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Research Article

Informing Best Practice for Supportive Housing with care for Older Adults: A Qualitative Investigation of Service Provider Views

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Abstract

The older adult population is increasing, with subsequent socio-economic challenges worldwide. Internationally, a well-recognised model that enables healthy ageing is 'supportive housing with care' which provides basic care for older adults that require minimal support. In Ireland, policy towards public provision of older adult care is nursing home based. To inform policy further, this study explores the views of service providers of supportive housing with care facilities. An instrumental case study methodology was adopted. 28 staff participated in focus group discussions; 6 staff from 4 centres (n=24) and 4 staff from 1 centre (n=4). Focus group participants included kitchen/catering staff, laundry staff/cleaners, multi-task attendants, healthcare assistants, care workers, student nurses and nurses. 5 managers (n=5), one from each centre, were interviewed separately, resulting in 33 participants in total (N=33). Six themes emerged from the focus group and interview data: accessing supportive housing with care; advantages of supportive housing with care; provision of care; governance; older adult care options, and; improving supportive housing with care. Results indicated that supportive housing with care facilities were clearly viewed by staff as providing an essential older adult care service. However, participants perceived that supporting residents with increasing dependency levels, regulation, legislation and funding allocation needed to be addressed further when informing the future development of the model for supportive housing with carel.

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Introduction

The World Health Organisation (WHO) recommends structured political and policy actions are undertaken to support healthy and active ageing that will address the global issue of providing healthcare for an ageing population [1]. By 2050, one in five people will be 60 years or older, totalling 2 billion people worldwide [1]. In Ireland, older adult population trends are in line with those internationally. There will be an estimated 1.3-1.4 million people aged over 65 years by 2041, representing 20-25% of the total Irish population, with the greatest increases expected in the over 80 year's age group, where numbers are predicted to increase fourfold from 110,000 in 2006 to 440,000 in 2041 [2]. Current policy towards older adult care in Ireland falls within the 'Rudimental System', which consists solely of the basic model of social care services, that is, a home based service and one form of institutional care. Family based or community-based care is the preferred option and the role of public provision of older adult care is mainly provided only when this is not available [3]. This system takes the form of home care based packages and nursing home based care systems, with little offered in terms of interim care to support those requiring less intensive older adult care provision [3]. Therefore, it is necessary to explore alternative care options to update political and policy actions that align with international recommendations [1].

Worldwide, a well-recognised and popular model that would be suitable is one that supports independent home and nursing home care, known as supportive housing with care, where older adults live in a setting with communal facilities that is staffed over a 24 hour period and provides a level of care for those that can function with basic support for practical and personal needs. In Ireland, the identification of such facilities is difficult, in part due to a lack of a centralised funding stream which would enable a clear mapping exercise [4]. It would seem however, that those facilities are not widely available nationally and little is known about them. The small number of facilities which were identified were predominantly founded by charities, with some state funding provided. This situation indicates the need to further explore the internationally recognised supportive housing with care model within the Irish context in order to inform the future development of such care facilities.

The supportive housing with care model is based on a social model of care; it provides a home like environment and promotes autonomy, privacy and freedom of choice among residents [5]. Typically, staff in these settings provide watchful oversight, help residents with activities of daily living in addition to assistance with medication management, meal preparation and household cleaning, for example, as required [6]. Ascertaining the views of such staff would provide a deeper insight to inform a model for best practice in such facilities. Therefore, the aim of this study is to explore the views of the staff of the facilities that have been identified.

Materials and Methods

Study design overview

An instrumental case study methodology was adopted, involving qualitative and quantitative data collection from residents and staff within three cases of supportive housing with care in Ireland. The aim of this broader research was to inform future policy development relating to care provision of older adults who could benefit from supportive housing with care. This paper presents the qualitative data ascertained from focus groups with staff and individual interviews with managers of the centres (N=33).

Descriptions of the organisation and specifics of case boundaries is essential to provide context [7]. Therefore, an overview of each case, the organisational governance, facilities and staffing, is detailed in table 1. Case 1 comprised of one centre, and Case 2 and Case 3 had two centres, consequently participants were drawn from five supportive housing locations (n=5 facilities). Organisational anonymity has been maintained for ethical reasons. Prior to commencing data collection, ethical approval for the study was granted from the Institution and Regional Ethics Committees.

Recruitment

Purposive sampling was undertaken and three organisations participated in the study (Table 1). The manager of each center was invited to participate in the study. Upon agreement, recruitment for the staff focus groups was conducted via expression of interest posters displayed at each of the centres. These advised staff to contact the research assistant directly if they were interested in participating in the study. An information session with potential participants was facilitated by the research team. Signed consent forms were obtained and confidentiality assured.

Data collection and analysis

Data was collected in each of the cases using focus group interviews with staff. Two researchers facilitated each focus group; one asked questions and the other observed and recorded the speaker and non-verbal interactions. Individual interviews with managers were undertaken by one researcher. Focus groups and individual interviews were digitally recorded with permission from the participants. The interviews explored participant experiences and perspectives of supportive housing with care for older adults; the advantages and disadvantages of supportive housing with care; service regulations and policies within each centre; finance and governance; and views and suggestions regarding service improvements. Participants were re-minded about confidentiality, the right of participants to withdraw at any time and the recording of the interview, prior to commencement. A thematic approach to data analysis, informed by an analytic hierarchy [8], was employed. This involved the transcription of all focus groups and individual interviews; reading and re-reading of transcripts whilst listening to the digital recordings (familiarization process); coding of recurring concepts and the formation of themes and subthemes.

Rigour

Reading and re-reading of transcripts allowed for constant comparison to search for and identify emerging themes. Saturation was deemed to have been reached when sequential conducting of focus groups led to concepts being repeated multiple times without new concepts or themes emerging, thereby indicating that additional focus groups would not yield further insights [9]. Two researchers independently undertook this process prior to agreeing findings.

Case 1 is a charitable organisation governed by a Board of Trustees that provides supportive housing for 60 older adults over the age of 65. The supportive model of care offers 24 hour supervision and assistance with health needs including nutrition, medication compliance, reduced mobility and short term memory problems, whilst promoting independence as much as possible. A registered nurse is responsible and accountable for the daily running of the home (although 24 hour nursing care is not provided) assisted by 29 staff (some part-time) which include nurses, carers, catering and household support. Residents retain their own GP, with other health care professional support accessed through the existing community care pathways. Each resident retains a key to their own room containing washing, living and sleeping space and a call bell linked to a central system for assistance. The communal facilities include a large dining room and kitchen (with provision of meals daily); an oratory for religious services/ prayer; library; conservatory; seated garden and patio area; smoking room with TV; two sitting rooms and a hair salon. Social activities are arranged daily and rely on volunteer assistance. The home is located in an urban setting adjacent to a community care health center and near to an acute hospital. Residents have access to all local amenities such as shops, banks, pubs, post office and cinema; thus promoting social inclusion. A bus stop is located at the gate of the grounds. The residents have access to a mini bus with volunteer drivers for regular outings.
Case 2 is a not-for-profit limited company formed by guarantee of the members and without a shareholding, which provides housing with care for frail and older people, including those who have been diagnosed with dementia and is governed by a Board of Directors. This case consists of two centers: Case 2(a) and 2(b) are both located in urban settings. These care services provide 24 hour support relative to the individual needs and preferences of each resident. Each scheme provides 56 units of accommodation that include ground floor secure dwellings dedicated to those with dementia. Employees include managers, nurses (I day per week per center), care staff, domestic and catering staff. Many staff are trained in Dementia care and provide support to both residents and their families. Both centers have communal areas where residents can socialise and take part in group activities along with sensory gardens and/or patio areas. The schemes provide access to individual care, such as support with medication management and activities of daily living, as well as social activities and exercise programmes. For those with dementia there is provision of a range of daily activities to promote functioning. Where possible, residents retain their own GP and other healthcare providers.
Case 3 is a not-for-profit organisation, governed by a Board of Directors, dedicated to helping older people live safely, securely and independently with a choice of services to suit individual needs. Case 3 provides housing and support to the elderly in six locations throughout Ireland, two of which participated in this study; Case 3(a) and 3(b). Both cases include 24 hour call service, a 4 course lunch 365 days of the year, laundry service and weekly domestic cleaning services to each apartment/bungalow. Each residence is served by an emergency response system. Employees include center managers, night supervisors, catering, and domestic staff. Case 3(a) houses approximately 46 residents. The development is situated near a town centre on a main road and consists of 50 self-contained apartments. Each resident has their own private apartment, with one or two bedrooms, bathroom and a kitchen/living room. Case 3(b) is adjacent to a rural village and consists of 36 bungalows together with communal facilities. The central communal facilities include a dining room; a sitting room with a selection of books, television and a grand piano and a prayer room. There are communal gardens with seating areas and walkways in addition to small manageable gardens for each bungalow.

Table 1: Overview of supportive housing with care cases.

Results

Staff working in the supportive housing residences participating in this study included a range of roles: kitchen/catering staff, laundry staff/ cleaners, multi-task attendants, health care assistants, senior care workers, student nurses, registered nurses and managers. 28 staff participated in the focus group discussions; 6 staff from 4 centres (n=24) and 4 staff from 1 centre (n=4). 5 managers (n=5), one from each centre, were interviewed separately, resulting in 33 participants in total (N=33). Data analysis revealed six main themes relating to the questions asked about the advantages and disadvantages of supportive housing with care for older adults, centre policies and practices and suggestions for improvements for future models of care. Findings across the focus groups and manager interviews were similar and

revealed six themes: (1) Accessing supportive housing with care (2) Advantages of supportive housing with care (3) Provision of care (4) Governance, policies and funding (5) Older adult care options, and (6) Improving supportive housing with care (Table 2).

Theme	Subthemes
Accessing Supportive Housing with Care	Family Influence GP Referrals Increasing need for support
Advantages of Supportive Housing with Care	Home from home; Maintaining independence; Safety and security; Daily living supports; Health improvements and quality of life; Social participation
Provision of Care	Staff roles and responsibilities; Care transitions End of Life Care
Governance	Policies and training; HIQA
Older Adult Care Options	Person centered care Nursing home care Filling the gap
Improving Supportive Housing with Care	Physical design and facilities; Communication; Increasing public awareness; Legislative change Funding

Table 2: Themes and subthemes.

Accessing supportive housing with care

Participants described the reasons for residents accessing supportive housing with care, which primarily related to the need for 'some' level of support. The death of a partner or spouse often precipitated a transition to supportive housing; living at home alone was linked to perceived feelings of loneliness, isolation and fear, particularly amongst women, that prompted a move from home. Referrals to supportive housing with care came from a range of sources: hospital referrals, (for example, age related care referrals); community referrals (social worker); rehabilitation services, in addition to family and self-referrals.

Increasing health needs were also seen as reasons to access supportive housing with care. Older adults with decreasing mobility were 'at risk' of injury, falls or accidents occurring in their own home. Once care needs increase to a point where they (older adults) are not able to fully 'support themselves alone' in their home, supportive housing with care was seen to provide a 'fitting' supportive environment. The majority of centres had a waiting list indicating increasing demand for supportive housing with care.

Advantages of supportive housing with care

An overwhelmingly positive response from participants was evidenced in relation to the supportive housing with care model. Many advantages for residents living in these facilities were described such as it being' home from home'; safety and security; improvements in health and quality of life; residence independence; family satisfaction with care; and social participation through activities and outings. Supportive housing with care was described by participants as the residents' 'home'. One staff member quoted a resident who spoke to the former Minister of Health about their supportive housing with care centre:

- "This is my home away from home…" I thought it was lovely to hear her say that because they [residents] feel like this is their home and it is" (S6, FGS1).

Supportive housing with care was seen as the 'next best option' for independent older adults once living in one's own home was no longer possible. Described as 'nurturing independence' maintaining resident independence was encouraged by all staff; ''we assist them if they need it" (S5; FGS1).

The safety and security of living within supportive housing with care was perceived as a major advantage, through the provision of 24 hour alarm bells and panic buttons:

- "At home, they would have to try and call someone in …….whereas here they can press a button and someone will be up to see if they are ok" (S1; FGS4)

The support available to residents in relation to daily living activities such as the provision of laundry, cleaning services and meals in addition to the removal of the need to pay household bills (heating, electricity) and maintain the home, further promoted a 'worry free environment' for residents.

Participants perceived that residents of supportive housing with care experienced improvements in health and quality of life. Some residents were reported to have had poor nutritional habits or have been non-compliant with their medicines when living at home alone. Further issues related to the inability to maintain their own home:

- "Within our service they have less chance of picking up an infection like they might if they were at home and not looking after themselves or eating properly" (MI, 1)

Social participation and the development of friendships amongst residents' were observed. Social inclusion was further promoted through social activities. Although optional, staff reported that generally residents would 'give it a try'. There were a variety of activities and outings available across all centres such bingo, arts and crafts, music and day trips. In general residents were eager to participate in organised activities:

- "They will ask you from first thing in the morning 'so what are we doing today', [Group agreement]" (S4; FGS1)

However, staff also acknowledged that some residents naturally prefer their own company, although knowing that someone is available is always advantageous: "Sometimes a chat is all they need" (S3; FGS4). Non-participation in organised activities and outings was often by choice, however staff showed concern that sometimes it was due to residents not having the funds to participate.

Provision of care

The 'provision of care' within the supportive of housing with care model emerged as a major theme from data analysis and included staff roles and responsibilities; care transitions; and end of life care. The roles and responsibilities of those working at the centers varied

however most included managers, general care staff, support staff (such as catering, laundry and cleaning), and administration staff. Four out of the five centers had a registered nurse employed as the manager (case 1), and number of nursing hours for general nursing care were also funded in cases 2 and 3. Nurses described their role as undertaking general observations, blood pressures, promoting and reminding of medication and communicating with pharmacists and doctors as required. The advantage of having nursing staff available within supportive housing with care centres was acknowledged by all participants relative to their ability to assess residents for early signs and symptoms of disease or provide urgent care in situations of sudden illness or injury.

- "We will identify the symptoms earlier and get them treatment so it stops them from ending up in hospital" (S5; FGS1)

Role confusion emerged from non-nursing staff as it related to providing care in emergency situations such as falls or first aid interventions. Some staff argued roles in relation to their response to such an occurrence were not clear, nor were there any guidelines, policies or procedures in place to address such an event. Rather, there was an acceptance that in such an event, staff summon for help by means of calling a paramedic, GP or a nurse. Staff reported that they use their 'own initiative':

- "well you are not going to call the guards or the paramedics to come and pick someone up if you know it's a simple thing and if they are not injured" (S3; FGS4)

Debate ensued for the need for further training in relation to first aid with some in favour and others reluctant to take on such responsibilities. The staff in favour argued that training would instil a sense of confidence in staff in their response to a situation; "We are working in that area [older adults] and it wouldn't take much training" (S2; FGS5). Conversely, such training was seen to take away from the independent living environment of supportive housing with care. This signalled staff questioning their roles and responsibilities and the need for further clarification of their role from management in such an event.

Care transitions and end of life care for residents were areas for concern amongst participants. They acknowledged that in cases of increased dependency levels transitioning to nursing home care was the best option as supportive housing with care centres lacked the capacity and staffing requirements to cater for higher dependency residents with increasing health and mobility issues. However the need to move from their 'home' again could be distressing:

- "It's their home, but it's only their home, unfortunately for a period of time until they become more dependent" (S5; FGS1)

Once residents care needs surpassed the capacity of the centres defined care package staff agreed that it was in the resident's best interest to move to higher dependency care. However, in relation to end of life care, participants expressed a desire to care for residents in their 'home' with support. Comparisons were drawn to palliative care in the community:

- "Let us care for them and give them comfort measures and the end of life care and medical team can come in and take over - bring hospice care in where it needs be" (MI, 4)

Older adult care options

Participants described the advantages of supportive housing with care for older adults compared to alternative care options such as nursing homes (Table 3). Within supportive housing with care older adults were described by participants as 'independent residents' compared to nursing homes where older adults were viewed as 'dependent patients'. Participants perceived nursing homes as being restricted to the confinements of dependency where free choice and independence were not an option:

- "In a nursing home you are not going to have your car parked outside - you're there and that's it" (S1; FGS4)

Participants felt that supportive housing with care offered a more cost effective and Person Centred Care (PCC) approach for those with low to medium support needs. One of the core elements to PCC (and difference between the two care options) being time:

- "In a nursing home you do not have time to give your 'patients' whereas here we have time to give to 'our residents' individually" (S1; FGS1)

Participants described how they fostered holistic PCC by supporting residents' social, psychological and spiritual needs and recognising that care needs are not always physical in nature. Staff advocated for residents, between their GPs and other health services, and felt this was of particular importance to residents who may have little or no family support.

There was a concern that older adults who struggled with activities for daily living at home may have unnecessarily ended up in nursing home care:

- "They don't need nursing care - just a hand with little things like cleaning, having their dinner handed up to them and their laundry and then they can live quite independently here" (S5; FGS4)

	Supportive Housing with Care	**Nursing Home Care**
Model	Social model	Medical model
Physical	'Resident' Able-bodied Home/intermediate care service	'Patient' 'Looking at someone being fed' Next step 'waiting room for god'
Social	Independent 'Part of the family'	Dependent 'A number'
Organisational	'Free flowing' Person centered care Holistic Cost effective: average cost 177euros/week	Regimental Institutionalised Expensive - average cost 1000 euros plus/week

Table 3: Staff views on care options.

Governance

Over the past number of years centres have implemented new regulations and undergone changes in organisational structures to link

their model of care in line with Health Information Quality Authority (HIQA) governance. Overall, staff welcomed HIQA regulations and acknowledged their governance offered guidance, structure and support for both residents and staff. However, there were also challenges with HIQA regulations. Absence of HIQA guidance specific to supportive housing with care gave rise to centers being regulated on the same level as nursing homes. Staff reported they were expected 'to tick boxes' which do not necessarily have to be ticked:

- "We are not a nursing home, we have a completely different ethos, a completely different model of care" (MI, 5)

Awareness was drawn to the need for procedures to be in place to safeguard vulnerable older adults within supportive housing with care centres. However, as a result of the ambiguity between the structured nursing home models of care versus the supportive housing with care approach with no defined supportive model of care at national level, staff fundamentally argued for a change in legislation and policy. It was deemed unethical to be 'ranked' on the same level as nursing home care standards when the level of care provided in supportive housing with care centres was ''very different to a nursing home". In terms of monitoring and auditing, participants were frustrated at the lack of distinction in the regulations between supportive housing with care and nursing homes and the consequent need to conform to the nursing home standards: "We are never going to fit that category of care" (M1, 4).

Common center policies cited by staff included an admissions policy, risk assessment policy, uniform policy, fire evacuation policy, medication management and administration, end of life and palliative care and food safety (Hazard analysis and critical control points). Training courses completed by some staff included health and safety, fire safety, elder abuse, bullying in the workplace complaint issues, dementia care and reminisce, care of the elderly, infection control, hand hygiene, first aid, CPR, defibrillator and SONAS training (activities for those with dementia). Staff welcomed the idea of increased training. Suggestions included; first aid, manual handling and health and safety. However there remained some reluctance in relation to issues such as 'first aid' by some staff as indicated previously.

Suggestions for improvement

Participants' suggestions for improvements to current practice related to legislation change; funding; physical design of centers and increasing the availability of supportive housing with care. The need for legislative change in relation to policy guidelines specific to supportive housing with care models was clearly articulated with arguments negating the need to be aligned with nursing home standards. Participants suggested government intervene to develop a standalone model relative to services provided under supportive housing with care. Inadequate funding for supportive housing with care centers was raised as participants perceived an over reliance on volunteers and fundraising. The majority of centres fundraised for operationalisation of the centre with 'very little funding available to cater for other activities', such and outings or events. As one manager noted "we are stretched to our limits" (MI, 1); all participants agreed additional funding would enhance the services provided to the residents.

Participants suggested the physical design of facilities could be enhanced. Greater consideration of older adults requirements in terms of the physical environment such as levels, adequate outside walking spaces, easy access to storage cupboards in residents' rooms, ensuring en-suite bathrooms, in addition to improving décor and furnishings.

- "For me, it's the little things like that that should be thought out better, like the way they are furnished and laid out(S1: FGS5)

On the continuum of older adult care, supportive housing was seen to lie firmly "in between" one's home and nursing home care thus providing an intermediate service. The need to promote, develop and drive supportive housing with care was raised by managers who suggested a multi-agency approach was required:

- "It's not all about medical care, it's about support and housing, older adults living their own independence…." (MI, 1)

An appreciation amongst participants of the ageing population in Ireland and associated growing costs and demands on services for older adults was evident. Staff called for a need to increase the number of supportive housing with care centers, to mitigate against premature nursing home placement for older adults:

- "This type of service is missing all over the country. If you look at it in the long term basis with the ageing population, it will cost less to run this facility than it would a nursing home" (S6; FGS2).

In addition, the need to raise public awareness of supportive housing with care as an option for older adults, was also identified.

Discussion

This study ascertained staff views regarding best practice for the provision of supportive housing with care for older adults. A range of staff took part in the focus groups including healthcare assistants, nurses and ancillary staff. Themes emerging included staff views on reasons for residents coming to live in the centres, which comprised of increasing health needs, loneliness and isolation and inability of family to take care of the person. Similar to the residents' views [4], the centre was viewed as a 'home from home', which promoted independence and provided safety and security. Residents were given the support they needed with activities of living with ensuing improvements in health and quality of life including increasing social participation.

These findings correlate with results of a longitudinal Swedish study that examined transitions between levels of dependency among 415 older people receiving supportive care over time [10]. Here, it was reported that a significant number of participants who were initially more dependent, transferred to a lower level of dependency (28%) within one year demonstrating improvements in overall health and quality of life [10]. However, it was also noted that 34% of participants with mild or moderate dependency transitioned to higher dependency levels within the same year [10].

When considering this in the context of the current study it is quite significant, as staff identified that residents need to leave the centre as dependency increases and highlighted the issue of short term end of life care, as well as the wishes of resident, staff and families to care for the resident in place at this time. In response to this challenge, current literature advocates for the implementation of preventive measures at specific stages to minimize functional decline and optimise the health of older adults [11-13]. Despite this however, the inevitable ageing process can limit the effectiveness of such interventions [12], with little solutions identified in the literature to support older adults that access this model of care to 'age in place'. A recommendation from the current study would be to ensure a transition plan devised in conjunction with the resident and their significant others is in place

should the dependency levels of the resident increase. Internationally, some facilities link supportive housing with nursing home facilities enabling residents to transition easily if and when their care needs increase [5]. End of life care is another contentious issue for such facilities. Ideally, residents ought to have access to palliative support services as any other home dweller to enable them to 'die in place' and thus further research and discussion is warranted for future development and regulation of such centres.

The need for regulation, legislation and funding within this model of care delivery was also highlighted by staff, particularly as it is so different from the nursing home model, which is currently regulated. Guidance on regulation of supported housing facilities in the United Kingdom is provided by the Department of Health [14] where it is clearly stated that such facilities should not be registered as care homes, although flexibility in care should be built into schemes so that any changes in dependency levels of residents is addressed from the outset. Any provision of personal care within such schemes would lead to the need for registration of this as a care home [14]. The variety of models for the provision of care and accommodation within supportive housing is acknowledged and the regulatory guidance encourages the development of good practice models that promotes collaborative partnership and independent living, but this is open to interpretation [14].

In terms of funding requirements, this is difficult to assess at present as the potential is there to reduce demand on nursing home beds, but this would be totally dependent on the number of such facilities put in place, decisions about specific admission criteria (including dependency and cognitive function), and the extent to which admission would depend on either housing or care need [15].

Conclusion

This research highlights specific points that would need to be addressed in the development of an 'ideal' model of supportive housing with care. Despite the resounding positivity for such a care model, ascertaining the views of staff working within such facilities has identified specific deficits in the current delivery of supportive housing with care in Ireland. This includes care planning for transitioning residents as dependency levels increase; the provision of short term end of life care; specific regulation and legislation for the supportive housing with care sector; allocation of appropriate funding for future planning. These findings could inform national and international policy to underpin the further development of the supportive housing with care model.

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