviewed (61) felt they had benefited from the care provided by the intermediate care scheme. Fifty-eight participants said they were happy with the recovery they made.

Table 3.10 Perceived benefits (n=64)

	Yes	No
Patient benefited from care they received	61	3
Patient was happy with recovery they made	58	6

The 61 participants, who felt they had benefited from receiving the intermediate care, identified a variety of ways in which they benefited. Three main themes emerged:-

- Mobility
- Independence
- Confidence

The most frequently mentioned way that participants felt they had benefited was in terms of their mobility. This included; having better balance, being able to walk further and being less dependent on the need for a stick to assist with walking. Some also mentioned the importance of continuing the exercises in order to maintain their improved mobility.

"I have indeed because it has helped me to get more mobile I suppose".

". . . each day I was able to walk that little bit further and . . . my breathing was becoming more normal . . . and I was able to use my puffers and . . . I was getting into a routine that I would have to continue when I got home".

"Definitely, it is really good, I feel really good now even with the walking . . . I might not be able to walk . . . miles. I'm getting there, I can't expect a whole lot because it is only 6 weeks last Friday since I had the operation".

"I was able to walk and all better and that's all I wanted. Well I am walking with my stick

but sometimes I can go without my stick . . .”.

Another commonly mentioned way in which participants felt they benefited was in relation to regaining their independence. A large proportion of patients felt that after receiving the care on the scheme they were more independent. Areas in which they became more independent included washing and dressing themselves, preparing meals and getting out and about.

“ . . . I can dress myself and wash myself and put myself to bed”.

“Well putting on socks and that, I can put off me now, I can dodge about and make a bite to eat for . . . myself now”.

“I think I am getting on well. I can get things out of the cupboards and, you know, put things on the table, I couldn't do that before”.

“I think my independence has improved because I am fitter and can do things . . . I am able to go out and about feeling more comfortable”.

“I can drive the car and all that”.

Some participants mentioned that they benefited from the care received on the scheme in terms of improved confidence in their own ability to manage and cope on their own.

“ . . . you had more confidence about walking I suppose and things like that”.

“ . . . they were there to help you and they were reassuring you and make you feel confident, give you your confidence back”.

“It enabled her to get back to the lifestyle that she had before she had the fall and to get her confidence back. That was very important”.

Other ways in which participants felt they benefited were in terms of their physical and mental health.

“Yes well my aches and pains, I have got rid of those”.

“Well there is no pain in the leg”.

“Well coming back into the likes of Crozier House you had the staff there and they knew what was wrong and what you had to get and if you had an infection you were there”.

and they could find it out”.

“. . . feel better now, I felt depressed and all when I came out at first . . . but as I was saying I'm feeling a lot better now”.

Participants were asked what they found most beneficial. Some did not identify any single specific aspect but rather felt that the whole package and the combination of various elements of care was what benefited them the most.

“I think all the different people coming in, I think it took them all to bring it together because if one wee bit had been done in isolation . . . I don't think it would have been as good. I think it was the very fact that you had different people coming and each had their own area of expertise and each was willing to give advice to you and to want to help you get whatever you needed to achieve”.

“Well I thought them all very good to be quite honest, I can't pick out one and say . . . one done more than the other, so I found that they were all good, helpful”.

“The team all contributed so I couldn't pick out anyone”.

“. . . because everyone of them were just a fantastic team and all the family said the same thing and I think that aspect of it was very important as well”.

However others did point to specific elements of care which they found most beneficial. A large proportion of participants said they found the therapy elements of the care most beneficial. The benefit of the physiotherapy in improving their mobility was highlighted as was the input from the occupational therapist, although some said they found it difficult to accept in the beginning they had to do the task themselves rather than having someone else do for them.

“Well I suppose it would be the physio and the washing and helping you to wash and dress would have been the two important things”.

“I suppose . . . showing you how to get in and out of the bath”.

“Well at the time I saw the physio, for me, getting my mobility was good”.

“Well I would say the occupational therapist insisted that I did the things for myself, it seemed tough at the time but it meant that I gradually got use of my arms and getting my clothes on”.

“And been taught the correct way to wash and change with the handicap of your hand . . . how to put the things on and take them off. They did a lot of exercises with my hand and arm, you know, and even standing up holding onto a big ball”.

Some participants said they found the practical help they received most beneficial. This included carers coming in to assist with washing and dressing and getting participants ready for bed.

“Well I gained with somebody coming in to do the washing and dressing and at night particularly”.

“Well I think the carers coming in and helping him were more beneficial than anything because they washed him in the morning and cream him and get his clothes on and put him up here and then at lunch time it is the toilet and the wee walk and of course at night it is the putting him to bed”.

“I said the most helpful and even now is the homehelp”.

“. . . the carers came at the start they came at night and took my clothes off and put me to bed and all that, sure it was great”.

Other elements of care mentioned as most beneficial included counselling and the nursing care.

“I thought the social workers talking to me was . . . very good. Well with her talking to me, me talking to her relieved all the tension and everything, talking about my husband and that helped an awful lot”.

“Well the nurse coming in every morning. Well she done your blood pressure and that and she knew how you were going on and that”.

Participants also commonly mentioned 2 other features of the intermediate care which they found most beneficial. One of these was the encouragement and support they received from the staff. This included providing reassurance and instilling confidence in their rehabilitation and ability to function independently.

“He was very happy when . . . went out and would say that his blood pressure was alright and he was doing well. It did encourage him that”. (Relative)

“Given him a more optimistic outlook, a positive help, things that can do, in other words the encouragement that he got and I got”. (Relative)

“It encouraged me to get out of bed and I had the day in front of me”.

“They come and they helped me, they give me a wee bit of courage you know, a bit of courage coming and made me feel I was able and coming on alright”.

“They broke it up into steps for you, so that you gained a wee bit and then they were able to say to you ‘well look now, you are able to do that, we can move on now’, I think they gave you the confidence”.

“You know what was a really important aspect of it as well, that we felt as a family for mummy they just gave mummy such a lift because they were so positive and they were saying to her ‘aren’t you just brilliant’.” (Relative)

The other feature was the equipment which enabled them to be more independent.

“Handles and . . . a thing for the toilet and I had a commode and this chair, I have a handle grip at the back door which they are going to do then put the rail down”.

“Well the biggest thing was the thing for the bed, that was a life saver . . .”

“The stair rail was just a gift because mummy is able to walk straight up the stairs . . .” (Relative)

“. . . definitely; the aids they put into the house were fabulous”.

Two of the 3 participants who stated that they did not gain any benefits were from the Craigavon and Banbridge Trust area, the other participant was from Armagh and Dungannon Trust. All 3 participants had received domiciliary care. Two of these participants were over 80 years of age.

Table 3.11 Perceived benefits by Trust (=64)

	Yes	No
Armagh and Dungannon	15	1
Craigavon and Banbridge	28	2
Newry and Mourne	18	0

One person didn't receive the physiotherapy which they had expected, another felt they hadn't benefited because staff didn't do anything for them but rather watched them and another thought it was a matter of time until the improvements came about.

"No they don't do nothing, that's the problem, they don't do physio . . . the nurse said that I would need physio on that, well the physio doesn't do that, she said I would need that to get that fluid moving".

". . . I don't see where they helped me at all . . . Because they didn't do anything for me . . . if they had done something for me I would probably have put on me or something . . . but they never done that. They just stood back and watched you . . . I mostly had on me when they came but I hadn't washed or maybe shaved or something".

"What they did for me was really, it amounted to nothing at the finish because you had to wait to take time".

- **Satisfaction with Recovery**

The majority of participants (58) were satisfied with the amount of recovery they had made. Participants felt that they had made good progress; having feared not being able to regain their previous level of functioning, they were now fit to do things for themselves.

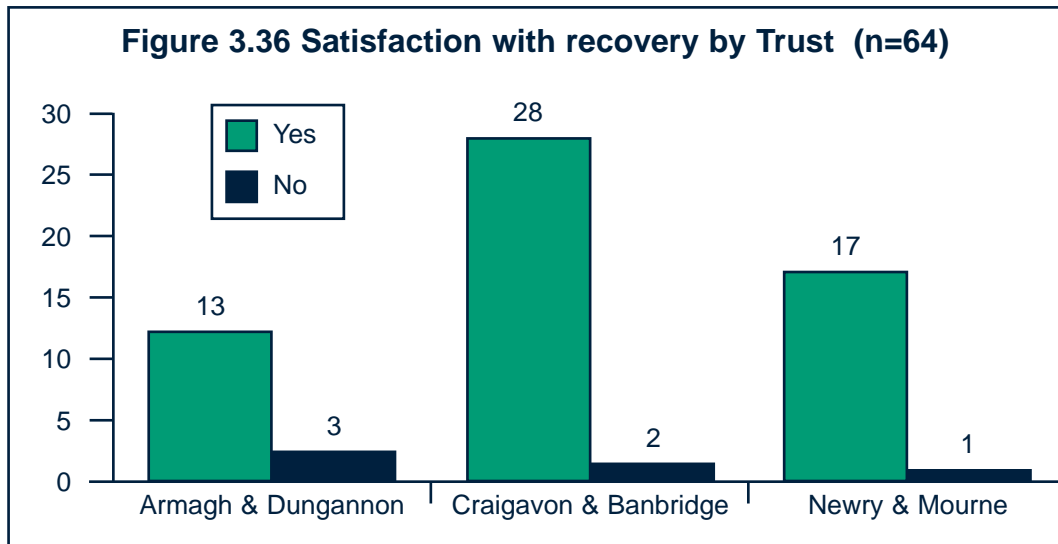
"A hundred percent, I never thought I would have been back to the way I am now, I can't get over it. I am just so glad every morning that I waken to think that I'm back to myself again".

"It seems steadily improved so I am still going that way so it's quite good".

"Well I am fit to do those things myself, I can make my dinner, I can make my breakfast and do all that, just what I used to do. If I just get a little bit more help in the hand here I will be able to lift the things".

"I can go up and down the stairs".

Overall 6 participants were not happy with the amount of recovery they had made. Three of the participants were from the Armagh and Dungannon Trust area, 2 from Craigavon and Banbridge and one from Newry and Mourne.



Four of these 6 participants had received domiciliary care and 3 were over 80 years of age.

Table 3.12 Participants satisfaction with care by age (n=64)

	Yes	No
60-69	10	1
70-79	22	2
80+	26	3

Those participants who were not satisfied with the progress they had made felt their recovery had been very slow.

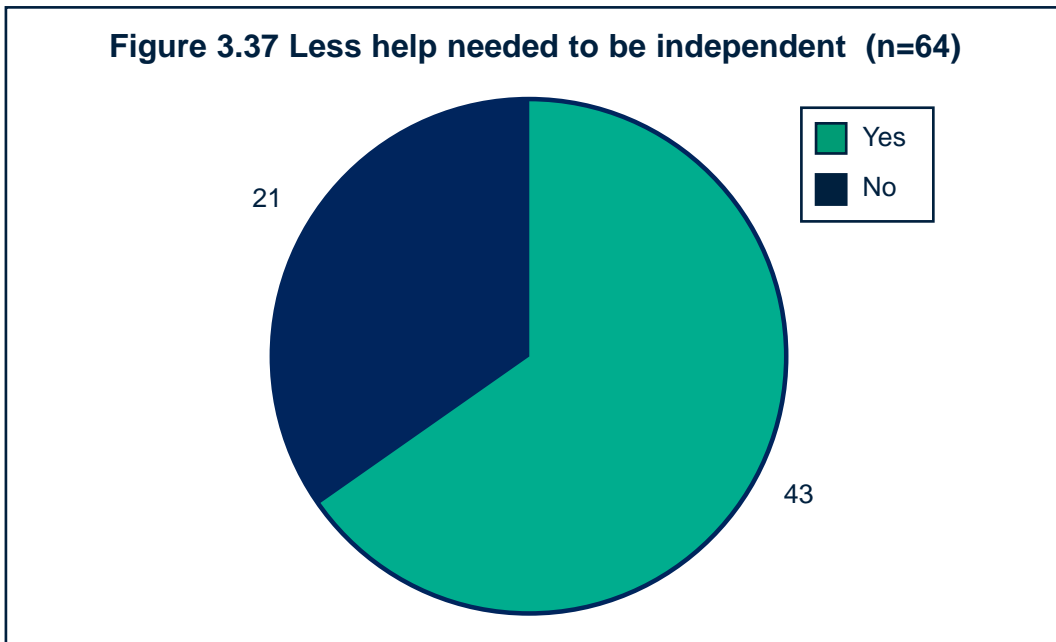
“Her recovery has been very slow”. (Relative)

“I thought I would have been better with the operation and all which I am not. That is why I have all this pain and problem, but that is nobody’s fault . . . it’s just one of those things”.

“It’s a slow thing, it will take time”.

- Help to be Independent**

Forty-three participants said that they now needed less help to allow them to be independent, however 21 said this wasn’t the case.



The number of participants who felt they now needed less help to allow them to be independent varied across the 3 Trusts. Twenty-two participants in Craigavon and Banbridge said they needed less help to allow them to be independent, 11 in Newry and Mourne and 10 in Armagh and Dungannon. The number who felt they still required help varied from 6 in Armagh and Dungannon to 8 in Craigavon and Banbridge. Out of the 21 participants who said they still needed help, 13 were over the age of 80.

Table 3.13 participants needs less independence by Trust (n=64)

	Yes	No
Armagh and Dungannon	10	6
Craigavon and Banbridge	22	8
Newry and Mourne	11	7

The reasons why they viewed they did not need less help were due to their inability to manage independently. Some required assistance with either their personal care or domestic chores.

“He can’t wash his hair or nothing himself, he can’t shower himself right, he can’t get the arm up to get the shower”. (Relative).

“Even showering yet, one of the girls has to be with me in the house all the time. I feel I need more help now, to help get me out of this. Well, I could just get over this now, I would be alright (depression)”.

“Well I am still not to the point yet, I am afraid, like this girl comes in and cleans, but I would be afraid not to have her come, because I don’t think I would be able yet to do all the things I always did. I am not anywhere near as independent as I was”.

“I think I’m less independent. I have to try and manage myself. I get nothing now it is all finished”.

“She is still very weak and she’s not getting over her illness that quickly. She needs all the help that she is getting”. (Relative)

Some participants felt that they needed extra help or additional services. They felt that they could not do the things they could have done previously.

“No, I still need help, maybe a bit more, you see, I can’t do the things that I could have done”.

“Oh I could do with more, I am not myself yet, but it will come, the nurse says it takes time”.

OVERALL SATISFACTION

• Aspects Liked Most

There were various aspects of the care which participants liked best. These included the multidisciplinary aspect of the care or, specific elements such as physiotherapy. Some liked best the benefits the care provided and other identified psychological or social aspects and the food as the aspects of the care they liked the best.

Some participants liked the multidisciplinary nature of the care the most. Participants liked the whole package of care and could not identify one element as better than another.

“It’s a question that all the different people were coming in for their various reasons and they all had a purpose”.

“The whole lot . . . it was of benefit”.

“The whole package was beneficial”.

“ . . . overall it was very good”.

Other participants liked specific elements of the care and stated the elements they liked best. This included physiotherapy, occupational therapy, nursing care and the homehelps/homecare services.

“Well the physio part, I liked that because it was helping my arm and shoulder and all”.

“The physiotherapy, the one that was in charge, she was very good and very helpful and she would explain all to you, what it was for and what was the idea of it and why it helped you or why it didn't”.

“Well I am going to have to say the district nurse because the physio was very good too but she sorted me all out with the tablets and the medication and my blood pressure and stuff”.

“ . . . the occupational therapist, they were brilliant I must say”.

“The homehelps”.

“Well the one working on my leg that I could walk, that I could stand and walk and make the stairs up and down. I felt it was great, the physio was really great”.

Some participants liked best that they had benefited from the care they received in terms of regaining previous levels of functioning.

“Well, I can wash myself right and well and I can dry myself and all. At the beginning I couldn't have washed that arm or anything with this bad arm and now I can”.

“Well I found as I went along . . . I was getting better every week, I was increasing”.

“Well they made me ready to look after myself and they were good company coming in”.

“Just because it helps to improve your mind and bring you back to health again, that's what it's all for to bring you back to health”.

A small proportion of participants identified the psychological aspect of the care as the aspect they liked the most. This included the reassurance provided in knowing someone was coming into their homes to check on them, improved mood, reduced anxiety and for some just the human contact.

“Because it is a good secure feeling to know that . . .”

“I’m not quite as nervous as I was”.

“You got an outside opinion not just what you feel yourself but somebody else giving you an idea”.

“When I knew they were coming that was . . . the best part of it really, I knew they were coming in to check on everything”.

“. . . just for somebody to . . . talk to, it’s about the most important thing, somebody you can tell your troubles to”.

“I got better mood while I was going to Archway”.

“. . . maybe what got from them I needed at the time was the kindness, you know just somebody to say, ‘oh you’ll be better’ and touch your hand”.

Other participants felt that the company was the part they liked best. This was particularly relevant in Newry and Mourne where participants identified the company of the other patients at Archway Rehabilitation Centre and getting out of the house. However participants in other Trust areas also mentioned the company of the carers coming into their home as it broke the monotony of the day.

“. . . it took me out of the house, you see, . . . I think it was good to get out of the house I think that was part . . . meeting the other people”.

“I did for my spirit I enjoyed it with the company, I enjoyed the company”.

“. . . I was happy when I was out there with the company and all”.

“There was good crack at it in the mornings too. You know, everybody had there own conversations as well. We had good company for one another and everybody talked in general, we all mixed and we all talked”.

“I like them coming at night, . . . I liked them coming at all times, they’d come and it broke the monotony . . . it gives you a wee bit of, you know, that somebody is coming”.

Some participants felt that the food they received in Archway Rehabilitation Centre or in the nursing homes was the aspect they liked the most. Getting a meal provided for them.

“ . . . having a wee meal it was lovely”.

“ . . . the lovely dinner I got there”.

“Well I suppose the meals were the best”.

- **Aspects Liked Least**

Participants were also asked what aspects about the care they had received, did they like least. A large proportion of participants felt that there was nothing about the intermediate care scheme they disliked.

“Like the least, em there was really none of it, you sort of needed it all”.

“There wasn't anything that I was dissatisfied with”.

A smaller number of participants however did identify aspects they disliked. This varied from staff coming into participants' homes, to waiting on staff coming to their homes and also included waiting at Archway Rehabilitation Centre.

A few participants were apprehensive at the beginning about staff coming into their home and them not being able to do things as they normally would.

“ . . . it was a very big thing somebody coming in to her house and her not be able to do the thing that she normally would and be in control. That is not easy to accept”.

“At the very early stages you would have been apprehensive about people coming in, in general”.

The report has previously identified that participants in Newry and Mourne were dissatisfied with the delay in transport being arranged for the return journey from Archway Rehabilitation Centre. Linked to this, participants in Newry and Mourne commonly identified the lack of things to do while waiting on the transport as the aspect of care they liked least.

“They tried to get the patients painting, it was a bit of a waste of time. It was a bit of a mess. If they had bought about 3 newspapers every morning and set them on the table and whether it was time to go home or waiting for the taxi you could have sat and read them”.

“I think that there wasn't enough activity, not enough going on in the afternoon . . . to get your total interest and people were there for their treatment and suppose when most

of the treatment was over they wanted to go”.

A small number of participants didn't like the loss of dignity and control which they experienced. They felt embarrassed in relation to the personal care aspects of the scheme.

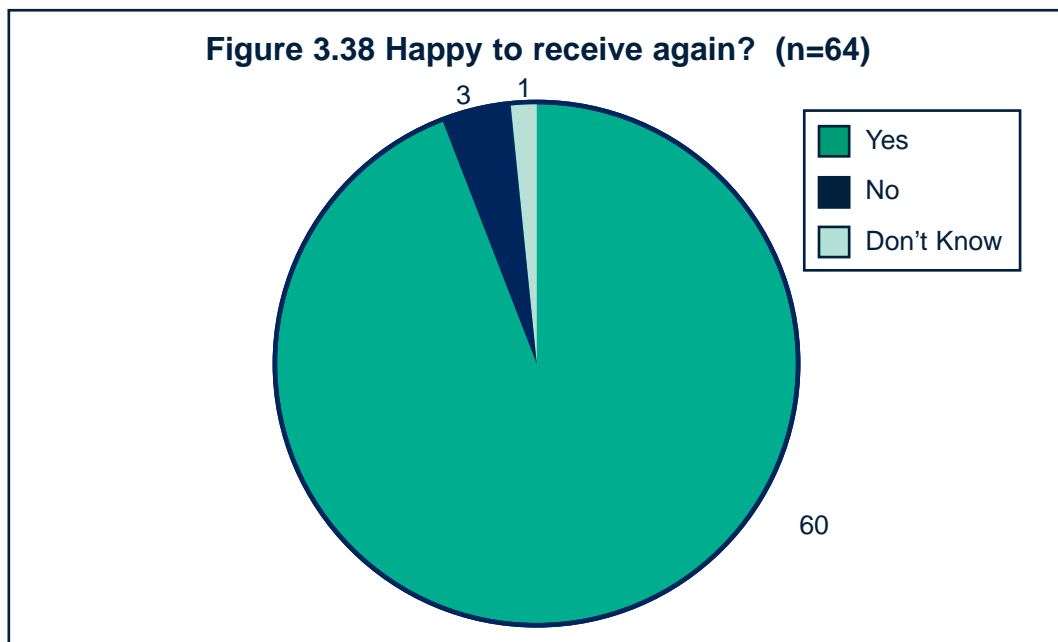
“I hate to say this but it is the carers, you loose a lot of dignity . . . nothing against the carers but it was just the dignity”.

“Well I didn't like the woman washing in morning now, it was a bit embarrassing for me like as you could understand”.

“I suppose, it was really having to get washed, your personal hygiene”.

• **Willing to Receive Again**

The majority of participants (60) said if required, they would be happy to receive a similar type of care in the future. Three participants said they would not be happy to receive this type of care again and one participant didn't know.



Out of the 3 participants who said they would not be happy to receive this type of care again, two were from Craigavon and Banbridge and one participant was from Newry and Mourne. All 3 had received domiciliary care. Two participants were in the 80+ age group.

Table 3.14 Happy to receive again (n=64)

	Yes	No	Don't Know
Armagh and Dungannon	16	0	0
Craigavon and Banbridge	27	2	1
Newry and Mourne	17	1	0

Those participants who said they would not be happy to receive the care again were dissatisfied with the initial arrangements and didn't think they got any assistance from the scheme.

"It's really a waste of time because they only come out to you to see what you can do for yourself and when . . . they think you can do the thing for yourself, that's the end of the story".

"It wasn't adequate at the start, it was really chaos, shambles, terrible. My sister had to make as many phone calls that weekend and we could get nowhere for everybody was away on holidays for the bank holiday and eventually she got through to some nurse, she rang the hospital and it was the nursing division in there that got the two nurses to call . . .". (Relative)

• Improvements

The vast majority of participants felt that there were no changes necessary to the intermediate care scheme.

"I don't think there is anything more they could have done. I couldn't fault them at all. I was so happy with my experience".

"There is no way that I think there could be an improvement I would be quite happy with the way it is".

". . . because I think it is very good when you come out of hospital and you are weak and everything and you are glad to get some help".

"I couldn't see you could improve it. I got the best of care, best of attention, everybody was so nice".

"They done their best and they done it very well and I was content with everything they

done . . . I couldn't find any fault with them at all, maybe if they started doing more I would have".

One suggested change commonly cited was in relation to an extension to the scheme. Participants felt that if necessary, patients should be assessed to see if they needed the care to be extended.

". . . but in some cases it maybe would need to be extended a wee bit, . . . it is strictly at the minute the 20 odd whatever days and I think each case should be looked at and if needs be there should be, provision whereby it can be extended, if required".

"I think it shouldn't just finish on the day of 6 weeks but for me it was alright. For some people that have a problem and it hadn't cleared up, it wouldn't be alright, so it should be reviewed at the end of 6 weeks and see do you need another week or two weeks. I think that would be the weakness in it".

*"I personally think reviewed at the end of 6 weeks to see if they need any more care".
(Relative)*

"I could see maybe how in some circumstance if an older person was living on their own that 6 weeks wouldn't be enough". (Relative)

A smaller proportion of participants felt that they would have liked more contact with the staff whilst on the scheme.

"Spend more time with me and put in more time, but they haven't got the time but if they could give you more then it would be lovely because on your own it's not easy".

"Well more physiotherapists and able to give more time to you otherwise it was grand".

Other suggested changes included the addition of a shower in Archway Rehabilitation Centre and addressing the issue of smoking in Crozier House.

"I mentioned there about having a shower".

"Well I just say again about Crozier House about the smoking, that's the only thing".

4. SUMMARY & RECOMMENDATIONS

OVERALL

This research has identified some very positive experiences of the intermediate care schemes throughout the Southern Board area. Participants expressed very positive views about the staff and the treatment they received and they felt they had benefited from the care. Indeed the majority were happy to be discharged from hospital to receive the intermediate care and they also said they would be happy to receive the same type of care again.

This section summarises the main findings of the research and where appropriate makes recommendations for improvements to the intermediate care services to better meet the needs of patients and relatives.

Recommendation 1

The Southern Board and the Trusts should consider patients' and relatives' experiences of the intermediate care services throughout the Southern Board area, as documented by this research, and incorporate the issues identified into future service provision including the Intermediate Care Development Plan.

ABOUT THE PATIENTS

Nearly twice as many women than men participated in this research (43 female and 22 male). However this reflects the overall sample of men and women who were admitted to the intermediate care schemes between 1 April and 30 June 2003. Eighty-five females and 37 males were admitted to the schemes. Nearly half of the patients (29) were over the age of 80 years and a similar proportion (32) lived alone.

REFERRAL AND ADMISSION

Differences in the classification of 'step-up' and 'step-down' intermediate care across the 3 Trusts were revealed during the course of this research (analysis included in Appendix 3). This presented an inaccurate picture on the extent to which the schemes were used to prevent hospital admission ('step-up') or facilitate hospital discharge ('step-down'). The incidents of 'step-up' care were overestimated. The Trusts classified 35 patients as 'step up' whereas the vast majority of patients (55) were admitted to facilitate discharge from hospital. All 16 patients in Armagh and Dungannon, 26 out of 30 patients in Craigavon and Banbridge and 13 out of 19 patients in Newry and Mourne had been in hospital prior to their admission to the intermediate care scheme. The actual incidence of admission to the intermediate care scheme being used to prevent hospital admission ('step-up') was 10.

Recommendation 2

The Southern Board and the Trusts should ensure that the definition used to classify 'step-up' and 'step-down' intermediate care is accurate and consistent across all Trusts.

This illustrates that admission to the intermediate care schemes is mainly used to facilitate hospital discharge. While there were 10 referrals from the community to prevent hospital admission, only one of these was from a GP and this was in the Armagh and Dungannon area.

Recommendation 3

Awareness of the purpose of the intermediate care schemes to prevent unnecessary hospital admission should be increased among health and social care staff working in the community, particularly GPs.

A large proportion of patients (23) had been in a hospital outside the Southern Board area including; Musgrave Park Hospital, the Royal Hospital, Ulster Independent Clinic and the Ulster Hospital. One of the factors which created the anomaly in the classification of 'step-up' and 'step down' was because patients who were discharged from a regional hospital were not assessed for the intermediate care scheme before their discharge to the Craigavon and Banbridge Trust area, rather the intermediate care team visited the patient at home after their discharge from hospital and conducted the assessment there. Because of the location of the assessment the Trust classified this as 'step up'.

Recommendation 4

The Southern Board and Trusts should examine how intermediate care assessments in regional hospitals can be conducted before the patient is discharged. This might include closer liaison and joint working to improve current channels of communication.

The majority of participants (58) understood that they were referred to the intermediate care scheme for one of 5 reasons - ill-health or frailty, they had undergone surgery, had mobility problems, couldn't cope any longer or to receive specific therapies. However a small proportion of patients in each Trust area (7 in total) did not know why they were referred to the intermediate care scheme.

Recommendation 5

All patients should receive an explanation as to the reason for their referral to the intermediate care scheme, including the purpose of the care and the overall goal.

In terms of having an option whether or not to receive the intermediate care, some participants did not remember this being discussed with them. On the other hand some said they were able to choose which specific element of care to receive. The National Service Framework for Older People¹⁵ states that older people should be involved in making their own decisions, where this is possible and is what they wish, about the options available to them.

The Good Practice in Consent guidelines¹⁶ states that 'patients have a fundamental legal and ethical right to determine what happens to them. Valid consent to treatment is therefore absolutely central in all forms of health care, from providing personal care to undertaking major surgery. Seeking consent is also a matter of common courtesy between health care professionals and patients'. The guidelines also specify 'in many cases, 'seeking consent' is better described as 'joint decision-making': the patient and health professional need to come to an agreement on the best way forward, based on the patient' values and preferences and the health professionals clinical knowledge'.

Recommendation 6

All patients considered for admission to an intermediate care scheme should be involved in the decision-making process regarding whether or not to be admitted to the intermediate care scheme. Similar to the experiences of some participants in this study, they should also be involved in negotiating which elements of care they wish to receive.

ABOUT THE SCHEMES

There were similarities between the intermediate care schemes in the 3 Trust areas, however there were also some differences. Most patients in Armagh and Dungannon and Craigavon and Banbridge received the care in their own home whereas in Newry and Mourne the majority attended Archway Rehabilitation Centre. However, regardless of where the care was delivered, participants found the arrangements suitable, whether this was at home, in a nursing or residential home or at Archway Rehabilitation Centre. At Archway, participants found it convenient because the care was delivered in their local area and transport to and from the Centre was provided. Those who received the care in their own home considered it convenient because it suited them to have someone come into their home to provide the care.

The length of time patients remained on the scheme varied from less than 10 days to 51+ days. Patients in Armagh and Dungannon tended to stay on the scheme for the shortest period of time and those in Newry and Mourne tended to stay on the schemes for the longest time. However in Newry and Mourne, the frequency of contact while on the scheme was less than the other two Trust areas.

¹⁵ Department of Health (2001) National Services Framework for Older People. DOH, London

¹⁶ Department of Health, Social Services and Public Safety, (2003). Good Practice in Consent.

The various elements of care which comprised the intermediate care scheme in each Trust area varied to some extent. While there were certain similarities in that physiotherapy and occupational therapy comprised the core elements of each of the schemes, 55 received physiotherapy and 53 occupational therapy, there was variation between the schemes in relation to elements of care such as; nursing care, speech therapy and podiatry. Newry and Mourne was the only Trust to provide dietetic and podiatry services but did not provide a nursing care service. Speech therapy was available in Newry and Mourne and Craigavon and Banbridge but not in Armagh and Dungannon.

Recommendation 7

The Trusts along with the intermediate care facilitator should consider whether it would be beneficial to incorporate additional elements of care, provided by other schemes, into their schemes. This should include creating opportunities for networking to share examples of good practice.

Participants throughout the Board area identified they would have liked additional care, in particular more physiotherapy (8), homehelp (6) and occupational therapy (6).

Recommendation 8

The Trusts should examine ways in which additional physiotherapy, occupational therapy and homehelp services can be provided in the intermediate care schemes.

STAFF AND TREATMENT

The vast majority of participants expressed positive views about staff. They found them friendly (63), helpful (64), kind (64) and respectful (65). The majority also said staff always introduced themselves (64) although not all wore name badges (9 sometimes or never wore name badges).

Most participants considered staff approachable in that if they had any questions or problems, they felt able to raise these, but some did not feel able to approach staff.

The majority were satisfied with the care and treatment received (63). They thought staff did everything they could to make them well again (61) and 62 did not think that staff could have done anything more for them. The encouragement which staff provided, including reassurance and building confidence in their rehabilitation and ability to function independently, was commonly mentioned as what participants found most beneficial.

INFORMATION

While the majority of participants were satisfied with the information they received about

their condition (58), treatment (54) and progress (54) some shortfalls in the provision of information were identified. On admission to the scheme, 40 participants said they did not receive any written information about the scheme and 20 were not told how long they would receive the care for. While 50 participants said they saw written information about their care and treatment 15 said they did not.

Research carried out by Byrne and Curtis (2000)¹⁷ found that written information was the most effective format. The provision of information has been identified as one of the many goals of staff-patient interaction and its importance for older patients has been linked to giving the patient a sense of control¹⁸. An increase in information leads to an increase in knowledge and ability of the older person to make informed decisions about their health and treatment¹⁹.

Research has identified that if older patients feel a loss of control this can result in them developing an expectancy of further inability to control aspects of their environment, which can result in 'learned helplessness'²⁰ which in turn could have repercussions in decreasing the older patient's ability to achieve independence and rehabilitation.

In the Good Practice in Consent guidelines it states that people need enough information before they can decide whether to consent to or refuse treatment or care. In particular they need information about: the benefits and the risks of the proposed treatment or care, what treatment or care will involve, what the implications are of not receiving the treatment or care, the alternatives that may be available and the practical effects on their lives of receiving, or not receiving the treatment or care.

Recommendation 9

All patients admitted to an intermediate care scheme should be provided with written information about the scheme, including the elements of care they shall receive and how long the care will be provided for and that patients will be involved in the decision-making process and have the opportunity to feedback their views and experiences of the care received.

The Southern Health and Social Service Board's Intermediate Care Development Plan²¹ states that *"intermediate care teams should move towards the development of a single assessment tool and records, in line with the recommendations of the National Service*

¹⁷ Byrne, M. & Curtis, R. (2000) Designing Health Communication; Testing the explanation for the impact of communication medium effectiveness. *British Journal of Health Psychology*, 5, 189-199.

¹⁸ Turton, J. (1998) Importance of information following myocardial infarction: a study of the self-perceived information needs of patients and their spouse/partner compared with the perceptions of nursing staff. *Journal of Advanced Nursing*, 27, 770-778.

¹⁹ Ley, P. (1988) Communicating with patients: improving communication, satisfaction and compliance, Chapman & Hall; London

²⁰ Myers, D. G. (1996) (5th ed.) Social Psychology. McGraw-Hill; USA.

²¹ SHSSB (September 2003). Intermediate Care Development Plan.

Framework for Older People” and that “*the assessment tool and care plan should be held by the patient/client*”. The Trusts provided copies of the patient held files and the information leaflet to the Council in advance, the interviewer prompted the participant showing them the relevant written information, however 15 still said they had not seen this information. This suggests that these participants either did not receive the written information or did not remember receiving it. If written information was provided it may be that they didn't remember it because they had not read it. Of the 50 participants who said they did receive written information only 27 read it and 21 shared the information with family members.

Recommendation 10

The provision of patient held files is positive - however there is a need to look at the type of information included and how it is presented to ensure that it is accessible and relevant to patients and relatives. Patients should be encouraged to read this information and share it with family members.

In addition 41 participants said they did not receive any information on how to make a complaint. This is important information to highlight to patients and relatives because some said they would not make a complaint because they did not know how to.

Recommendation 11

Information on how to make a complaint should be included in the patient held file. Where this is already the case, this information should be highlighted to patients and relatives.

Eighteen participants said their care, treatment and progress was not discussed, 11 were not satisfied with the information provided to them about their progress and treatment and 7 said they would have liked more information. The type of extra information desired was in relation to health promotion type advice - advice on what exercise they could do to continue and/or maintain their rehabilitation. This was desired by both patients and relatives. Some relatives suggested that staff should meet with the relatives when the patient is discharged from the scheme to outline and explain any exercises which the patient could continue to do in order to maintain and/or continue their rehabilitation. Good information is essential for carers and enables them to become partners in the provision of care. In return carers are less likely to suffer from stress and consequently be less able to continue to care. With little information carers can't be involved in the rehabilitation of the person.

Recommendation 12

Patients and relatives should be provided with information as to how the patient's rehabilitation can be continued and/or maintained both during and after their discharge from the intermediate care scheme.

PATIENT INVOLVEMENT

Just over half the participants interviewed (35) said staff set goals for them to work towards. While this means that 30 didn't, of those who did, there was an understanding of the purpose of the care they received on the intermediate care scheme. They outlined that goals were set progressively and understood that the purpose was to help them to regain as much independence as possible. Participants also expressed an understanding that the achievement of these goals entailed them undertaking exercises outside of the therapy sessions.

Just less than two thirds of participants (39) did not feel involved in making decisions about their care, however this did not cause dissatisfaction. Generally they felt that they didn't need to be involved and were happy to leave the decision-making to staff.

Those who did feel involved highlighted two main ways this occurred. One way related to receiving information from staff, being advised on what exercises to do and how to do them. The second way related to patients providing information to staff - being asked about decisions, providing feedback about their care and progress. In a primary care setting Little et al. (2004)²² found that encouraging patients to raise issues and discuss symptoms improves their satisfaction and perceptions of communication.

Recommendation 13

Patient involvement in making decisions about their care should be promoted by involving them in decisions about their care and asking them for their views on their care and progress.

TRANSPORT

The transport service to and from Archway Rehabilitation Centre was considered valuable and important in facilitating patients' attendance at the intermediate care scheme in Newry. Indeed some participants said that they wouldn't have been able to attend if transport had not been provided. Fourteen of the 15 people who attended Archway Rehabilitation Centre used the Trust provided transport.

²² Little P, Dorward M, Warner G, Moore M, Stephens K, Senior J, & Kendrick T. (13th February 2004) Primary Care; Randomised controlled trial of effect of leaflets to empower patients in consultations in primary care. BMJ online doi: 10.1136/bmj.37999.716157.44.

However some problems with the transport were identified. There was variability in the collection time in the mornings. Some participants quoted differences of up to 2 hours in the time the transport arrived to collect them in the morning. However participants seemed to tolerate this unreliability because the transport service was perceived as provided voluntarily by the drivers. Participants were more dissatisfied with having to wait around in the afternoon for collection to go home. Participants were eager to get home once their session was finished and having to wait for the taxi to return caused dissatisfaction.

Recommendation 14

The arrangements for the provision of transport to and from Archway Rehabilitation Centre should be changed to accommodate the needs of users. A regular collection time in the morning should be agreed and adhered to and transport should be provided for those wishing to return home once the morning session is finished.

DISCHARGE

Most participants (51) felt ready for discharge when they were and at this time 57 had received the treatment they had expected. However 13 people did not feel ready to be discharged. The reasons why were either because they did not feel fit enough or they enjoyed the social aspect of the scheme and did not want to give this up. Factors which promoted a feeling of readiness for discharge included:- improved mobility, reduced pain, ability to attend to personal care needs and improved confidence in their own ability to manage independently.

Most participants did not feel involved in making the decision to be discharged from the scheme (43). Those who did feel involved did so because either they initiated the decision or were asked by staff whether they were ready to be discharged.

Recommendation 15

Patient involvement in making the decision to be discharged from the scheme should be promoted by having a detailed discussion about their progress while on the scheme. Patients should also be asked whether they feel ready to be discharged from the scheme.

Seven participants hadn't received the treatment they had expected when they were discharged. Younger participants in the 60-69 age group were more likely to have had their expectations met whereas older participants were more likely not to have received the treatment they had expected. Recommendations 5 and 6 should also address the issue of establishing expectations on admission which can be met.

Only 18 participants said their options after they were discharged from the intermediate

care scheme were discussed with them, 46 said this wasn't the case. Older participants were less likely to have had their options, after discharge, discussed with them.

Recommendation 16

Post discharge planning should be an integral part of intermediate care for every patient. This should include a re-evaluation of the individual's needs post-discharge as well as presenting and discussing the options available to them. This could include referral to other social services or services provided by voluntary groups.

BENEFITS

The majority of participants felt they had benefited from the intermediate care scheme (61), were happy with their recovery (58) and now needed less help to be independent (43). The main ways in which participants said they had benefited included; improved mobility, regaining their independence and improved confidence in their own ability to manage.

When asked what they found most beneficial some participants said they could not identify one aspect rather it was the multidisciplinary nature of the care. But others did mention specific elements including the therapeutic components, practical help, the encouragement and support received from staff and the provision of equipment. In addition, the social contact which the scheme facilitated, particularly for those attending Archway Rehabilitation Centre, was highlighted as having a positive impact on psychological well-being.

Three participants did not feel that they had benefited from the intermediate care, two of whom were over the age of 80 years. The reasons why they felt they had not benefited included; not having received the physiotherapy they expected, another said staff did not do anything for them, rather they watched them and the third person felt the care was not going to assist their rehabilitation as it would only come about with time. Of the 21 participants who did not feel they now needed less help to allow them to be independent, 13 were over the age of 80 years. They felt they still required assistance with their personal care and/or their household tasks.

Recommendation 17

On discharge from the scheme all participants should be asked for their views and experiences of receiving intermediate care, whether and how they benefited and whether their expectations were met.

The vast majority of participants did not dislike anything about the care however others identified the psychological impact of needing to receive it. Apprehension about someone coming into their home or the loss of dignity they felt in relation to the personal

care aspect of the scheme, were mentioned.

SUGGESTED CHANGES

The vast majority of participants did not identify any changes needed for the intermediate care schemes. However some felt that there should be flexibility in extending the scheme, more therapeutic input, providing a shower in Archway Rehabilitation Centre and if the care is delivered in a nursing or residential home, there is a need to ensure that the home's smoking policy meets the needs of the individual.

Recommendation 18

Trusts should look at how the specific suggestions of participants in this research can be incorporated into current service provision.

Appendix 1

PATIENT INFORMATION LEAFLET

Research in to: - **Patients' Views of Intermediate Care Services**

Dear Patient

The Southern Health & Social Services Board has asked the Southern Health and Social Services Council (the Council) to carry out research to find out what patients think about the quality of intermediate care services in the Southern Board area. Intermediate care is the name given to the special type of care provided to patients after they come out of hospital or to prevent them going into hospital. The Council wants to speak to approximately 100 patients to find out their views of the care received and whether any improvements could be made. This information will be used to help to improve the services for patients in the future.

A researcher from the Council would like to visit you at home 2-3 weeks after you are discharged and ask you some questions about the care you have received. The interview should last approximately 1 hour. If you wish, a relative can also be present. The interviews will be tape-recorded so that the researcher obtains accurate information and the tapes will be confidential and only the researcher will listen to the tapes. No members of staff involved in your care will know what you've said. Once the research has been completed, the tapes will be destroyed. Your name will not be recorded. The information gathered will be included anonymously in a report which will describe the views and experiences of patients throughout the whole Southern Board area.

Your participation is completely voluntary. You do not have to take part if you do not wish to and your decision will not affect, in any way, any future care you may receive. If you do decide to take part you are free to change your mind at any stage and you can stop the interview at any stage.

If you decide you would like to take part it is necessary to obtain permission for your name and contact details to be passed to the Southern Health and Social Services Council. A researcher from the Council will then contact you directly and arrange a convenient date and time for the interview to take place.

If you have any questions please feel free to contact the Research Officer, Karen McCoy, at the Southern Health and Social Services Council on (028) 3834 9900.

Appendix 2

CONSENT FORM

Patients' Views of Intermediate Care Services

You are invited to take part in an interview about your views on the quality of care provided on the intermediate care scheme. This will involve a researcher from the Council visiting you in your own home at a time convenient to you. The answers you give will be confidential and no member of staff involved in your care will know what you've said. The information gathered will be included anonymously in a report which will describe the views and experiences of patients throughout the whole Southern Board area.

I (name) _____

of (address) _____

_____ Telephone _____

I consent to take part in an interview about patients' views on the quality of intermediate care. I have received an explanation about this research and what it will involve. I understand that in order to arrange a date and time for the interview the Trust will pass this form with my contact details to the Southern health and Social Services Council. Any questions I wished to ask have been answered to my satisfaction. I understand that I may withdraw from the study at any stage without necessarily giving a reason for doing so.

Please tick one of the boxes below to tell us whether you are a patient or the relative of the patient.

I am the patient

A am a relative of the patient

Signed (Patient/Relative) _____ Date _____

(IC Co-ordinator) _____ Date _____

THANK YOU

Please return this form to the Intermediate Care Co-ordinator

Appendix 3

Analysis of 'step-up' and 'step-down'.

The Trusts classified 35 patients as 'step-up' as shown in table 1/1 below. However our date revealed that only 10 patients had not actually been in hospital prior to their admission to the intermediate care scheme.

Table 1.1 'Step-up' and 'step-down'

	Step-up		Step-down	
	Trust classified as step-up ²	Actual no. were not in hospital prior to Intermediate care ³	Trust classified as step-down ¹	Actual no. of patients who were in hospital prior to Intermediate care ²
Armagh and Dungannon	1	0	15	16
Craigavon and Banbridge	18	4	12	26
Newry and Mourne	16	6	3	13
Total	35	10	30	55

Twenty-five of the 35 patients who were classified by the Trusts as step-up were actually in hospital prior to their admission to the intermediate care scheme. One in Armagh and Dungannon, 14 in Craigavon and Banbridge and 10 in Newry and Mourne.

² Information provided by the Trusts

³ Information provided by the interviews

Table 1.2 Patients who were classified as 'step-up' but who had been in hospital.

	Number of patients
Armagh and Dungannon	1
Craigavon and Banbridge	14
Newry and Mourne	10
Total	25

A further examination of the cases where there was a discrepancy between the Trusts classification and whether or not the patients had been in hospital revealed:-

- **Craigavon and Banbridge**

Fourteen of the 18 patients who were classified by the Trust as 'step-up' had been in a hospital other than Craigavon prior to their admission to the intermediate care scheme. Six had been in Musgrave Park Hospital, 2 in the Ulster Independent Clinic, 4 in Daisy Hill Hospital and one in the Royal Victoria Hospital and Lurgan Hospital.

Table 1.3 Other hospitals

Hospitals	Number of patients
Musgrave Park	6
Ulster Independent Clinic	2
Daisy Hill	4
Royal Victoria	1
Lurgan	1
Total	14

The length of time these patients were in hospital varied from less than 1 week to more than 5 weeks - a similar pattern as for the whole sample.

Eleven of the 14 patients were referred to the scheme by the hospital staff including

hospital social worker (6), liaison sister (2), occupational therapist (2) and physiotherapist (1).

- **Newry and Mourne**

Ten of the 16 patients who were classified as 'step-up' by the Trust had previously been in hospital prior to their admission to the intermediate care scheme. Eight had been in Daisy Hill Hospital, 3 in Musgrave Park Hospital and one each in the Ulster Hospital and the Royal Victoria Hospital.

Table 1.5 Hospitals patients were in. (n=10)*

Hospitals	Number of patients
Daisy Hill	8
Ulster Hospital Dundonald	1
Musgrave Park	3
Royal Victoria	1
Total	13

*Three of these patients had been in more than one hospital.

The 3 patients who had been in an intermediate care nursing bed and then attended the day centre had been classified as 'step-down'.

- **Armagh and Dungannon**

Armagh and Dungannon had only one patient whom they classified as 'step-down'. This patient had previously been in South Tyrone hospital but was referred to the scheme by a GP.

Summary

- There isn't a common way of classifying whether 'step-up' or 'step-down' across the 3 Trusts.
- If 'step-up' is taken to refer to 'preventing a hospital admission' and 'step-down' as 'rehabilitating after a hospital discharge' then our data would suggest that the real number of 'step-up' is 10 and 'step-down' is 55. Therefore intermediate care is predominately used following a hospital discharge.
- The discrepancies between the number of patients classified by the Trusts as 'step-up' and the number who had been in hospital prior to the intermediate care scheme is most prevalent in Craigavon and Banbridge (14) and Newry and Mourne (10).
- The reason for this discrepancy is due to the definition used. In Craigavon and Banbridge it seems to be because the patients had been in hospitals other than Craigavon Area Hospital. Even though these other hospitals had made the referral to the scheme the assessment was conducted by Craigavon and Banbridge intermediate care staff after discharge in the patients own home. The Trust then classified this as 'step-up'.
- In Newry and Mourne only patients who were in an intermediate care nursing bed and then attended Archway Rehabilitation Centre were classified as 'step-down'. Everybody else was classified as 'step-up' regardless of whether they had previously been in hospital.



NOTES

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**Southern Health
& Social Services
Board**

Tower Hill, Armagh,
BT61 9DR
Tel: 028 3741 0041
Fax: 028 3741 4550
Web: www.shssb.org



SOUTHERN
health & social services
COUNCIL

Quaker Buildings, High Street, Lurgan,
BT66 8BB.
Telephone: 028 3834 9900
Fax: 028 3834 9858
Textphone: 028 3834 6488
E-mail: reception@shssc.n-i.nhs.uk
Web: www.shsscouncil.net