Nearly home…. Ageing Places and the Nestling Project.

Transforming social networks, environments and technologies for longer living.

Rodd Bond
nearly home ..... 

• ‘--- as they are now, nursing homes do not serve the needs of the elderly ... they can show well-cared for bodies, but they house broken spirits’
  – (Carter C. Williams 1999)

• ‘--- the length of life ain’t important to me – the quality is’.
  – (Ralph Nelson 84; Almost Home film)

• ‘--- He said, “....... I was walkin’ down an old dirt road Past a field of hay that had just been mowed Man I wish you'd just left me alone 'Cause I was almost home” ’
  – (Craig Morgan – Almost Home Lyrics)

• ‘--- place is space with meaning attached’
  – (Yi Fu Tuan 1977)

HOME AS A PLACE .....  HOME AS A JOURNEY ..... 

PLACE & PACE AS DIMENSIONS OF EXPERIENCE FOR AGEING PEOPLE
the demographic challenge

**Figure 3.5 CSO Irish population projections**

- **Population pyramid 1996**
  - Total population: 4,253,800
  - Population 65 & over: 467,920 (11%)

- **Population pyramid 2031**
  - Total population: 5,568,220
  - Population 65 & over: 1,002,280 (18%)

*Source: Central Statistics Office*
The Nestling Project

• Collaborative demonstration project
  – Health Services, Local Authority, Institute of Technology
  – Research Partners – University of Ulster, DCU-NCSR
  – Part funding through Philanthropy, EU regional grant
  – Ageing-in-Place project around Barrack St., Dundalk, Ireland

• Proposition
  – Maximise opportunities for community based ageing-in-place – based on the fusion of:
    • new integrated community care model(s),
    • environmental improvements (housing & neighbourhood)
    • and new technologies (telecare / telehealth / automation)

• Key outcomes
  – Evidence-base for broader adoption and home service intensification (high dependency)
  – Inform appropriate policy areas to remove barriers/accelerate
  – Promote regional innovation - product/service development
  – Foster culture of continuous quality improvement in community

A CROSS-COMMUNITY APPROACH FOR BETTER AGEING
Q1: How well do people experience place in supporting their needs and aspirations?

Q2: How well does a community model(s) work in sustaining itself and its members. (cohesion and inclusion)?

Q3: How well does the environment and supporting technologies enable autonomy and support community?
preliminary investigation - needs

Cognitive decline
High use of respite services
Multiple chronic diseases

Needs care in the home / community setting

Need care in a long term / nursing home setting

Isolation in the home
Declining functional status
Concerns with falling
WHO Age-Friendly Cities – Oct 2007

- WHO Ageing and Life Course Programme
  - 33 cities in 22 countries contributing
  - Focus groups, carers and provider groups
- Topics for consideration
  - Outdoor spaces and buildings
  - Transport
  - Housing
  - Respect & social inclusion
  - Social participation
  - Communication and information
  - Civic participation & employment
  - Community support & health services
WHO: Age-friendly cities local report:

- The most important things
  - Sense of security
  - Respect
  - Cross-generational community vitality and sustainability
  - Joined up services and better information
  - Environments that are considerate of seniors’ increasing frailty
  - Environments that reinforce community
  - Transportation
  - Affordability
  - Valuing seniors’ time
Should our efforts be aimed at inverting Maslow’s pyramid?
demonstrator - barrack st.,

Site

Town Centre

1 km
neighbourhood - facilities

150 m

- Public House
- Pharmacy
- Supermarket
- Post Office
- Church
- Primary care
barrack st., details

16 units
Out-reach centre
1 unit transition
Primary care centre

space features
• Lifetime adaptable
• Accessibility
• Healthy home

energy features
• orientation
• fabric
• fenestration
• energy source
• management

Tech. features
• base infrastructure
• social connectivity
• tele-care/health
• home-automation

elements
Teams across the network
community-oriented model development

- Acute hospital
- Residential / Household settings
  - House support
    - Self-managed
  - Home support
    - Self-managed
  - 3rd party support agency
  - voluntary groups organisation
- Primary Care
  - G.P.'s. specialists
  - Care centre specialists
- Care centre specialists
- Consultants specialists
- Hospital in the home
  - Chronic disease
- citizen at home
- Continuous improvement pressure
  - External pressures
    - resources/regulation
  - Internal pressures
    - CQI / CPI
  - Demographics
    - Increased demands
  - Person-directed
    - Cultural change
- older person
- Family
- Friends
- service broker
ICT DOMAIN AREAS

Continuous improvement pressure
- External pressures: resources/regulation
- Internal pressures: CQI / CPI
- Demographics: Increased demands
- Person-directed: Cultural change

Acute hospital
- Consultants specialists

Residential / Household settings
- House support: Self-managed

Primary care
- G.P.'s. specialists

Care centre specialists

Service broker

Cultural change

Voluntary groups

Home support
- Self-managed

Hospital in the home

Chronic disease

3rd party support agency

Older person

Family

Friends

Information / ICT
Incremental impact model (based on CMHC 2005)

Achieving a richer, personalised, quality of life measure to QALY

The slope and value of the long term care line is moving

Paradigm shift from extended home stay until an event breaches QOL threshold to full life-course model reaching to end-of-life.

WHAT COMBINATION OF COMMUNITY BASED SUPPORTS, ENVIRONMENTAL IMPROVEMENT AND TECHNOLOGY SUPPORTS CAN KEEP OLDER PEOPLE’S QOL ABOVE THE LINE FOR LONGER.

evolving QOL aspirations of the individual

evolving individual ability, sustainable environmental adaptability, responsive community care services.

Quality of ‘FIT’
some lessons

Lesson 1

• Resources
  – It’s not about lots of new resources – it’s about channelling, aligning and optimising the resources we already have.
  – It’s about doing what we already do - but better !!
Lesson 2

• Capacity
  – Collaboration
    • building cross-agency community capacity to collaborate – to share budgets – to each work on the edges of their core competencies - isn’t easy!
  – Trust and empowerment
    • trusting and empowering the community and voluntary sector - to be equal partners in services delivery - doesn’t come naturally!
  – Participation (from telling to asking)
    • empowering older people to exercise choice – to shift from consultation to participation - loosening control - is scary!

However, building capacity – to collaborate, to trust and to participate - is a finite challenge with an infinite return !!
Lesson 3

• **Time**
  - Time is a very precious resource – particularly for older people. We must not only examine the structure of our neighbourhoods and cities – we must examine the PACE of them.
  
  - If we value seniors’ time (as we do our own) – we’ll go along way to building the respect and dignity they deserve.

We were once ‘good at time’ in Ireland – can we re-capture our excellence?
an aware care services model

ICT elements

Early detection
Early diagnosis
Early intervention
Continuous assessment
Preferred interventions
Orchestrate delivery

SENSORS / SENSING
Envir. A.D.L. health Medical

PATTERN DIAGNOSIS / SERVICE NEED
Recognition Analysis Needs

INTERVENTIONS - SERVICE DELIVERY
SERVICE PATTERN / CHANNEL MAP
ambiently directly indirectly

INTERACTION EVALUATION - FEEDBACK
Learn adapt score

Frailty / mobility muscle strength
Sensory decline
Chronic diseases
Cognitive impairment