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The Training Implications of a Social Care Approach to Working with Older People

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Abstract
Nursing homes and day care centres have developed and expanded in recent decades with little input from the emergent social care profession. This is despite the significant role played by professionally trained social care workers in the management, planning and direct provision of day and residential services for a wide range of other client groups of all ages. This paper will argue that alongside policy developments in provision of day and residential services for older people work needs to be done on identifying the training needs of the personnel who are working and will work in these services. Social care education and training has many of the elements which would help staff from a variety of backgrounds to meet the needs of older people in a more holistic way thus enlarging the possibilities for a fuller life for dependent older people. A social care model would address social, emotional and spiritual needs, would seek to empower older people and provide a more normal atmosphere for residents of nursing homes, sheltered housing and day care centres.

Key Words: Older people, recreational and creative activities, social care model, training

Introduction
While care of older people involves both medical and social care nursing homes are essentially an extension of the functions of the home rather than of a hospital. The largest group of employees in residential care settings are nurses and care attendants. A medical model could be said to dominate not a social care approach. However there has been a move away from large institutional settings with a hospital atmosphere to smaller more homely units where there is more emphasis on purposive activity and links with the community. Traditionally many of the day services for older people were provided by voluntary organisations and nuns from religious orders provided
much of the expertise. With the decline in the number of religious these services are increasingly coming under the remit of the health board and staffed by people from a variety of nursing and social care backgrounds.

This article is based on an exploratory study of the provision of care for older people in residential and day settings with particular focus on recreational, social and creative activities. The services and programmes examined were mainly in the Dublin area. The aims of the article are:

- To outline the structure of provision of residential and day services for older people who need additional support in daily living.
- To give an overview of policy development in relation to these services.
- To examine quality of life in relation to provision of recreational and social activities in these services and
- To put forward an argument for social care education in the provision of training courses for staff working with older people.

The article outlines the main institutional services for dependent older people, discusses the principal policy reports that have shaped the services, and describes the historical evolution of services and the main policy developments to date. The article contrasts services based on older concepts of care with more recent practices. The quality of care is examined with reference to legislative requirements and quality indicators particularly related to purposive recreation. The characteristics of a medical model of care are contrasted with a social care approach and an argument is advanced for adopting a social care approach for meeting the needs of the dependent older person. Finally the training implications of adopting a social care approach are considered.

Dependency and Formal Social Care

As is well known there has been an increase in the proportion of older people in the populations of many western countries. Ireland has been an exception to this trend.

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1 This article is based on an exploratory study that was funded by the Dublin Institute of Technology to investigate the training implications of providing care to older people in residential and day settings. The focus of such training was to provide stimulation, enhance personal autonomy and provide opportunities for self development in care settings for older people. The methodology involved a review of current literature on ageing and older people in Ireland including policy documents, publications by the National Council on Ageing and Older People (NCAOP), research reports and publications by advocacy groups such as Age Action Ireland and Age and Opportunity. It included interviews with key people such as a Director of Services for Older People, an Area Medical Officer for Community Care, the Directors/Matrons of several different types of nursing homes, occupational therapists working with older people and representatives of several voluntary groups providing services for older people. Informal observation also was undertaken in residential and day services. Part of the literature review and some of the interviews were carried out by Ms. Gay Brockelsby and Ms. Natasha Lucey from October 1999 to March 2000.
as while the absolute size of the elderly population has increased its relative size has changed little since the early decades of the present century. (Fahey and Murray, 94: 55) The results from the 1996 census showed that 11.4% of the population were aged sixty-five or over. However, population projections suggest that the population aged 65 years or more will grow by almost 108,000 in the period 1996-2011, and will represent 14.1% of the general population in 2011. (Census, 1996) In relative terms the greatest increase is expected to occur in the age group 85 and older. (Fahey and Fitzgerald 1997: 78) The increase in the numbers of older people will give rise to additional demands for formal social care, both non-residential and in residential institutions for the dependent elderly. (Fahey and Fitzgerald 1997: 95)

There are approximately 17,000 older people in long-term residential care in Ireland representing about 5% of the population of people over 65. (National Council on Ageing and Older People 2000) The Eastern Health Board 10- year Action Plan 1999) considered this norm which has been in place for many years to be a reasonable guiding norm for future development of residential services and they noted that it was in line with other comparable European countries.

Long-term residential care in Ireland is provided by three sectors: the statutory sector, the voluntary sector, and the private sector. The statutory sector is the biggest provider accommodating about half the total in 1996. Extended care facilities for older people are provided by the Health Boards in a variety of institutions including geriatric homes and hospitals, district/community hospitals, community units and welfare homes. Private nursing homes provide approximately one third of all extended care facilities for older people. The remaining places are provided by the voluntary sector, mainly religious and charitable organisations for approximately 3,200 older people in geriatric homes and hospitals. (National Council on Ageing and Older People, Report 2000: 12-13)

Day Care for Older People
Day care for older people is provided in day care centres or day centres when a person needs support with daily living or is socially isolated. Day care centres provide a fuller range of therapeutic and social services and are usually run by the health boards while day centres are mainly managed by voluntary groups and are locally based and provide a more limited programme mainly recreational in purpose. The main objectives of day centres as set out in the Years Ahead report are:

- To provide a service such as a midday meal, a bath and a variety of other social services
- To promote social contact among older people and prevent loneliness
- To relieve caring relatives, particularly those who have to go to work, of the responsibility of caring for older people during the day
- To provide social stimulation in a safe environment for older people.

(The Years Ahead – A Policy for the Elderly 1988)
In the Eastern Region Health authority area there are approximately 156 day Centres/Clubs for older people mainly managed by voluntary/parish based organisations whose primary purpose is to provide social interaction (Eastern Health Board 10 Year Action Programme, 1999). The Health Boards also run day care centres either attached to their new Community Units, to voluntary nursing homes or long-stay geriatric hospitals. These provide a fuller range of services for example physiotherapy and bathing. Contrasting models of day care were observed in two day centres visited in one locality in the course of this study. In one centre a full range of services including bathing, chiropody, hot midday meal and recreation were provided by paid staff which included a full-time nurse, care attendant, driver and part-time staff. In the other centre where a hot midday meal and a recreational programme were provided all the staff were volunteers including the manager herself. Variation was also found in relation to the types of recreational activities available. One day centre had bingo and an exercise programme while another day centre attached to a nursing home had a much wider range of activities including crafts, singing, reminiscence therapy, poetry, painting and quizzes in addition to bingo and an exercise programme.

Policy Development in Day Care
Convery (1987) carried out a social policy analysis study of day centres in the Eastern Health Board area. She found a lack of coherence in aims, structures, funding, range of services available and monitoring and evaluation criteria. The author argued that day centres could be accomplishing much more with older people and their social value could be greater. She specifically criticised existing services for 1) supporting a dependent mentality, 2) segregating elderly users, 3) making little allowance for the needs of different client groups and individuals, 4) scarcity of professional staff, 5) absence of training for voluntary staff and 6) lack of formalised funding procedures. As our research above indicates the lack of consistency in day care provision still existed over a decade after Convery’s study.

However, there have been policy developments since the 1980s that sought to address some of these criticisms in relation to health and welfare services generally. The Department of Health policy document, Shaping a Healthier Future, 1994 set out principles for ensuring quality in delivery of health and social services. In particular the concepts of health and social gain which refer to the value that can be added to a person’s life required services to focus on what people wanted and to be more accountable. The reorganisation of the Eastern Region Health Authority in 2000 involving new management structures and more formalised relationships between voluntary providers and the Health Boards was intended to lead to better quality and more accountable services by drawing up service plans between the Health Boards and the larger voluntary providers. The person appointed to the newly created position of Coordinator of Community Services for Older People in each
Community Care area of the Eastern Region would play a key role in liaising with the smaller voluntary groups who typically run day centres at a local level. Policy innovation was also evident when Dublin Corporation and the Eastern Regional Health Authority signed a Protocol of Agreement in 2000 setting out details of co-operation on a range of measures to improve the quality of life for older people. (Services for the Older Person - A Co-Operative Approach, 2000) An example of this new inter-agency cooperation was the establishment of a day care centre attached to a sheltered housing complex at Clareville Court in Glasnevin, Dublin in 2000. In addition to treatment and showering facilities there is a full meals service and a wide range of activities to suit what residents themselves want. It is interesting to note that the newly appointed supervisor was from a youth work background.

**Policy Development in Residential Care**

The provision of long-stay care for older people who can no longer be cared for at home for social and medical reasons gives insight into perceptions of the life course and in particular what are considered to be the needs and possibilities for frail older people in the fourth age.\(^2\) We can document changes in policy direction through the two key reports on the care of older people: the Care of the Aged Report, 1968 and the Years Ahead Report, 1988.

The Care of the Aged report was a seminal report that initiated the development of domiciliary and community services and challenged official thinking dominated at the time by institutional approaches typified by the County Home model. Public provision of long-term residential care was originally part of the Poor Law of the early 19th century that catered for a mix of persons deemed to be destitute. Towards the end of the 19th century County Homes were adapted from workhouses as the appropriate setting for the aged and chronic sick. (The Years Ahead, 1988: 16) Inadequacies identified in the County Homes included the unsatisfactory standard of many buildings, the admission of patients without any medical or social assessment and no system of assessing those who would benefit from active treatment and rehabilitation from those who need long-term care. The Care of the Aged committee recommended the abolition of the concept of the County Home and recommended four different types of extended care accommodation: general hospitals, geriatric assessment units, long-stay units and welfare homes. (Care of the Aged Report: 75-76). As an alternative method of meeting the social and dependency needs of older people the Years Ahead Report published in 1988 recommended a range of facilities including sheltered housing with back-up day care facilities, boarding out of

\(^2\) There is no agreement in the literature on the use of the term 'the fourth age'. Laslett (cited in Schuller and Young 1991:181) has defined it as an "era of final dependence, decrepitude and death" and distinguished it from the 'third age'. However this classification has been challenged by Schuller and Young 1991: 182) who quote Cribier in arguing that the term distances the very old from society even more and is another form of age stratification which the term the 'third age' had attempted to dismantle.
The intention of this report was that long-stay hospitals should be radically restructured to enable them to function as community hospitals providing a mix of services, including long-stay care, convalescent care, respite care, information, advice and support for carers in the community. However, a review of The Years Ahead Report 1988 concluded that the development of community hospitals has been slow and uneven around the country because of totally inadequate funding. (Ruddle et al. 1997). In recent years Community Units which are modelled on the concept of a small multi-purpose locally based facility and which were pioneered in County Donegal have become a model favoured by many Health Boards when establishing new facilities. The Eastern Health Board in their Ten Year Action Plan for Services for Older People 1999-2008 stated that Community Units:

have proved of immense benefit in the provision of a spectrum of services for older people either as short stay patients i.e. day care, respite/intermittent, convalescent/ rehabilitation care or as long stay patients....the provision of Community Units has resulted in a responsive humane service and has allowed older people to remain in their own homes for as long as possible.

(Ten Year Action Plan, 1999: 63)

Features of the Community Units include

- They are small nursing units catering for 50 persons approximately
- They have long stay beds, respite beds and day care places
- Residents are highly dependent in nursing terms and they cater for a certain proportion of psycho-geriatric patients
- They have a full-time Activities Nurse and there is considerable emphasis on recreational and social activities

There are only three community units in the ERHA though the EHB 10 Year Action Plan, 1999 recommended the establishment of 29 by the year 2008. This indicates how aspirational many policy documents are. Many of the Health Board's extended care facilities are in old unsuitable buildings which belong to models of institutional provision for fever control in past centuries and which are totally inappropriate as homes for vulnerable and dependent older people. In the Dublin area examples are St. Brigid's Home, a 150-bed facility in Crooksling which is built in an isolated position near Tallaght and whose original purpose was to treat tuberculosis, and Bru Chaoimhin, Cork Street, a 183 bed facility which was built in 1807 as a Fever hospital. The community unit provides a sharp contrast with these larger institutions in almost
every respect—in architectural style, in location, in the provision of individualised programmes of animation, in the range of recreational activities on offer and a sense of being part of the community. However the proposal in the EHB 10 year Action Plan, 1999 to phase out these old and outdated facilities and replace them with community units appears not to have been matched by political or public interest. The profile of residents in long-stay institutions shows that almost 70% are aged 80 years or more while almost 40% are aged over 85 years. (National Council on Ageing and Older People, 2000). Nursing homes cater for people with high levels of dependency. A high proportion of residents suffer from confusion and dementia. In one long-stay facility visited during the course of this study which had 215 beds about 85% of patients were said to have a moderate to severe cognitive deficit. The Matron of this facility described the residents as “not cognitively alert and would be intermittently confused - perhaps do not know where or why they are there.” There were some diversional activities, for example arts and crafts. However there was only one member of staff who worked full-time at diversional activities and this permitted a one-hour per week art and craft session with seven residents per session. The problem with trying to engage in activities with highly dependent residents is that they require a high input of staff.

Private Nursing Homes
In the Years Ahead Report (1988) the private nursing home sector was explicitly recognised for the first time in a policy document and the 1990 Health (Nursing Homes) Act facilitated the integration of private nursing homes with public sector provision. Private nursing home provision increased dramatically between 1968 and 1988 (O'Shea et. al. 1991) and this trend has continued particularly in the Eastern Region. The Health Boards in the Eastern Region have been contracting private nursing home places to deal with long-term waiting lists. (EHB 10 Year Action Plan, 1999: 10) It has been suggested that tax incentives introduced by the government in the 1998 and 1999 budgets indicate a policy of promoting provision of long-term residential care by the private sector as a means of meeting the current upward trends in demand for long-term residential care. (NCAOP, Report 2000) At the National Council on Ageing and Older People Annual Conference, 2001 Mr. Denis Doherty, CEO, Midland Health Board suggested that the fact that the Health Boards are mandated by law (1990 Health Act) to subsidise private nursing home places while subvention to community based services remains discretionary has reduced funding to the latter. He suggested that this has diminished public confidence in community based services and further reduced the choices available to frail or incapacitated older people and their families. Ruddle et. al. (1997) noted that during the period 1993-1997 over £65m had been spent on the implementation of the 1990 Act compared with £2.5m spent on the development of day-care facilities.
Quality of Residential Care

There are many examples of good practice in relation to the quality indicator of providing satisfying recreational opportunities. The Director of Nursing of a newly opened Community Unit commissioned a paper that investigated ways of enhancing the quality of life for its residents through recreation and entertainment. (Hurson, 1998) Following questionnaire based interviews conducted with residents and nursing and care staff the author concluded that "elderly patients do have recreational needs which when given the opportunity they can articulate and articulate well" (Hurson 1998:7). The author found that their suggestions were realistic in that they could be met within the confines of a residential facility and that among the staff there were many ideas and skills which could be used to help meet their needs and interests. Following the research a number of initiatives were taken including a small gardening project, purchase of games, introduction of art sessions, membership of a local library, introduction of pets, playing taped music and a tape recording of the rosary played in the Oratory.

In contrast with the community unit where the emphasis is on purposive recreation and links with the community there does not appear to be any articulated public policy or any societal vision of what private nursing homes should aim for. An empirical investigation into the quality of care in long-stay facilities for older people was undertaken two decades ago. (O'Connor and Walsh 1986). The authors of this extensive survey of private and voluntary nursing homes found an environment where residents lived a passive life in a public space and they saw the failure to foster the potential or to broaden the recreational experiences of residents as an indicator of poor quality. The ethos of care in the nursing homes surveyed emphasised dependency and reinforced the stereotype of older people as unoccupied and separate from society. While the present research was small scale and exploratory some differences were identified between commercial private nursing homes and the voluntary private nursing homes:

• The voluntary sector homes
• Can potentially use any profits to provide a better level of equipment and facilities
• Specialise in an ethos, usually Catholic, and are more likely to have daily Mass and an active chaplain
• Tend to have closer liaison with the local community through encouraging use of their facilities by groups such as the local Active Retirement Association or schools. This provides opportunities and links with the local area for the residents
• May have more high dependency residents
Legislation
The Health (Nursing Homes) Act 1990 provided the basis for the regulation of private and voluntary long-term residential care in Ireland. The main provisions of the Act were:
1. The introduction of a system of subvention for people entering long-term residential care
2. A regulation and inspection system for both private and voluntary nursing homes
3. Greater quality control measures including:
   • compulsory registration,
   • stricter enforcement of standards of design, nursing care, nutrition and general management
   • greater accountability of proprietors and stiffer penalties for offenders
   • better information and complaints procedures for the consumer

Regulations were introduced in 1993 to give effect to the quality control measures contained in the 1990 Act. (The Nursing Homes (Care and Welfare) Regulations, 1993) These included regulations in relation to information and contract of care, welfare and well-being, staffing, accommodation and facilities, provision of services by health boards, inspection, complaints and staff training. However it has been pointed out that measurable standards were established for only a small proportion of these aspects of care and the terminology used for other aspects is often vague and open to different interpretations. The effect of terminology such as ‘adequate’ or ‘appropriate’ is that health boards and inspection teams apply the standards in inconsistent ways. (NCAOP 2000 p. 11) A further serious criticism of the legislation is that the statutory sector is exempt from the quality controls and inspections that apply only to the private and voluntary sectors.

Voluntary Code of Practice
To overcome some of these criticisms a voluntary Code of Practice was agreed by a group representing nursing homes, health boards, carers and others with experience in the care of older people and published by the Department of Health. (Code of Practice for Nursing Homes, 1995) The Code is designed to encourage nursing home owners and staff to go beyond the minimum standards set by the Act and Regulations with the aim of promoting a good quality of life for residents in nursing homes. This Code of Practice offers a set of principles and recommended practices that are based on a holistic view of the person and the vision that life enhancing possibilities can be created for a person at any age and with high degrees of disability or dependency. This is evident in the general aspirations contained in the code that “nursing homes should create an environment that seeks to develop, maintain and maximise the full potential of each resident”. (Code of Practice, para. 2.2) More specifically it
suggests that this can be achieved by encouraging individuality and choice in matters such as clothing, food preferences, bed times, meal times and throughout the usual daily activities. (Code of Practice, para 2.7) The code emphasises that day-to-day life should be a normal as possible and that social activities should be a priority. Residents who are able should be encouraged to keep up their links and interests outside the home – going out alone or with relatives, friends or volunteers, walking, shopping, attending at religious worship, social outings to the cinema, clubs, pubs etc. (Code of Practice, para 2.9 and 18.1) They should also be encouraged to access local community facilities such as library or community centre. (Code of Practice, para 2.9 and 15.1). Recreation should be provided for residents who have the physical and mental capacity to participate by providing regular occupational and leisure activities including programmes recommended by physiotherapists and occupational therapists. (Code of Practice, para 15.4) Games such as bridge, chess, bingo and scrabble should be encouraged. (Code of Practice, para 15.6) For residents who are more dependent “opportunities for social interaction should be encouraged to the limit of a person's ability”. The home should try to ensure that they have company and volunteering from the surrounding community is encouraged particularly for residents who are without close family ties or friends. (Code of Practice, para 18.2) This Code reflects a holistic approach to care of the older person. It could be said to be based on a social care rather than a medical model. However a study carried out on behalf of the National Council on Ageing and Older people suggested that the code has received little attention. (NCAOP 2000: 11)

The National Council on Ageing and Older Persons published a framework for fostering quality in long-term care and recommended that national minimum quality standards be introduced (NCAOP 2000). The achievement of such standards would have clear implications for the training of staff working in long-term care facilities.

Medical Model
An important factor in the delivery of services to the older person is the dominance of the medical model particularly in residential settings. This incorporates an ideological dimension that affects cultural attitudes and values and an institutional dimension that affects the structures and practices in relation to service delivery. Characteristics of the medical model of care are that it

- Focuses on problems and deficits
- Takes control, disempowering the “patient” and placing them in a passive role
- Tends towards institutional provision of care, with routines designed for efficiency. This can lead to individuality being ignored.
- Can label people in terms of their disease or difficulty, which in turn may determine how they are perceived and treated.
• Is ready to use medication to treat problems, sometimes before all other avenues have been explored.
• Tends to emphasise physical care

Twigg (2000) in her examination of the assistance with bathing given at home to older people in the UK examines the relationship between the medical and the social in community care. She argues that at an ideological level the relationship between the medical and the social is an unequal and asymmetrical one in which the medical is the dominant category, associated with high status knowledge, technological mastery, political and social prestige. The power of the medical profession is most evident in the public medical space of the hospital ward or the nursing home typical of older institutions. Twigg analyses the disempowering features of institutional care for the older person when such care is dominated by the medical model. There are two main processes involved in this disempowerment:

1) Access of professionals involving relationships which are not kin or friendship based and which the individual cannot exclude and
2) The professional scrutiny where the person’s physical, emotional and social functioning is observed, recorded and rationalised in a total institution outside normal reciprocal social relationships.

In a recently published study of Care and Case Management for Older People in Ireland (NCAOP, Report no. 66) a recurring theme among those professionals interviewed was the dominance of the medical model in the care of the older person. One interviewee stated:

Older people can be looked at from a very “medical” point of view [I] don’t think that everything in terms of services for older people should be led by medical personnel.
(NCAOP, 2001:78)

A view seems to be emerging amongst all the health and social care professionals that a more holistic view of the older person needs to be adopted in relation to service planning and delivery. This was expressed in a recent report of the National Council on Ageing and Older People:

If the concept of ‘holistic’ care is seen as one of the core principles of Care Management, then a model of health care that is mechanistic and biomedical in outlook cannot match the vision of care espoused.
(NCAOP, report no. 66: 78)
This is an issue with which the nursing profession has been engaged for some time. Hurson in her examination of an activities programme in a newly opened community cites Crump (1991) who argues that many nurses working with older people do not accord social and recreational activity any real priority, often viewing it as the responsibility of other professional groups. However she also cites Trolley (1997) who argues that while social activities are not the direct responsibility of the nurse in most long-term facilities, the nurse as the co-ordinator of the resident’s inter-disciplinary health plan as well an advocate for the resident should take responsibility for planning and evaluating an activity schedule which enhances the health of the client. In Hurson’s study many of the nurses, while willing to “give it a try” did not see the running of such activities as a legitimate part of their job. In contrast care attendants said they were looking forward to being actively involved in all planned activities.

**Social Care Model**

In contrast with the medical model the social care model tends to

- Be holistic
- Enable clients to do as much for themselves as they can and involve them in decision making in as far as is practicable
- Stress individualization and normalization in the provision of care
- Use non-medical interventions wherever possible
- View social emotional and spiritual needs as on a par with physical needs

However the social care model needs to be informed by critical social thinking which challenges existing presumptions about what older people can expect from life and which can imagine new possibilities for life enhancing experiences in the older years. Age stratification can confine people to a straitjacket of narrow social, recreational and creative activities because of presumptions about them being slow, rigid, unenterprising, incapable of innovation, and intellectually limited by reason of their age alone. Critical social gerontology has argued that there is not only one way of ageing or one pace of ageing. The creation of new language such as the ‘third age’ can itself help to improve the social image and hence the self image of ‘the old’. (Schuller and Young, 1991: 165) Research that examines the lived experiences of older adults can also contribute to the body of knowledge which informs social care perspectives.

**Social Care Education and Training**

There is a growing recognition that services for the dependent elderly should follow other services, such as those for people with intellectual and physical disabilities, in adopting a social care model in preference to a medical one in meeting the needs of older people. Social care education and training has many of the elements that would
help staff including nurses, care attendants and others to meet the needs of dependent older people in a more holistic way. These include:

- exploring attitudes and expectations within a value framework which stresses individualisation and normalisation,
- developing effective communication techniques and use of creative activities
- using space to bring life in from outside and bring residents out
- using older people themselves as a resource

Social care education in the third level sector also includes a strong social theory element which can help practitioners develop more critical understanding of ageist structures, understand the forces of social change and help in imagining new possibilities for the latter stages of the life course.

An interesting training initiative “Arts for Older People in Care Settings” was undertaken recently by a partnership involving the Midland Health Board, Laois County Council and Age and Opportunity. The initiative was designed to enhance the quality of life of long stay residents by providing stimulation that was regular, reliable and part of the normal routine. This was to be achieved by developing the necessary facilitation skills in the staff themselves to bring art and drama to residential care settings. A pilot training course commenced in October 2000 that was open to all the nursing and care staff of the Care Centres for older people in the Midland Health Board. There were twenty-five participants drawn from eight Care Centres in the Midland Health Board. An evaluation report gave positive feedback from participants, facilitators, residents and Directors of Nursing. An Accreditation structure has been agreed under FETAC (NCVA) and a plan is being drawn up to establish the training course on a firmer footing.

At present social care education and training is separated institutionally from the training of nurses and of care attendants. However developments in services for older people mean that there is going to be a growing demand for education and training that can provide the creative mix of skills and value base which existing social care courses provide. At present professionally recognised social care education and training takes place in the DIT and the Institute of Technology sector to degree and diploma level. Social care training is also provided at vocational level (FETAC former NCVA level) in VEC colleges. In the Higher Education sector social care education and training is generic and while it may include practical and course work related to care of older people there are no specific career opportunities for graduates to work in these services at present.

The main group of employees in residential care settings are nurses and care attendants. Nurse education and training is now integrated into the third level education sector.
and there are specialised post-graduate courses in gerontological nursing. While training of care attendants is mainly on-the-job short formal courses are provided by the Health Boards themselves. Thus the parallel structures for education and training of nurses and social care workers may accentuate the division between the medical and the social care models. Nurses who are recruited to positions of Activities Nurse in residential units or Co-ordinators of Day Care Centres must access courses themselves. There is no course available which would arm them with creative skills and an appropriate value base to enhance their work. The courses which staff undertake, often on their own initiative, tend to be special interest courses such as Art or alternative type therapies such as Aromatherapy, or a music/exercise therapy course specially suited to older frailer people called Sonas. There is therefore a unique opportunity for providers of social care education to address the training needs of this sector.

A post-graduate course could be developed in Animation of the Older Person that would focus on creative and recreational activities and the use of the environment including community involvement to create a more normal and a more stimulating environment. Modules could be offered to staff without formal qualifications and these could be accumulated towards a full course. A training initiative such as this would require co-operation among the Institutions providing social care education and training and with other institutions such as the Universities, the Nursing Board, the Health Boards and Age and Opportunity. The latter two have already cooperated on a training initiative as discussed above. There is clearly a need also given their key role in the care of the older person for formal training for care attendants. Training could be provided by the VEC colleges that currently offer social care qualifications with FETAC accreditation. The opportunity to progress to an appropriate third level qualification such as a diploma or degree in Social Care with specialisation in the care of the older person should be open to people who have completed such a course. The benefits of developing such training would be enhanced job satisfaction for staff and an enriched environment for the dependent older person.

While there are at present no dedicated career posts for social care graduates in the services for older people this is not so in the rest of Europe where the role of 'animateur' is well established and filled by social care graduates. A comparison can be made with the field of early years child care where training has developed in advance of a career structure but has stimulated the development of services and job opportunities. Training initiatives in working with older people could be expected to have similar consequences.
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