Homes and Housing for Elderly People

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This is the third in a series of 14 articles edited by Eileen Burns, Neil Penn, and Graham Mulley

Most elderly people in Britain live independently in their own homes. Moving to alternative accommodation may be necessary for some people but requires careful consideration. A multidisciplinary assessment should be performed when a person plans to move into residential care; this should include the input of a doctor trained in geriatric medicine. A range of housing options is open to elderly people and these options are discussed here.

Most elderly people in Britain live independently in private or rented accommodation. However, more of the "oldest old" people live in residential care or long stay hospitals (29% of people aged over 85 compared with only 1.1% of those aged 65-74).¹ As the proportion of oldest old people rises, the provision of appropriate housing will become increasingly important.

A recent housing survey found that 10% of people aged over 65 were living in the worst housing category. Although this is the same proportion as in the general population, it represents around 700 000 households.²

Private housing

REPAIRS AND ADAPTATIONS

Home repairs may be overlooked by some elderly people, and housing grants are given least frequently to people aged over 75. Elderly home owners can get advice about repairs or adaptations from several sources.

Housing agency services (sometimes called "Care and Repair" or "Staying Put") give practical advice to older home owners on arranging surveys and grant applications, obtaining estimates, and monitoring work

as it proceeds. Although these agencies are non-profit making, a charge may be made; this charge can be included in the grant or loan application.

Citizen's Advice Bureaux and the *renovation grants section of the local council* also provide information on ways to get help with paying for repairs and improvements.

If adaptations are needed because of disability, the local social services department will arrange an assessment by a community occupational therapist.

To pay for repairs or adaptations, three main housing grants are available from the local authority: renovation grants, grants for minor works, and grants for providing facilities for disabled people.

Renovation grants are means tested. Up to £20 000 can be obtained for housing repair or improvement. Renovation grants are mandatory if the house is in serious disrepair, structurally unstable, or lacking basic amenities such as cooking or bathing facilities or sewerage. Grants for lesser repairs (including heating systems) are discretionary.

Minor works grants are discretionary up to a maximum of £1080. They can be obtained for essential repairs or adaptations to a home occupied by a person aged over 60; these repairs may include insulation and draughtproofing. Applicants for minor works grants must be receiving income support, community charge benefit, or housing benefit.

Disabled facilities grants are mandatory if a disabled person does not have full access to the property and its amenities. They can be used to provide easier access and kitchen and bathroom facilities for independent use and to improve and adapt heating and lighting. For a wider range of work, these grants are discretionary. If there are problems with obtaining these grants, contact the local social services department or the Royal Association for Disability and Rehabilitation (address below).

SECURITY

Police stations have a crime prevention officer who can visit the home and advise on securing doors and windows. They will also advise on suitable locks and burglar alarms. Some local councils and voluntary organisations produce leaflets on security measures and may give grants. No specific grants are available for security measures on a national basis, but a minor works grant may be given by the local authority.

HEATING

The home energy efficiency scheme provides grants for insulation (this includes changing loft insulation from 50 mm to 150 mm) and draughtproofing up to a maximum of £305. This is available to people aged over 60 whether or not they are receiving benefit. Further advice about the grant and local approved "network installers" is available from the energy action grants agency.

The Social Fund, administered by the Department of Social Services Benefits Agency, provides loans and grants mainly to people receiving income support, and some of this money may be used for heating systems or fuel bills. Payments of £7 a week for cold weather are also made to people aged over 60 who receive income support to meet the cost of extra fuel.

"An elderly couple" by Leonard Campbell-Taylor (1874-1969)

Leeds General Infirmary,
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P Wanklyn, senior registrar in
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Further advice on financial help with heating costs and ways of keeping warm are given in Age Concern's factsheet 1, and between October and March a Winter Warmthline (freephone 0800 289404) provides information on heating.

Moving

If an elderly person is thinking of moving to specialised housing, all the housing options should be discussed with the individual and their carers. Advice is available from many sources:

- general practitioners
- the local social services department
- the registration officer for residential homes at the social services department
- the registration officer for nursing homes at the district health authority
- Yellow Pages, Age Concern, the Community Health Council, Citizen's Advice Bureaux, and local voluntary support groups and charities (for example, Alzheimer's Disease Society, Carers National Association).

It is recommended that any elderly person who is considering a move to specialised housing should be offered a multidisciplinary assessment, including a medical examination by a doctor with experience in geriatric medicine.³ It may be that rehabilitation or provision of suitable aids and appliances would allow the patient to remain in their own home (if that is what they wish to do). An example is the provision of an alarm system to obtain assistance which may improve confidence. Alarm systems for the home have been described by Davies.⁴

If the patient is self funding, he or she can apply directly to the home, which will provide details of conditions and charges.

Specialised housing

SHELTERED HOUSING

Sheltered housing is available to rent or buy, but it is usually in short supply. It usually consists of self contained flats, bungalows, or houses in developments

of 24-40 properties. Developments may be run by the local authority or a housing association and provide varied levels of care and support from specifically designed housing with no communal facilities to units with wardens or extra care (meals on wheels, home care, or visits from the district nurse).

Properties are purpose built for elderly people and may include flat or ramp access, waist high sockets and switches, walk in showers, and grab rails. Other facilities in a development usually include a guest room, common room, and laundry. There may be a resident warden and alarm system. Meals are not usually provided.

The landlord is responsible for external maintenance, insurance, gardening, window cleaning; a service charge is payable for warden and services. Pets are sometimes allowed.

Functions of a warden in sheltered housing

- Visits daily
- No obligation to provide personal assistance
- Not a proxy relative
- Will contact relatives/general practitioner if problems occur

ABBNEYFIELD HOUSES

These are run by the Abbeyfield Society (address below). They tend to be large, with seven to ten residents who come together for main meals prepared by a resident housekeeper. The weekly charge tends to be higher than sheltered housing.

Residents are licensees so their rights are not as secure as those of other housing association tenants. It is wise to obtain advice from a solicitor, the Citizen's Advice Bureau, or a housing advice centre.

ALMSHOUSES

Most almshouses have been in existence for centuries, and many consider only particular applicants, depending on conditions given by the original benefactor. Accommodation is provided rent free, but a weekly contribution for upkeep may be required.

Trustees manage a group of almshouses and standards of provision vary considerably between groups.

Residents are legally considered to be licensees so tenure is less secure than with a housing association.

Residential care

Detailed advice about what to look for in residential care is available from local social service departments and also in Age Concern's factsheet 29. It is useful for the person to have a trial stay in a residential or nursing home to decide if they will be happy before finally committing themselves.

RESIDENTIAL HOMES

In general, residential homes give care that a relative or friend might provide, such as help washing, dressing, eating, toileting. Residents may, however, become disabled, incontinent, and dependent, and often they continue to stay in the home. Some homes cater for particular groups of people, such as those with mental disorders or drug and alcohol dependency.

Homes may be run privately for profit or they may be voluntary (sometimes for particular groups of people) or local authority (part 3) homes. They must be registered with the local authority if caring for four or more elderly or dependent people, and inspected at least twice a year.

Adaptations, such as lifts and alarm systems, may allow people to stay in their own homes

ULRIKE PREUSS

Considerations when choosing a residential or nursing home

Staff

- Respectful, polite, friendly

Other residents

- Consider whether one will be comfortable living with current residents

Location

- Easy for family or friends to visit
- Near local amenities (shops, pub, library)

Rooms

- Single or sharing
- Locks on doors
- Personal belongings and furniture
- Own bathroom or toilet (if not, how far is it and how many share it)
- Separate dining and sitting rooms
- Separate smoking areas
- Televisions available

Food

- Varied menu
- Flexible mealtimes

Social activities

- Garden
- Able to continue current hobbies
- Outings arranged regularly

Accessibility

- For wheelchairs, walking frames

Telephones

- For personal use

NURSING HOMES

Most nursing homes are run privately. They provide 24 hour nursing care by qualified nurses, so they are able to accept people who are more severely disabled. Some cater for elderly mentally infirm people. There must be two whole time equivalent nurses for every three occupied beds. Nursing homes must be registered and inspected by the health authority at least twice a year.

To be eligible for local authority funding of a place in a nursing home, a person must have a condition with constant or unpredictable nursing requirements for maintenance of health or to prevent a deterioration. Hence, people who are bed bound or chair fast, need help with feeding, or are moderately dependent in various activities of daily living are eligible, as are those whose condition will deteriorate, resulting in a high level of dependency.

FINANCE

If the local authority agrees for the patient to enter residential care, it will usually suggest suitable homes. However, if the patient has chosen a different home the local authority must arrange a place there if it is suitable for the patient's needs and does not cost more than the local authority would normally pay. If the preferred accommodation does cost more, a place may still be arranged if a third party is able to make up the difference in cost.

People who require help with the fees are assessed by the local authority. A person with savings and capital over £16 000 pays the full fee; when savings fall below £16 000 the local authority will top up the difference after income support has been paid. When savings fall below £3000 the local authority will pay the full fee (see article by Teale, later in this series).

STANDARDS

The British Geriatrics Society has stated³ that a home should provide:

- personal choice in food, clothing, form of address, social activities, daily routine, general practitioner
- privacy
- an easily accessible complaints procedure
- an advocacy system for residents
- personal control of finance and medication where possible
- access to a full range of diversional activities
- access to community, health, and social services
- an individualised care plan.

Housing for people with special needs

Elderly mentally infirm people—Some homes cater for people with dementia or are registered also to take people with physical disabilities. Nursing staff should have suitable training in mental illness.

Visual impairment—The Royal National Institute for the Blind (RNIB) and other societies for blind people have worked with housing associations to develop sheltered schemes for people with visual impairment; they provide four residential homes. The RNIB will supply a list of suitable residential and holiday accommodation for blind people.

People who use wheelchairs require well designed housing with good access by ramps to wide doorways and adequate space in hallways. Modifications may be needed to the bathroom, and sockets, switches, and surfaces are best at waist height. The Access Committee for England has argued strongly for a change in the regulations for all new buildings to ensure access for all, but this has not yet been agreed.

Ethnic minority needs—Few housing associations or homes cater for the specific social, cultural, dietary, and religious needs of ethnic minorities. The Housing Corporation provides a list of registered housing associations which house people from ethnic minorities.

Housing for people who use wheelchairs needs good access and some modifications in kitchen and bathroom

Further reading

Two useful books can all be obtained from Age Concern England, Astral House, 1268 London Road, London SW16 4ER:

Bookbinder D. *Housing options for older people*. (1991.)

A buyer's guide to sheltered housing. (1995.)

Age Concern also produces a series of numbered factsheets, of which the following relate to housing:

- (1) Help with heating
- (2) Sheltered housing for sale
- (8) Rented accommodation for older people
- (10) Local authority charging procedures for residential and nursing home care
- (11) Preserved rights to income support for residential homes and nursing homes
- (13) Older home owners—financial help with repairs
- (29) Finding residential and nursing home accommodation

Useful addresses

Care and Repair Ltd, Castle House, Kirtley Drive, Nottingham NG7 1LD (tel 0115 979 9091) Royal Association for Disability and Rehabilitation (RADAR), Unit 12, City Forum, 250 City Road, London EC1V 8AF (tel 0171 250 3222)

Abbeyfield Society, 186-92 Darkes Lane, Potters Bar, Hertfordshire EN6 1AB (tel 01707 651774)

Almshouse Association, Billingbear Lodge, Wokingham, Berkshire RG11 5RU (tel 01344 52922)

RNIB Housing Service, Garrow House, 190 Kensal Road, London W10 5BT (tel 0181 969 2380)

Housing Corporation, Head Office, 149 Tottenham Court Road, London W1P 0BN (tel 0171 387 9466)

1 *Care of elderly people, market survey 1992/3*. London: Laing and Buisson, 1993.

2 Department of the Environment. *English house condition survey 1991*. London: HMSO, 1993.

3 British Geriatrics Society. *Policy statement no 4: private and voluntary homes*. London: British Geriatric Society, 1990.

4 Davies K. Emergency alarms. In: Mulley G, ed. *More everyday aids and appliances*. London: BMJ Publications, 1991:39-45.

Lesson of the Week

Pitfalls in contact tracing and early diagnosis of childhood tuberculosis

Julia E Clark, Andrew J Cant

Tuberculosis is easily missed in children; a combination of contact history, tuberculin testing, and radiology aid diagnosis

The incidence of tuberculosis in Western countries has steadily declined, but this trend is reversing.¹ Effective contact tracing and screening remain essential to prevent secondary cases and are especially important for child contacts, given their greater susceptibility to disseminated disease and the difficulty in diagnosis in this age group.

We describe three cases of serious tuberculous disease in children that illustrate their vulnerability to this infection and the problems that can be encountered with apparently straightforward contact tracing procedures.

Case 1

A 5 month old Asian girl who had not been vaccinated for tuberculosis was seen as a contact of her grandmother, who had fully sensitive pulmonary tuberculosis. She was well at this time and after one negative result on Heaf testing (grade 0) was given a BCG vaccination and discharged.

Six weeks later she presented to her general practitioner with fever, poor feeding, and vomiting. She was referred to hospital. On examination she was pale and unwell and tachypnoeic, with widespread crepitations on auscultation, but no hepatosplenomegaly. A chest x ray film showed extensive miliary shadowing, with a small opacity in the right mid zone. Miliary tuberculosis was diagnosed. A nine month course of triple antituberculous chemotherapy produced a full recovery.

Case 2

A 6 year old white girl was screened as a contact of an aunt who had fully sensitive smear positive pulmonary tuberculosis. Two Heaf tests six weeks apart gave negative results, and she was given a BCG vaccination. Two weeks later she presented at her local hospital with a history of cough, headaches, weight loss, and fever. A chest x ray film showed right middle lobe consolidation.

The family history of tuberculosis was not volunteered or asked for; an initial diagnosis of bacterial pneumonia was made, and antibiotics were started. She was no better when reviewed at two weeks; a further chest x ray picture showed right hilar lymphadenopathy, with right middle and lower lobe consolidation. The family history was then ascertained; rifampicin and isoniazid, 10 mg/kg of each daily, were prescribed by her local hospital. She relapsed after one month of treatment, with complete right middle and lower lobe collapse on chest x ray film, and was referred to this centre for further investigation and management. A Mantoux test (10 U) was positive at 10 × 25 mm induration, and broncho-alveolar lavage fluid showed plentiful acid fast bacilli. Pyrazinamide 25 mg/kg and prednisolone 2 mg/kg were added and intensive physiotherapy started. There was re-expansion of both affected lobes, although clinical and radiological evidence of bronchiectasis remained two years later, at the time of writing.

Case 3

Both an uncle and a grandmother of this 10 month old white boy had fully sensitive smear positive pulmonary tuberculosis, and all were living in the same house. On screening, the child's Heaf test and chest x ray picture were negative. Two further Heaf tests—one after eight weeks, followed by a BCG vaccination, the second another eight weeks after this—also had negative results. Prophylactic isoniazid (10 mg/kg) was taken for 4.5 months.

The child remained well until 13 months later, when he developed a painless limp. Hip radiographs showed a lytic lesion in the neck of the right femur from which sterile pus was drained. Culture for mycobacteria was not requested and the family history of tuberculosis not ascertained. He remained in a hip spiker and receiving flucloxacillin for three months, but an x ray film showed that the lesion had worsened. At this time a Mantoux test (10 U) produced a positive result of 17 × 17 mm induration and he was referred to this centre. Chest

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