A Needs Assessment of Community Physiotherapy Services for the Elderly

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Supervised by Mr Michael Bezzina
I declare that the following is my own, original work.
My sincere acknowledgments go to all those, who in some way or another, have assisted me in this ‘adventure’ for each and every one of them, has, indeed, helped me to achieve my goal. It is always a pleasure to thank the people who made this thesis possible. Undoubtedly the list is not exhaustive:

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EXECUTIVE SUMMARY

Due to the dramatic increase in individuals aged sixty and over it is imperative that they remain as independent as possible and still give an effective contribution to society. The focus lies in the quality of life rather than longevity on its own. While the importance of physiotherapy in prevention and rehabilitation has been widely recognized, Community Physiotherapy Services (CPS) for older people might help identify problems early on and hinder a chain reaction of multiple complications which might lead to decreased independence and eventual institutionalisation. Furthermore the Maltese healthcare system encourages people to be institutionalised who really do not need to be admitted to a residential home due to the gap in service provision. Since CPS is not yet available in Malta the purpose of this study is to assess the need for setting up such a service.

Methodology: Due to the complexity of the issues under study, both qualitative and quantitative measures were used by collecting original information and adapting what was already available as suggested by Wright, Williams & Wilkinson (1998). A self-administered questionnaire was distributed to physiotherapists (N=99) working with the Ministry of Health, Elderly and Community Care. Analysis of application forms of St Vincent De Paul Residence (SVPR) between 1999 and 2005 (N=332) was also carried. From the application forms between 2003 and 2005 (N=152), 55 older people accepted to take part in a structured interview and mobility assessment. A semi-structured interview was also carried out with key persons who can play an important role in the implication or not of CPS. From personal communication with physiotherapists responsible from Physiotherapy Units or Departments, information about the present physiotherapy services for the older people obtained. Also through analysis of data obtained from records of the Physiotherapy Department of St Luke's Hospital (SLH), the average ages of the patients referred for physiotherapy was determined.

Results & Discussion: Both Physiotherapists and key persons recognised the importance of CPS especially in enabling early discharge from hospital and in preventing early institutionalisation. While they acknowledged the important role that physiotherapists play in rehabilitation of the older people, they agree that physiotherapists cannot work alone in the community but need to be part of the multi-disciplinary team.

Older people did not feel the importance for CPS. This could be due to the lack of information and awareness about CPS. In fact decreased awareness of Community Services in general was also noticed.

From the older people taking part in the interview, 39 (71%) showed difficulties in carrying out activities especially during mobility. Also from the application of SVPR it was evident that the older people were stated to be suffering from a variety of limitations ranging from communication, mental, physical and social.

Physiotherapists deemed those older people whose journey to hospital would have counteracted the affect of treatment, those whose family needed advice about handing techniques and those whose acute nature of the condition is better treated at home, to be the most eligible candidates for CPS.

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A Physiotherapy Department responsible for the national provision of CPS was deemed to be most appropriate due to economical reasons. The need for adequate but not lengthy planning and the formation of operational guidelines both to help physiotherapists and to be used by managers were suggested. Requirements for implementation of CPS as suggested by participants included the need for motivated, mature and skilled physiotherapists, flexible working schedules, portable equipment and supplied transport modalities or adequate remuneration. Increased autonomy to physiotherapists, adequate promotion and increased awareness about physiotherapy and community services were suggested, especially to General Practitioners, to enable timely access to services.

Conclusion: For the introduction of CPS to be carried out, support from the policy makers has to be obtained. Also changes will be required to accommodate the dynamic nature of CPS accompanied with a shift to primary health care. For this reason action research is deemed to be the next step forward.
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1.1 Background to the Study

The world is getting older and the number of old people is alarmingly on the increase. Today, one in every ten persons is 60 years and older, ranging to about 600 million people. Yet, at the second World Assembly on Ageing (2002), the United Nations (UN), stated that by 2050, one out of every five will be an older person, meaning that the number of older people will nearly quadruple to almost two billion people. By 2150, one third of the people in the world is expected to be 60 years and over.

In most countries, the total fertility rate (TFR), which is the average number of children women have during their reproductive life, is well below 2.1 (Camilleri, 2004). This index is considered as a threshold for a population to replace itself, meaning that birth rates have fallen below replacement levels, with the number of older people now exceeding the number of children. In Malta the TFR has gone down from 2.17 in 1975 to 1.46 in 2002 (Camilleri, 2004).

The ageing of the world's population is a matter of concern for everyone. This transformation in the make-up of the population will have profound consequences on every aspect of life, that is, for individuals and societies. This so portrayed time bomb is in reality one of the twentieth century's biggest success stories; albeit an ageing population represents a huge challenge for an already-
stretched healthcare system. Health economists fear that without radical change, the healthcare system could become a victim of its own success (Majeed, 2004).

Developing countries, with the inclusion of Malta, will face the most difficult resource challenge, as they will be forced to deal with development and population ageing at the same time. Not only will retirement policies have to find an innovative structure to accomplish their purpose, but society will also have to deal with new and difficult demands in the field of health, psychosocial and economic factors (Camilleri, 2004). But as people live longer, healthier and more active lives, an ageing population also offers opportunities that must be harnessed.

For this to be achieved, it is imperative that older people remain as independent as possible and still give an effective contribution to society. Of all disabilities, impairment of locomotion increases drastically with age. As mobility is very important for social and health reasons, the importance of physiotherapy rehabilitation at an appropriate time and as prevention for disability has been identified at a higher level (CHMU, 1992 in Squires & Livesley, 1993).

Health is defined by the World Health Organisation (WHO) (Wright, Williams & Wilkinson, 1998) as a state of complete, physical, psychological and social well being and not simply the absence of disease or infirmity. Health needs incorporate the wider social and environmental determinants of health, such as deprivation, housing, diet, education and employment. The wider definition allows us to look beyond the confines of the medical model based on Healthcare services (HCS).
And it is on these lines that treatment of older people in the community would be ideal so that both the social and environmental aspects can be addressed.

Concerns over provider-led HCS have encouraged refocusing on the goals so that the person’s needs will always be paramount (Squires & Livesley, 1993). Presently a patient assessment means ‘fitting’ the client in the existing service but ideally care managers should co-ordinate assessment and commission care according to individual needs. For this reason a needs assessment, the latter being an effective tool to determine the balance between needs, supply and demand and to gain insight based on evidence and not on experience can aid in the implementation of patient driven services (Wright et al, 1998).

1.2 Problem Statement

The older people will increase as will their need for HCS. Although disability and dependency are not directly related to age, yet risk of disease and therefore use of services does increase with age. According to the Center for Strategic and International Studies (CSIS) (2000), older people consume three to five times more HCS than any other age group. Moreover, the older the persons are, the more HCS they consume.

Ageing has for the past decades been a central theme on Malta’s socio-political agenda. With the effect that the expected increased number of frail older people in the next two decades will have on the global economy and HCS (UN, 2002), it is only understandable for our country to prepare for such an event.
Both political parties in government have in no uncertain terms centralised the issue of the care and provision of community services for older people as a main propaganda for their sphere of activities. Suggestions have been made on paper leaving the impression that healthcare has or should be shifted to the community. Yet this is taking a long time and to-date nothing has been done to clearly define targets and award appropriate tailor-made strategies.

The formation of the Ministry of Health, Elderly and Community Care (MHECC) seemed to pave the way to the much advocated integration of health and social services for older people in the community (Warden, 1998). However this integration has so far not yet been noticed. The need to improve joint planning between the health and social services as an essential prerequisite has been identified in other countries to improve HCS (Audit Commission, 1986 in Powell, 2001) but has never been carried out in Malta.

Dr A Mifsud Bonnici (2002) in a statement at the second World Assembly on Ageing rightly points out that the “provision of services has always been perceived as a means of communication, alternatively a way of responding to elderly persons’ needs” (n.p). While adding further that service providers respond to individual needs by awarding the appropriate support strategy, Dr Mifsud Bonnici further affirms that older people prefer to stay at home, and in so doing he describes a set of social domiciliary services aimed to help older people in the community.
It should be noted that while there is a supply of social community services in Malta, HCS provision, including physiotherapy services in the community are more limited and the integration of these services is not present. Thus, in the absence of a diverse array of community-based services to support people at home, vast numbers of older people are taking the only option available to them and, in so-doing, they are entering residential care at the expense of the public sector (Mooney, 1997 in Powell, 2001). Also lack of financial arrangements to facilitate the re-settlement in the community of long-stay hospital patients colloquially known as ‘bed blocking’ or ‘social cases’ are increasing the demand on long term residential care and causing inadequate use of hospital beds (Cachia, 2004).

In the absence of adequate service provision, demand of long term residential care will increase drastically in the next two decades with the decline of formal family support. Therefore, it is up to policy makers to prepare for such an event through analysis of needs of older people and provision of adequate services which can help them remain in the community as much as possible through prevention and treatment. Likewise physiotherapy services should be targeted to help treat older people in their own environment.

1.3 Purpose:

The purpose of this study is to assess the need of Community Physiotherapy Services (CPS) for the older people in Malta.
1.4 **Aim:**

This study aims to examine the need of CPS, and develop a model proposal for improving such a physiotherapy service for the older people in Malta.

1.5 **Objectives:**

- Establish and characterise existing physiotherapy services;
- Identify the perspectives of various stakeholders regarding CPS;
- Identify appropriate patient categories that will benefit from CPS;
- Formulate a plan for the delivery of CPS;

1.6 **Research Questions:**

- What services are being provided by physiotherapists in the community?
- Which are the categories of older people that need CPS and under what circumstances?
- How can CPS be delivered in the best possible way?

1.7 **Significance of the Study**

Over time and in different places, there have been many changes that have provided greater opportunities, including also greater challenges for the ageing and older people. The changes in gender-related values, behaviours, and preferences individually and collectively impact upon the quality of life of older people both presently and in the future (Lawton, Moss & Duhamed, 1995). The issue also resolves around what is well known as sustainable development. The latter stresses the need for a holistic approach conducive to a better quality of life within a long-
term time frame, rather than one aimed at short-term gains. Sustainable development strategies are multifaceted, taking into consideration economic, social, cultural, environmental, participatory, and political factors that affect human welfare (Briguglio & Pace, 2004).

Physiotherapy services for older people in the community will help the Maltese healthcare system to provide a complete service of care to our clients. Unfortunately, it is not possible to meet every need when allocating scarce resources in accordance with needs. Thus, it might be found necessary to assign priority to certain categories of needs (Baldwin, 1998).

On the other hand, economic considerations constitute one of the most interesting factors in decision making (Baldwin, 1998). It is tempting to say that this factor should actually influence the decision. For instance, if only a certain degree of health can be afforded, it may seem pointless to choose a higher degree as the goal of healthcare needed (Acheson, 1978 in Baldwin, 1998). Obviously, this attitude is not correct. There is no contradiction in saying that there is a need but this need cannot be satisfied.

Noteworthy is the fact that HCS purchasers are increasingly demanding evidence of effectiveness for all aspects of patient care. This is still evolving in physiotherapy but where the evidence exists (either positive or negative) it should be incorporated into physiotherapy practice to optimise patient care. As mentioned earlier, it is important to note that the health and happiness of the older people is
dependent upon social, emotional and psychological factors. Therefore it is imperative for physiotherapists to address these issues and treat the older people as a whole and not just the condition they are suffering from. Perhaps, the best way to do this is in their environment, that is, the community (Seymour & Kerr, 1996). In this way physiotherapists will be able to identify problems that would otherwise go undetected.

Solving these problems even if insignificant for others might make a huge difference for these older people by helping them to stay in the community, be more independent and still be able to make a contribution to our society for a longer time. Thus, the aim of CPS will be to increase quality of life and reduce the distress that older people have to go through to receive these services.

Bearing all this into consideration, this study will provide policy makers with insight on the needs of the Maltese older people with regards to CPS. It will also attempt to identify lacunas in the present physiotherapy service delivery and access for the older people. Furthermore, this study also aims to issue a specified goal of healthcare need in a joint venture between the older people, administrators and physiotherapists.
1.8 Work Definitions

Need: Perceived needs of older people or professionals’ defined needs as assessed by physiotherapists and key persons.

Physiotherapy: The use of physical means to prevent injury, to treat both injury and disease and to assist the process of rehabilitation by developing and restoring the function of the body so that the patient may return to an active and independent life as possible.

Physiotherapy Services: Physiotherapy services supplied by the MHECC.

Community Physiotherapy Services: Physiotherapy services provided in a person’s own home.

Older people: Persons aged 60 years and older.

Home: The place where an older person is living excluding nursing and residential home.
CHAPTER 2 - LITERATURE REVIEW

2.1 Introduction

One of the most significant phenomena of the twentieth century has been the dramatic increase in the number and proportion of persons aged 60 and over. The United Nations (UN) programme on Ageing (2002), demonstrates a worldwide increase of the old population. Population ageing is primarily the result of the process described by the World Health Organisation (WHO) as the 'epidemiological transition', whereby a population moves from high fertility and high mortality rates to low fertility and low mortality rates (WHO, 1984). According to UN (2002) these increases reflect successes in history of public health policies as well as social and economic development. However, it presents a challenge to humanity in both health and socio-economic arenas.

Population ageing has become a major global concern, posing unique challenges to every society. Following the Second World War, the world’s progress towards higher living standards – brought about by the advances in medical science, nutrition and social conditions, and by the control of communicable diseases – has resulted in a remarkable increase in life expectancy. In Malta, the life expectancy at birth for males is 76 years and 80 years for women (Falzon, 2004).

This unavoidably implies both a heightened demand for existing support services as well as for new services and alternative approaches for the care of older people. Though older people have many needs which they share with the rest of the
population, they have some which are specialised and age-oriented. Consequently, new approaches to medical care and to the delivery of health and social services may be required (Troisi 1995, p. 655-668).

The issues related to ageing are multi-disciplinary in nature. Care of the older people is a complex and interdependent matter. The health and happiness of older people is dependent upon physical, social, emotional and psychological factors and not merely the absence of disease and infirmity (WHO, 1984).

A concerted assessment of demographic patterns over the past decades and projected on the basis of current trends provides useful insights towards understanding the disproportionate, perhaps even alarming, share of the older people within the Maltese population. At the end of 1990, there were in Malta 52,536 persons aged 60 and over (COS, 1990). By 2001 older people made up 20% of the population and that is set to increase to 24% - almost one quarter of the population - in about 25 years’ time (Dunn, 2001). Further more, in 2025 every three workers will have to support one retired person. Consequently, the pension problem is fundamentally one of economic growth and increase in worker productivity (Falzon, 2004). Due to this increase there is a fear that the cost of caring will overwhelm the future budgets for pensions and healthcare ("Pensions in EU", 2001).
2.2 Defining Old Age

Ageing can be defined as a progressive loss of adaptability with the passage of time so that individuals are less and less able to react adequately to the challenge from both external and internal environment (Evans et al 1992, in Bujari, 2004). While ageing is an inevitable and irreversible biological process, both the onset and meaning of old age are culturally constructed.

Nowhere else in the life-span does a single stage so inadequately fit all those in it, as in the case of old age. In most developed societies, adults are declared to be "old" when they reach the ages of 60 to 65, as established by the first World Assembly on Ageing (1989) of the UN and secure their pension entitlement (UN, 2002). To-date the Maltese Government offers retirement pensions after the age of 60 for women and 61 for men (Pensions Ordinance, 2002). The idea of being a pensioner has led to chronological age being used to define old age. Such a definition is, of course, arbitrary.

On the other hand people over 65 can be divided into at least three stages-the young old (65 to 74), the old old (75 to 85) and the oldest old (85 and older) (Bennet & Ebrahim, 1992). This makes it impossible to categorise all stages as one. Comparing a 65 year old with a 95 year old is similar to comparing a newborn to a 30 year old.

Nevertheless, even with individual variations, age-related changes do exist, in that they affect more and more individuals as they grow older. Some of the most
obvious changes include physical characteristics as greying hair, loss of hair, wrinkling of the skin, decrease in height, decrease of acuity in sensory modalities such as vision, hearing and taste and the slowing of the central nervous system functioning (Howie, 1991).

Since these changes are typically associated with ageing they tend to be viewed negatively in our society. Thus, old age which is genetically determined has a strong environmental influence. The custom of accepting disease at old age shows low expectations among carers and healthcare providers and may lead to treatable condition being ignored.

On the other hand it is to be noted that about 80 percent of older people remain relatively fit, well and independent until the end of their lives and that they also perceive themselves as such (Partridge, Johnston & Morris, 1991). In fact, due to the increased life expectancy and improved quality of life it is the 85 plus cohort that is becoming of interest to healthcare services (HCS) providers. Also, the prevalence of limitations in activities of daily living triples as one moves from the 75 to 84 year-old age grouping to the 85 plus year old grouping (Selker, 1995).

Evidence has indicated that it is not old age that is responsible for higher health costs associated with increased life expectancy, but bad mental and physical health earlier in life that results in dependency and disabilities of all kinds in old age (Fenech, 2003).
2.2.1 Dependency and Ageing

As there is a large number of older people who are independent and show that chronology is not directly proportional with health needs, another aspect could be analysed. This is the phenomenon of ageing with dependency. This sum of incapability and necessity, is a dynamic process and can be prevented or reduced if there is an adequate environment and care (Caldas, 2004). Dependency levels can be the main determinants of the type of care that are needed.

In today’s society, the extent of interdependence is greatly increased as we have become dependent on others for example to produce food. On the other hand to be labelled as dependent can result in dehumanisation of individuals, depression and reduction of self esteem (Johnson 1998, Chap. 2).

Thus, it is the relationship between dependency and fragility that becomes of interest. Hazard, Blass, Halter, Ouslander and Tinetti (1994), define fragility as the vulnerability which the individual presents in the environment. Frail older people have reduced functional reserve, but may still be fully independent when well (Johnson 1998, Chap. 2). Also, loss of function is usually so gradual in older people that many in this age group who live ‘independently’ in the community learn to cope reasonably well with daily activities (Harpur, Coatler, Lennon & Breadon, 1994).

As fragility and dependency manifest themselves in varying degree in older people, Borrayo, Salmon, Polivko and Dunlop (2004) offer a definition of frail older
people as individuals with three or more deficits in activities of daily living which further includes the functional element in the context. Function is defined as the ability that the individual has to adapt to everyday problems, in other words, those activities which involve the immediate environment around older people, including the role as an individual in a society and whether the older person presents any physical, mental or social limitation (Caldas, 2004).

As well as general frailty, older people often have multiple disease and impairments with which to contend. Diagnosis of these conditions and assessment of their contribution to overall disability is important (Johnson 1998, Chap. 2).

Furthermore, when stressed by injury, even by minor illness, or sometimes by environmental factors, such as hospitalisation or institutionalisation, older people’s ability to perform the basic tasks of everyday life starts to break down (Barer 1998, Chap. 110). Inactivity and immobility can also drastically impair muscle strength and stamina, as well as joint flexibility, balance and reaction speed (Gray, Bassey & Young 1985 in Barer 1998, Chap. 110).

Wilkin (1987) in Johnson (1992, Chap. 2), states that more sophisticated measures that place physical and mental impairments in the context of relationships and environment will produce the capacity to release older people from excessive dependence on others. He calls for more focus on dependency relationships drawn back to individuals and their settings. Thus, difference in changes in level of disability between individual items may provide further insight into the disablement
process and the need for rehabilitation interventions. (Grimby, Andren, Daving & Wright, 1998).

2.2.2 Dependency and Disability

The association of disability, both physical and mental, with increasing age has been mentioned in several studies (Bennet & Ebrahim, 1992). Distinction between those with different levels of disabilities is therefore of importance.

For this reason, it is appropriate to list the terminological distinctions for different types of disabilities. In 1980, WHO published an initial document titled International Classification of Impairments, Disabilities and Handicaps (ICIDH), wherein an important distinction between impairment, disability and handicap was established as illustrated in Figure 1.

- Impairment is defined as a reduction in physiological function below that found in health.
- Disability relates to function, and the ability to undertake basic activities of self-care which is fundamental to any physical rehabilitation program.
- Handicap, the social consequence of disability or impairment, is defined as limitations faced by individuals in fulfilling their normal role in society.

These distinctions have helped to focus attention on the broader, long term aims of rehabilitation (Young, 1996).

Figure 1: ICIDH Model (WHO 1980)
Conversely, in 2001, WHO published the new International Classification of Functioning, Disability and Health (ICF), as seen in Figure 2, which does not negate the framework already given in 1980, but actually puts into evidence the proposing aspects and the value of the individual. ICF includes the concepts of activity and participation, which substitute for the words disability and handicap respectively. Thus provides for more complex relationships than its predecessor (ICIDH), in particular to achieve a synthesis of the medical and psychosocial approaches to disablement (Adamson, Lawlor & Ebrahim, 2004).

**Figure 2: New ICIDH Model**

This implied positive transformation, builds up a scheme that sees activity at its centre, which can be more or less developed according to the personal situation of individuals but also according to the influence of their external world. Unfortunately, practical action is still often contained by negative attitudes of society toward the role of older people, and sometime by ambivalence in the expectations of older people themselves (Barer 1998, Chap. 110) which can hinder rehabilitation.
2.3 Rehabilitation

Rehabilitation is an iterative, learning-based, problem-solving process (Barer 1998, Chap. 110). In general, it should aim to maximize the older people’s role fulfilment and independence in their environment within the limitations imposed by underlying impairment and availability of resources (Wade, 1992). The major areas of concern in rehabilitation are disability and handicap, that is, limitation in participation.

Of all disabilities, impairment of locomotion can hold the key to independence of older people (Squires & Livesley, 1993). Furthermore, chronic diseases which are common in older people are associated with locomotor activity limitation and participation. In fact, Adamson, Lawlor and Ebrahim (2004) following a survey concluded that at least 50% or more participants with stroke, coronary heart disease, ulcers, asthma, arthritis, depression, diabetes mellitus and bronchitis have locomotor activity limitation.

Thus, physiotherapists play a key role in identifying the practical problems associated with impaired mobility and build on a potential for rehabilitation and resettlement of older people. Also, there is no doubt about the effectiveness of exercise training in improving fitness, muscle strength, flexibility, and mobility in very frail older people (McMurdo & Burnett, 1992 in Barer 1998, Chap. 110).
Furthermore, the complexities of diagnosis and treatment of older people with multiple pathology and reduced functional reserve, have forced to reconsider the definition of ageing and disease and the boundary between them which can be mitigated by changes in the environment and behaviour.

The rehabilitation approach, within a stimulated environment that encourages greater activity and autonomy, can hold back age-related functional decline. Thus, its potential scope is widened enormously to include primary prevention of disability and disease.

For this reason physiotherapy rehabilitation in the community should be a progressive, goal-directed process aimed at restoring greater health, dignity and autonomy. If progress in rehabilitation achieves anywhere near its potential, the socioeconomic benefits will be enormous and attitudes to ageing itself could be revolutionised.

2.4 Patient-Centred Care

Patients and healthcare professionals have been found to have differing views of health and to monitor progress in rehabilitation in different ways (Malzer, 1988; St Claire et al, 1996). Thus importance of patient-centred care has been recognised in physiotherapy (Grant, 1994; Potter et al, 2003) along with general medicine, nursing and other allied health professions.
Potter, Gordon & Hammer (2003), endorse the importance of physiotherapists adopting a patient-centred approach and developing effective communication skills to optimise the physiotherapist-patient interaction. It is important to note that the older people's priorities might be different from those of physiotherapists.

May (2001) concluded that patient care should be tailored to meet specific patient needs, and that effective treatment outcomes require not only competence in certain techniques, but also that physiotherapists have a range of interpersonal skills to assist in patient management.

With rising healthcare costs and the ageing population, there has been considerable interest in the use of health and medical services among the older people (Mitchell, 1995) which has increased considerably (Rivnyak, Wan, Stegall, Jacobs & Li, 1989). Assessing the unmet health care needs that affect the quality of life of older people is an important task facing HCS.

With improvements in public health and increases in life expectancy, issues concerning quality of life have emerged as important areas of research in Gerontology. Most people who reach the age of 65 years can now expect to live into their eighties and although a large amount of these older people are satisfied with their life style, not all of those remaining years will likely be active and independent ones. Thus, improving the quality, and not just the length, of later life is an important element in the healthcare of this age group. Unmet needs for healthcare can have a significant influence on the quality of life of older people.
Need-based projection models focus on factors such as age, health status, incidence and prevalence while demand-based model incorporate patient and provider perceptions and coverage definitions (Selker, 1995).

While needs assessments examine the types and amount of services that are required in a community, assessment of unmet needs, highlight the problems that are not being addressed by the existing service delivery system. Unmet needs indicate the extent to which our present state of knowledge is being applied in a given population and focus attention on the organisation and delivery of HCS rather than solely on the biomedical aspects of disease (Elinson, 1974).

The task of defining needs is not a simple one. According to Kettner, Morowney and Martin (1990) needs are elastic and relative, rather than static and absolute. Need involves statements of values and preferences that are influenced by the existing socio-political environment, the standard of living and the resources and technology that are available to improve the quality of life.

Unmet needs generally compose those services that although judged necessary to deal appropriately with a health or health-related problem, have not been received.

2.5 Formal and Informal Support Services

The majority of frail older people including those with severe functional impairments still live in private households. To do so they depend to a greater or
lesser extent upon those who constitute their social networks, that is informal and formal support systems (Bennet & Ebrahim, 1992).

While informal support in the form of family (nuclear and extended), friends and neighbours has been the most diffused type of care for the older people throughout the world, migration, changes in the value systems and aspirations, changes in the role of women and breakdown of the family system have eroded this traditional form of support (Kosberg & Garcia, 2004). Also, caregivers are often older people themselves. The young old, that is, those between the ages of 60 to 74, often provide much of the care for the oldest old (Bennet & Ebrahim, 1992), which is projected to increase (Johnson 1992, Chap. 2). At the same time, this group is known to provide financial and social support to their children and grandchildren.

Therefore, from a position of considerable status, respect, care, and a social and psychological support from their families, older people are or will in the near future find themselves poor, uncared for, and without power or influence (Debanish, 1998).

On the other hand, family members, to date, are still the primary caregivers to older people. As strengths of families in providing care to older people were recognised in research (Diwan & Coulton, 1994), there was also the realisation of the family's limitations. Horowitz (1985) opines that institutionalisation of older people was associated more frequently with the family's inability to continue
providing care, together with the social factors already mentioned, than with the older person’s deteriorating health.

Research on formal and informal care indicates that decreased functional ability, advancing age, and living alone are all positively associated with the use of home care services, including physiotherapy services (Branch & Jette, 1983; Stoller & Earl, 1983).

The literature on caregiving is full with predictions about the decline in family caregiving and an increased reliance on formal systems (CSIS, 2000; Treas, 1977), which consist of private agencies or individuals, voluntary agencies and the public sector. But subsequent research has shown that both services complement each other and caregiving is conceptualised through the achievement of balance between formal and informal providers (Litwak, 1985). This is achieved with each provider performing those tasks that it can execute most efficiently. While informal caregivers carry out more non-technical activities in non-uniform events, they are unable to fulfil more technical, specialised medical functions.

Horowitz (1985) further suggests that not only is informal support supplied together with the much less available formal services, but that high level of family care is associated with high levels of formal service use. This shows that very impaired older people receive extensive assistance from both sources.
Research in the area of caregiving has focused on why providing care is often stressful due to the emotional strains and lifestyle disruptions reported by caregivers for dependent older people and how this stress may be buffered (Kinney, Parris, Franks & Norris, 1995; Sorensen, 1998; Stone, Cafferata & Sangl, 1987; & Suitor & Pillemer, 1993). Kinney et al (1995), suggest that caregivers are aware of the nature and severity of their relatives' impairments, and that more severe impairment is associated with caregiver's frustration in that specific domain.

One of the most compelling reasons for community physiotherapy services (CPS) is the concept that it is important to treat patients in their own environment, the latter including but not limited to their place of abode. Indeed, it has also been suggested by Young, McCormice & Vitaliano (2002) that families play an active role in sustaining and augmenting caregiving situations regardless of their living arrangements.

As physiotherapists work in many specialities, they come in contact with carers in all sorts of settings, and thus should monitor their well-being and give them importance as much as the older people. Carers are not only helping the older people to stay for longer in the community (Ayling, 1993), but also saving the country billions of pounds each year in caregiving. The provision and improvement of Healthcare Support Services, including physiotherapy services, will not substitute but facilitate the support provided by informal caregivers.
Even though most older people in need of social care still live in communities rather than institutions (Doty, 1986 in Diwan et al, 1994), these new challenges are being faced by older people and the informal support systems that have traditionally provided care. Thus, the Maltese Government has to face these challenges and plan for formal care solutions for the older people.

2.6 Services for the Older People in Malta

2.6.1 Community Services for the Older People in Malta

In 1987, the Parliamentary Secretary with the responsibility for the Care of the Elderly was formally included for the first time in a Ministry Portfolio in Malta (Abdilla, 2002). Consequently, the Department of Elderly and Community Care (DECC) was also set up later that year with the objective of promoting the dignity of older people by providing a range of domiciliary services designed to address the actual needs of the individual (DEEC, 2005), thus enabling them to continue living in their own home for as long as possible.

The Home Care Help Service offering physical, social and domestic support to older people was the first such scheme to be introduced in 1988. Telecare, a telephone life-line system was introduced in 1990 with the aim of providing peace of mind to older people, particularly those living alone, in their own home. Minor repair requirements in the home often prove to be too much of a hassle for frail older people to cope with. Thus, the Handyman Service providing minor repair works in clients' homes was introduced.
The Meals on Wheels service provides cooked meals to older people who live alone or are incapable of preparing their own food and is supplied by the Maltese Cross Corps, a non-governmental entity, in collaboration with DECC.

Other services which offer monetary subsidies are Telephone Subsidies, Incontinence Service which offers diapers, and the Kartaanzjan Card. All older people are entitled to this card which offers certain benefits. A Social Work Service is also available to whoever feels the need for assistance.

In acknowledgement of the fact that older people should remain active and socially integrated for as long as possible, fourteen Day Centres have been set up in various towns and villages. These venues offer older people the opportunity to meet with their peers, share experiences, practice their hobbies, widen their general knowledge and learn things that are of particular relevance to their physical and psycho-social needs.

The only health community service available in Malta, is that provided by the Malta Memorial District Nursing Association (MMDNA), which offers community nursing and midwifery services. MMDNA is employed on a contract basis with the MHECC (Cima, 2003). The association was founded by Captain R. Ingram in 1945 and in 2002, 404165 patients were treated of which 96.47% were referred from the Health Division with a daily average visits of 1,108 (MMDNA, 2004).
2.6.2 Health Services for the Older People in Malta

In Malta, the government is responsible for the delivery of HCS which are free at point of use (Cima, 2003). Older people needing hospitalisation are mainly admitted to St Luke’s Hospital (SLH). As Mallia & Fiorini (2003), pointed out, unlike Paediatrics and Gynaecology there is no special in-patient and out-patient Geriatric Unit in SLH. In 2004, older people aged 60 years and over constituted 31% of all admissions (Janulova & Distefano, 2005). While the average age of all patients admitted to SLH is 54.6 years, one has to take into consideration the large maternity unit which influences this figure.

Depending on their condition, older people may either be discharged home, or admitted on a short term basis to Zammit Clapp Hospital and Boffa Hospital, private residential homes or remain as ‘social cases’ awaiting admission to SVPR or other public residential home. In 2004, there were 167 (61%, females) and 107 (39%, males) ‘social cases’ which went down to sixty four in total by the end of the year (Janulova & Distefano, 2005). It is well noting that both hospitals and residences are limited in the number of patients they can accommodate and cater for, and due to the high waiting list, patients may have to stay in SLH for a long period of time. Till the end of 2004 total annual bed day occupancy of social cases in SLH was 28728, that is, 14.8% of the total number of bed day occupancy (Janulova & Distefano, 2005). This in turn has an adverse affect on SLH due to the financial burden of acute bed occupancy which in turn leads to overcrowding, unnecessary use of resources and a higher risk for individuals to become sick.
As stated by Lagoe et al (1991) one of the reasons for long term care patients staying in acute care beds could be that post-discharge services such as CPS are not available. Lagoe (1989) further opines that residential homes accept more clients who are awaiting admission from hospital rather than from their homes. Also personal cost needed for private nursing homes on a long term basis might be highly unattainable for older people (Stewart, 2004).

It follows therefore, that in cases where patients are medically stable but still require physiotherapy, early discharge, in conjunction with CPS can drastically reduce hospital bed occupation and decrease waiting lists. Also, some older people are admitted to hospital when they are too debilitated and cannot benefit from physiotherapy services provided. Thus, CPS for older people could hinder the mentioned process and help individuals stay in the community for longer.

2.7 Community Physiotherapy Services

Physiotherapy is defined by the Chartered Society of Physiotherapy as the use of physical means to prevent injury, to treat both injury and disease and to assist the process of rehabilitation by developing and restoring the function of the body so that the patient may return to as active and independent life as possible (Partridge & Warren, 1977).

Physiotherapy in the community refers to physiotherapy services outside the hospital (Partridge & Warren, 1977). It therefore includes physiotherapy at the patient’s home, physiotherapy in health centres, day centres, special schools and
residential homes. For the purpose of this study, due to time limitations only physiotherapy in the homes will be considered, although the other services will be mentioned.

The Australian Ministerial Review of Community Health (1985) gave a comprehensive definition of community health as:

"Community health is more than standard health care in a slightly more accessible setting. In our view it is a philosophy of comprehensive health care; a concept that involves looking at individuals in relation to their environment, as members of their families and communities, at work and at play, subject to the pressures and pleasures of society in which they live. Its aim is to keep individuals, families and communities at their optimum level of functioning." (n.p)

This definition can also be applied to CPS.

Mills, Huntigford & Belton (2002) also define CPS as help and services provided in a person's own home to improve their quality of life and enable them to maintain their independence.

CPS which involve preventive, post-acute, supportive, care of chronically disabled and end-of life home care have been established for a long time in developing countries such as Britain, United States, Canada, Germany, Australia, France and Sweden (Burnard, 1988). One of the first schemes of CPS provided in Britain was on a voluntary basis and was developed in 1943. Since then much improvement has been achieved.
Unfortunately, the research available on home rehabilitation varies with respect to many factors; initially studies in other countries (between 1970-1995), were more concerned with separate service provision such as CPS but later following integration of services studies included a variety of multi-service provision. In fact, most of the recent studies on community care services always incorporate a multidisciplinary team approach and never include separate service provision anymore.

In literature there is variation in the severity and variety of disease in the patient population, their age distribution, the training modalities, the intensity of the programme and the environment itself that has been defined as ‘home’. It is the heterogeneity of these studies that makes comparisons difficult. Nowadays cost effectiveness and clinical outcomes are being evaluated and not whether there is a need for such service.

Amid all the drawbacks, a review of the literature shows both positive and negative aspects of community services. Rudd, Wolf, Tilling & Beech (1997), following a randomised controlled trial which compared early discharge with home rehabilitation, including physiotherapy services, with conventional hospital based treatment, suggest that a policy of early hospital discharge and home based rehabilitation for patients with stroke can decrease the use of hospital beds without compromising clinical patient outcomes. Anderson and Rubenach et al. (2000), confirm these allegations in a similar randomised control study, with follow up of six months. They also suggested, even though not statistically significant, that there
is a potential risk for poorer mental health on part of caregivers in the early discharge group.

Moreover, Teng et al. (2003) concluded that early discharge for stroke patients is cheaper at home level than in acute hospital care. Indredavick, Fjaertoft, Eukberg, Lose and Morch (2000) further opine that early discharge in the community increases functional outcome and decreased length of stay in institutions.

Cunliffe et al. (2004), in a randomised controlled trial compared early discharge and rehabilitation with standard hospital aftercare. Outcome measures were assessed at three and twelve months. The sample constituted of 370 hospitalised older medical and surgical patients who received rehabilitation up to four weeks. They state that an early discharge and rehabilitation service for older people reduced length of stay in hospital and improved their health in terms of activity limitation and psychological well-being in the long term. Unfortunately this study doesn’t specify the rehabilitation team components.

On the other hand, Roderick et al. (2001) found no significant difference in physical function and social activity between domiciliary and day hospital care. Also, Chapell (1994) in his study could not conclude that CPS is less costly or necessarily better for the quality of life of seniors when compared with institutional care.
Fraser (1980) describes CPS as an effective way to provide treatment for the patient who is unable to travel independently to hospital. This has been confirmed by Forster & Young (1990) following a review of advantages and disadvantages of CPS for stroke patients. Furthermore, Mitchell (1995) found that community based services used are more pronounced among older people that have limited access to transportation and that are more socially isolated.

However, while one might contest this statement due to the size of the Maltese Islands and the availability of transportation by the ambulance sector, there are a number of problems such as long waiting hours for transport, the poor state of many roads and transport vehicles and inaccessibility of some residences to ambulances.

Also, transport may be tiring, uncomfortable and the journey may also increase muscle tone in patients with stroke, reducing the effectiveness of subsequent treatment (Forster & Young, 1990). Likewise it may increase pain and dyspnoea in other patients.

In a study by Kay (1991) on physiotherapy rehabilitation at the home of seven older amputee persons aged between 66-88 years, suggest that domiciliary care may be an effective and efficient alternative to out-patient treatment. Also, relating treatment specifically to the home increases its relevance, carer involvement and promotes compliance. Furthermore a more realistic assessment is carried out and environment and transport problems are eliminated.
Although often viewed especially by health professionals, as a humane alternative that defers costly dependence and institutional care (Bould, 1989 in Mitchell, 1995), the use of community-based services, namely physiotherapy has received less attention in Malta.

McCaslin (1988) concluded that age interacts with frailty, resulting in service use to address functional deficits. Diwan & Coulton (1994) also state that use of community-based services increase with age while according to Mitchell (1995) age had no direct affect on services used but needs and type of illness mainly chronic illnesses were found to affect service use. Thus services should be directed towards those older people with more needs.

Apart from the considerable proportion of physiotherapists represented in home and community-based care all around the world, the movement to portable and miniature therapeutic equipment and the ability of physiotherapists to recognise the importance of gaining an understanding of the social and psychological context of the patient’s world rather than just focusing on the diagnostic process (Jensen, Gwyer, Shepherd & Hack, 2000) provide implications for the development of physiotherapy services in the community.

The majority of older people reside in the community, and when faced with deteriorating health status and functional ability they overwhelmingly prefer to avoid institutionalisation and remain at home (McAuley & Bliezner 1985; Polivka & Oakley, 2000 in Borrayo et al, 2004).
Community based physiotherapy can help recipients cope with chronic conditions and improve their quality of life. They can potentially help frail older people to live independently, to be less burdensome to informal caregivers, and to avoid being cared for in institutions such as nursing homes. On the other hand, Lawton et al. (1995) carried out a study to determine the quality of daily life of 116 highly impaired older people receiving care at home. They state that one should not automatically assume that home life is more stimulating. In fact following interviews with caregivers it resulted that most impaired older people’s days seemed to be characterised by passivity. In pondering the meaning of the quality of life possible in the home as compared to in the institution, however we still do not know to what extent familiarity, freedom from institutional demands and especially the one-to-one commitment of a single caregiver, or family caregivers, compensate for the lower level of stimulation.

In spite of these claims there is some evidence that suggests that community programs as a whole do not reduce the number of nursing home admissions among high risk individuals (Jette, Tennestedt & Crawford, 1995) although subsequent research has found that by targeting certain services to high risk older people in increasing quantities, community programs may reduce institutionalisation (Greene, Lovely, Miller & Ordrich, 1995).

Malta is only meeting a fraction of the need for supportive services among caregivers of older people especially those suffering from dementia. Consumer
directed care programs, such as CPS, have considerable potential to meet this need and contain the demand for institutional care of the cognitively impaired by helping reduce caregiver burnout (Zarit, Stephens, Townsend & Greene, 1998).

It is well known that institutional care is the most expensive, but expansion of the already 1000 bed in SVPR is always under discussion, and 13 new applications for older people’s homes were considered by the Malta Planning Authority in 2004 (Cachia, 2004). There is a need to develop targeting strategies that will allow to contain or reduce residential home populations by systematically matching services to assessed needs and risk. The purpose of community care is not to compete with hospital care but to complement it for an optimum provision of integrated health services.

Hospitals have many attributes such as continuous availability, concentration of resources and quick access to a very wide range of specialist skills. But institutional care especially long term care offer also considerable disadvantages. There are the well-known dangers of institutionalisation which may lead to unnecessary dependency, over-investigations and treatment, inappropriate and wasteful use of institutional care and the rising costs of institutional provision.

Gleeson, Kearney, Lawless and Morris (1989) following a cross-sectional study of a CPS in South–Australia agreed on the benefits of this services as was noted in other countries (Burnard, 1988). Some of the noted advantages were:
The assessment of older people in their normal and familiar environment, helping to make treatment functionally oriented and realistic in nature.

- Early discharge from hospital;
- Improved responses in familiar surroundings;
- Greater participation in decision making by the older person; and
- Long-term support through provision of support and instructions of carers and reviews.

2.8 Development of Community Physiotherapy Services

As already mentioned, in other countries including Britain, CPS have long been established. For this reason, information about the development of CPS and problems encountered along the way can be obtained.

The transition in the early 1970's from hospital based physiotherapy care to the community in Britain has been gradual and very slow (Forster & Young 1990). In the beginning CPS consisted of home visits before and after discharge of patients, assessment of home adaptation requirements and advice to patients and relatives (Partridge & Warren, 1977).

As mentioned before, most of the older people that are house or bed-bound still live within the community. Warren (1977) suggests that these individuals receive inadequate care and therefore it is up to the relatives to carry out heavy nursing duties particularly with getting patients in and out of bed. Thus, an issue arises of how physiotherapists will get to know about the older people who need help.
Partridge & Warren (1977) suggests that general practitioners should have access to CPS together with other healthcare professionals. Warren (1977) further opines that physiotherapists should have the autonomy to assess all referred patients, decide mode of treatment and decline or terminate treatment if it is of no value to the patient.

The Association of Chartered Physiotherapists with a Special Interest in Elderly People (ACPSIEP), in 1991, due to the differences existing in different community schemes recognized the need to define clinical standards and monitorable criteria for its members and issued standards for clinical practice (See Appendix I).

CPS have been supplied to the disabled, the chronically sick, the mentally ill, deprived children, frail older people and to law-breakers (Warren, 1977). Also, physiotherapy services are supplied to all older people with a severe musculoskeletal condition, neurological conditions, mobility condition and chest condition with resolving pneumonia. Due to time limitations and due to the impact that older people have or will have on our society this group was chosen for this study.

According to Warren (1977), CPS should be concerned with prevention, cure, rehabilitation and supportive care. Thus treatment sessions should include assessment, advice and rehabilitation depending on the patient’s needs. He also
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opines that due to time, money and human resources available, allocation of priority to patient groups should be considered.

The CPS in Britain, due to heterogeneity, are divided in different districts (Forster & Young, 1990). Malta due to its small size can be categorized as one district. This could suggest that a national CPS can be responsible for home care throughout the island.

2.8.1 Multi-disciplinary Approach

The creation of multidisciplinary teams in a lot of HCS is due to the recognition of the fact that a range of skills and expertise is required to meet the multiple needs of older people. It should be noted that community care is not composed solely of physiotherapy but a whole team of health services including occupational therapists, speech-language therapists, social workers, general practitioners and nurses (Stone, 1987).

Working within a multidisciplinary team means that therapists need not face a problem alone. There is always support from other team members and the older person can be looked at from all aspects and the relevant services provided. Community services provided in other countries, namely Britain provide a comprehensive service in which physiotherapy is part of a total package of health care offered to people in their homes.
According to Fagin (1992) competitive healthcare today requires the broad spectrum of knowledge that no one provider can provide. The key is how to bring diverse expertise together and make it work for the older people. However this requires a broadening of attitudes. Healthcare professionals, including physiotherapists, are required to move away from their discipline’s traditional role and share their knowledge with all those concerned in the patient’s management (ACPSIEP, 1991).

Historically, before the integration of community-based services for older people, in other countries, separate services had been provided for a couple of years. In fact most of the recent studies on community care services always incorporate a multidisciplinary community service approach and never include separate service provision anymore. Due to financial and time limitations of the study and the limitation of other community service provision by health professionals, only the need for CPS will be tackled. Nevertheless, the perception of physiotherapists and older people regarding community care services by other professions will be evaluated.

2.8.2 Costs and Benefits of Community Physiotherapy Services

It is not the purpose of this study to evaluate the costs of CPS as the service has never been active and thus no physical evidence is available in Malta. However a review of other studies carried out in countries which have an extensive experience in such service could help to indicate the costs and benefits of providing it.
If a decision needs to be made whether to provide a particular service, the cost-benefit approach requires that the service should only be provided if the derived benefits exceed the cost, both costs and benefits being enumerated and valued in money terms.

While in terms of monetary values, cost of a CPS has been found to be more expensive in the short term, than that provided in a hospital based settings, the benefits could overcome these costs in certain groups of people in the long term (Vonkock et al, 2001). Furthermore, Anderson (2002) following a systematic review of early hospital discharge of older people with home rehabilitation compared with conventional care concluded that the overall mean cost for early discharge was 15% lower when compared with standard care.

Sharman (1972) described that CPS operate on the premise that individuals are restored to either full capacity or to a certain degree of independence which according to him is one of the best investments in the long term irrespective of cost.

2.8.3 Problems Arising due to Community Physiotherapy Services

Community physiotherapists experience a great diversity in their work which requires a range of skills and individual resourcefulness not normally experienced by hospital counterparts (Furnell & Furnell, 1987). The therapists are also required to cope with less-than-ideal situations, such as sagging mattresses, lack of space, differing standards of hygiene, pets and so on. On the other hand according to
Partridge & Warren (1977), most physiotherapy treatment, except hydrotherapy can be adapted in the patient’s home.

Time spent in travelling and mode of transport used can also be an inconvenience. The different types of transport used by different CPS include the use of own car with or without mileage transportation, van supplied by employer, the use of buses and going on foot (Partridge & Warren, 1977).

Also problems of storage of equipment and aids used during treatment also arise. In certain CPS a storage space is made available at different health centres (Partridge & Warren, 1977).

Community physiotherapists can feel isolated (Furnell & Furnell, 1987) although in a study carried out by Partridge and Warren (1977) it was not the case. Also visits to hospital for treatment are often the only opportunity for patients to socialise and meet other patients with similar problems (Forster & Young, 1990). However, Day Centres which are places were older people can meet, socialise and engage in various activities, the latter including education, keep fit and games; can mitigate this limitation of community-based therapy.

Thus, problems to be tackled before implementation of services include sources of referrals, human resources required for the provision of services, level of expertise of physiotherapists and type of treatment supplied. Also, selection of type of transport to be used to get to and from the patient’s home is problematic.
2.9 Conclusion

As the proportion of the world’s population in the older ages continues to increase, the need for improved information and analysis of ageing needs, increases. Knowledge is essential to assist policy makers define, formulate and evaluate goals and programmes, and to raise public awareness and support for needed policy changes.

The percentage of our gross national product devoted to healthcare expenditure is rapidly reaching the point at which all of us will soon be working full time to pay for our health care only. The Maltese healthcare system encourages older people to enter nursing homes who really do not need to be admitted. Nursing home admittees could access the care they need in other settings, particularly the home, but the nursing home is where one can access such needed care.

The prevalence of limitations in activities of daily living triples as one moves from the 75 to 85 year-old age grouping to the 85 plus year old grouping (Selker, 1995). The prevalence of disabling conditions for which physiotherapy can provide important services also increases dramatically. The Maltese healthcare system has yet to address how we might respond to accelerating needs as these large cohorts begin to arrive at advanced age around the years 2010 and 2030 to 2050. Because these needs will easily swamp our nursing home system one has to consider which providers are best positioned to provide the needed care in the home and in the community.
CHAPTER 3 – METHODOLOGY

3.1 Introduction

In order to answer the research questions mentioned in the introductory chapter, and to obtain all the necessary information regarding the need of Community Physiotherapy Services (CPS) for older people in Malta, different study methods were made use of. These methods are:

• Data collection from registers of St Luke's Hospital (SLH) Physiotherapy Department, with the aim to determine the average age of patients being treated by physiotherapists;
• Personal communication with Physiotherapy Principals to establish the present Physiotherapy Service provision for older people in the community;
• Self-administered questionnaire to evaluate the perception of physiotherapists regarding the need of CPS for older people in Malta;
• Data collection and analysis of applications of older people who applied for admission to St Vincent De Paul Residence (SVPR);
• Physical Assessment and structured interview with older people regarding their views on the need for CPS in Malta; and
• Semi-structured audio taped interviews with key persons who can influence the implementation or not of CPS.
3.2 Research Design

Defining the term ‘needs’ is difficult. This is due to the inherent complexity of the concept of need, so it is not surprising that numerous definitions have been proposed. ‘Health’ consists of a wide range of characteristics so ‘health needs’ ought to include personal and social care, health care, accommodation, finance, education, employment and leisure, transport and access (Baldwin, 1998).

As Franklin & Cutler (2000) observed, health planners use descriptive survey research as the basis for needs assessment for developing health strategies, programs and physical plants. A survey research is the descriptive study of populations whereas the major task of a researcher is to obtain reliable and valid data from a representative sample or population. The changing needs of populations as derived from surveys can contribute to planning of health service provision.

A survey design provides a quantitative or numeric description of some fraction of the population through the data collection process of asking questions of people (Fowler, 1988 in Creswell, 1994), though it need not be limited to questioning individuals. In fact methodologies that assess the physical characteristics of groups are also applicable (Franklin & Cutler, 2000).

Due to the fact that little is known about the need of CPS in Malta, and that there is no control over events, a cross-sectional design was adopted for the purpose of this study (Creswell, 1994). This design asks questions of people at one point in
time. However, this kind of survey may be highly fallible because the researcher may or may not be able to analyse the direction of causal relationships (Bowling, 2002).

3.3 Research Setting

Due to the different target populations, that is, physiotherapists, older people and key persons, the research setting was vast in its nature. As the study aims to examine the need of CPS for older people in Malta, the island of Gozo was excluded from the study due to time limitations and travel time requirements.

The first part of the study included the collection of data from registers of SLH Physiotherapy Department. This particular department was selected due to convenience, easy access and time limitations. The ages of all in and out-patients from the age of 15 years and over, being treated by physiotherapists between September 2004 and March 2005 were collected. The Physiotherapy Department at SLH offers a wide range of services, namely, medical and elderly care, neuroscience, orthopaedic, acute respiratory, cardiopulmonary and surgical in-patient care together with out patient care. All these units have a different form of documenting statistical data. Some Physiotherapy Units use a computer and others use registers. For this reason average ages of patients attending amputee rehabilitation were collected from the whole year 2004. On the other hand, only patients attending general out-patients for the first three months of 2005 were collected, due to the vast amount of data available.
The second part of the study included personal communication with physiotherapy principals in relation to CPS being supplied for older people.

The third part of the study included the collection of data and the selection of community-dwelling older people for interviewing. This took part in the Medical Records office of SVPR where application forms are kept and in the various localities from which older people were selected for the structured interviewing which consisted of the fourth part of the study. The list of the older people population was collected manually by the researcher.

SVPR was chosen from other residences because it is the largest institution for the older people presently accommodating 1000 residents, 668 females and 332 males. It is owned by the state and has the largest waiting list for admission (N=819).

The fifth part of the study included the distribution of self-administered questionnaires to physiotherapists working with the Ministry of Health, Elderly and Community Care (MHECC). Thus, this part of the study was conducted in all Physiotherapy Departments of SLH, SVPR, Sir Paul Boffa Hospital (SPBH), Zammit Clapp Hospital (ZCH), Mount Carmel Hospital (MCH) and Health Centres.

Although the majority of physiotherapists are employed with MHECC, some of them work privately or with private institutions. For convenience purposes, these physiotherapists were not included in the study.
All the above mentioned hospitals and Health Centres are owned by the Government. Physiotherapists in their respective hospitals or units offer both in-patient and out-patient services depending on the Unit, to patients of any age group from premature babies to older people given that they are formally referred by physicians working in the respective hospitals or units. Like all other public medical services, physiotherapy treatment sessions provided in the above mentioned units are free of charge at point of use to Maltese citizens.

The sixth part of the study was conducted in the various sectors from which key persons were identified for interviewing. All these individuals are also employed in various sectors within the MHECC. The key persons were divided in two groups. The first group (n=5) were asked more general questions about the Maltese older people, healthcare service provision and CPS. The second group (n=3) consisted of key physiotherapy persons who were asked more in detail questions about the topic.

3.4 Target Population and Sampling Techniques

3.4.1 Older People

Having outlined the research topic to be an evaluation of the need for CPS for the community-dwelling older people in Malta, the ‘relevant population’ was identified in the first part of the study as the older people who can be prevented from being institutionalised through the introduction of CPS.
The sample was chosen from applicants awaiting admission to SVPR but who are still living in their homes. This particular group of older people was chosen even though they are still living in the community, yet they are the ones who are having the major problems in the home setting. Thus, it is the scope of this study to identify such problems and attempt to determine whether CPS can help prevent early institutionalisation.

Due to time and cost limitations, not all applicants could be assessed individually, thus a sample of this population was identified. Initially the sample was not selected from all the applicants (N=819) but from those who have applied and were waiting for evaluation from the admission board of SVPR (n=167). This group was selected because they were the last to apply and because in this stage selection between those who were granted admission to the SVPR and those deemed as not urgent was not yet established. Unfortunately, permission was denied to use this sample group.

Thus, older people, 65 years and over, who applied between 2003 and 2005 were then selected. Initially, the sampling method chosen was stratified random sampling. This was done by dividing applicants by locality, that is different strata and sampling randomly from each stratum (Bowling, 2002). It is acknowledged that once a sample is chosen carefully, it is possible to generalise from it, that is, statements are made about the whole relevant population on the basis of that sample (Haralambos & Holborn, 1995).
In order to minimise the problem of sampling out-of-date addresses and respondents who died, older people were sampled if they were on both the waiting list of SVPR and the electoral register (Bowling et al, 1989 in Bowling, 2002). Still, this was not without problems. Any new address of respondents who might have moved since the list was updated was not shown, leading to inadequate population coverage.

Also, older people who were hospitalised, admitted in a residential home or who died in the period between collection of data and aggregation of sample hindered the sampling method. In fact, more older people had to be added to the initial sample to increase response.

100 individuals were randomly selected from all applicants (N=152) for SVPR between 2003 and 2005. They were contacted by telephone and if they accepted to be part of the study, they took part in a structured interview and a mobility assessment in their own residence.

3.4.2 Physiotherapists

The second part of the study involved all the physiotherapists (N=110) working with the MHECC, as mentioned in Section 3.1. It is to be noted that not all physiotherapists working in Malta are employed by the MHECC. This target population was chosen because the Ministry employs the majority of physiotherapists and due to convenience for the collection of data because they are more accessible.
Also, all physiotherapists presently working in Gozo General Hospital and those on maternity, emigration and study leave were excluded from the study. The rest of identifiable physiotherapy population \((n=99)\) was selected due to the relative small number which would produce a corresponding small sample.

### 3.4.3 Key Persons

The third part involved semi-structured interviews with key persons who are highly knowledgeable on the subject. Key persons are those people who can take part in the implementation or otherwise of CPS. The persons selected are employed by MHECC and occupy a position in institutions that have most contact with the elderly.

### 3.5 Research Method

This study aimed to use multi-dimensional methodological approaches in order to reach its aim and objectives because:

- Quantitative methods are advocated in view of their practicality. These methods are generally less time consuming and require less personal commitment. It is also possible to study larger and more representative samples which can provide an overall picture of a larger category.

- Qualitative research often has to be confined to the study of small numbers because of practical limitations. It is more suited to providing an in-depth insight into a smaller sample of people.

  *(Haralambos & Holborn, 1995)*
Patton (1990) and Pope and Mays (1995) are in favour of using both qualitative and quantitative data to be collected in the same study. Because both methods involve differing strengths and weaknesses, they constitute alternative, but not mutually exclusive, strategies for research.

3.5.1 The Questionnaire

A self-administered questionnaire was chosen for physiotherapists as it allows a large number of subjects to be surveyed in a relatively short period of time (Polit & Hungler, 1999). A questionnaire is a standardised list of objective questions or personal opinions (Franklin & Cutler, 2000). This method is less of a social encounter than interviews and so eliminates the problem of interviewer bias as there is anonymity. However as suggested by Bowling (2002), the method is only suitable when the issues and questions are straightforward and simple, when the population is 100% literate and speaks a common language. Thus, this is adequate for the physiotherapy population.

Other advantages of self-administered questionnaires include the fact that they are unambiguous and answers are easy to count leading to quantitative data for analysis (Polit & Hungler, 1999). Sweet (1990) suggests that questionnaires allow an amount of freedom to respondents which apart from eliminating interviewer bias elicit more honest replies. Furthermore, as respondents can take their time to respond, the possibility of having more accurate answers increases.
On the other hand pre-coded response choices may not be sufficiently comprehensive and not all answers may be easily accommodated (Bowling, 2002). Also, respondents might choose inappropriate answers that might not fully represent their views and elimination of control leaves respondents free to answer questions in whichever order they choose.

According to Haralambos & Holborn (1995), fixed-choice questions do not allow the respondents to qualify and develop their answers which make it difficult for the researcher to know exactly what is being measured. For this reason open-ended questions were introduced in the questionnaire to enable respondents to reply in their own words. The information collected is only limited by the respondent's willingness to provide it as it is more taxing for the latter to answer these questions (Bowling, 2002).

3.5.2 The Mobility Assessment and Structured Interview

The interview with older people was divided in two parts which consisted of a mobility assessment and a face-to-face structured interview. The mobility assessment chosen for this study is the same tool used by physiotherapists of SVPR to assess older people referred for treatment. Permission to use this tool was given by the Principal Physiotherapist of SVPR.

Structured interviews pre-establish the set of questions in a uniform manner and the pre-determined format cannot be changed by the interviewer (Franklin & Cutler, 2000). They aim to achieve as close as possible a standard format across
interVIEWers and respondents. In fact, it has been pointed out that structured interviews try to measure facts, attitudes, knowledge and behaviour in such a way that if they were repeated at another time or in another area the results would be comparable (Bowling, 2002).

A disadvantage of this type of interview is that the interviewer is not able to pursue topics of interest that arise during the actual interviews. For this reason open-ended questions were included in the interview as they give freedom to respondents to let their thoughts roam freely, unhindered by a prepared set of replies (Oppenheim, 1992). Thus, open ended questions enable the researcher to explore all the possible alternative responses (Polit & Hungler, 1999).

3.5.3 The Interview with Key Persons

The form of such interviews was semi-structured. This method of methodology has been selected in view of its flexibility while representing a compromise between more structured research methods like questionnaires and the more-in-depth methods (Haralambos & Holborn, 1995).

Semi-structured interviews utilise a general interview guide were issues are predetermined but not the question format and the exact content is not pre-specified allowing for adaptations as necessary during the interview (Franklin & Cutler, 2000). Thus, the participants can expand and clarify their response as interviews rest on the assumption that the perspective of others is meaningful, knowable and able to be made explicit (Patton, 1990).
The disadvantage of interviews is that there is subjective interpretation on the researcher's part (Haralambos & Holborn, 1995). Also, as Oppenheim (1992) highlighted, the interview, unlike most other techniques, require interpersonal skills of higher order such as putting the respondent at ease, asking questions in an interested manner, noting down the responses without upsetting the conversational flow and giving support without introducing bias.

3.6 Research Tools

3.6.1 The Questionnaire

As no known validated tool existed to collect data from physiotherapists, the researcher constructed a questionnaire which was tested for reliability and validity in a pilot study. The questions of the structured questionnaire were constructed following literature review on the subject.

The questionnaire was divided in two parts (See Appendix II). The first part contained the demographic data which were purposely placed in the first part of the questionnaire because they are easy to answer and will encourage respondents to continue answering the rest of the questions.

The second part consisted of closed and open ended questions. The closed-ended questions consisted of two types of questions. Likert Scale questions, ranging from strongly agree to strongly disagree, were utilised to assess the physiotherapists' perceptions as they provide more precise information about the
respondent’s degree of agreement. Rank order questions were also used as they allow the collection of a vast amount of information from one source without making the questionnaire too long (Polit & Hungler, 1999).

3.6.2 The Mobility Assessment and Structured Interview

Two different tools were selected to be used to collect data during the face-to-face interview with older people (See Appendix II). The first part involved a mobility assessment and the second part a structured interview with open ended questions. Even in this case the researcher constructed the questions following literature review on the subject.

In the mobility assessment the researcher had to tick the appropriate answer. The structured interview was also divided in two sections. The first part consisted of open and closed ended questions while the second part consisted of demographic information. In the case of the interview the demographic section was filled out last due the sensitivity of data and because by the end of the interview an element of trust between the researcher and respondent was achieved.

3.6.3 The Interview

The semi structured interview (See Appendix II), which was developed following literature review and analysis of data collected, consisted of guideline issues that where read aloud to the respondents. These guidelines allowed expansion to relevant topics regarding the person being interviewed.
To allow more detail to be obtained from key persons who were more knowledgeable in Physiotherapy Services (n=3), two different guidelines were provided.

3.7 Tool Reliability and Validity

Psychometric validation is the process by which an instrument is assessed for reliability and validity through the mounting of a series of defined tests on the population group for whom the instrument is intended (Bowling, 2002).

While more detailed definitions of reliability and validity will pursue, it is well noting that there are many threats apart from questionnaire design and scale construction. These are known as biases and errors in the conceptualisation of the research idea, and the design, sampling and process of the study, which can lead to systematic deviations from the true value (Last, 1988 in Bowling, 2002).

3.7.1 Validity

Validity is an assessment of whether an instrument measures what it aims to measure. It should have face, content, concurrent, criterion, construct (convergent and discriminant) and predictive validity (Bowling, 2002).

For the purpose of this study, face and content validity were selected. Face validity refers to the investigator’s subjective assessments of the presentation and relevance of the questionnaire (Polit & Hungler, 1999). Content validity is more systematic than face validity. It refers to judgements made by a selected number of
people knowledgeable in the field about the extent to which the content of the instrument appears logically to examine and comprehensively include, in a balanced way, the full scope of the characteristic or domain it is intended to measure (Bowling, 2002).

3.7.2 Reliability

Reliability refers to the reproducibility and consistency of the instrument. It refers to the homogeneity of the instrument and the degree to which it is free from random error (McKinley, Marku-Scott, Hastings, Fenech & Baker, 1997). There are certain parameters, such as test-retest, intra-rater reliability and internal consistency that need to be assessed before an instrument can be judged to be reliable (Bowling, 2002).

In this study the test-retest method was selected to test reliability which measures the reproducibility and stability of the questionnaire over a period of time in which it is not expected to change (Bowling, 2002). The questionnaire was administered to the same subjects at two points in time. The appropriate length of the interval depends on the stability of the variables which causally determine that which is measured (Garson, 2002).

In a true test of test-retest reliability the variable and measurement technique should be the same on both occasions. The lower retest scores may therefore also reflect the difference in the method of application. In this study one researcher carried out the study and thus inter-rater bias was eliminated. Nevertheless, these
data indicate that the retest reliability of the questionnaire is broadly satisfactory. Two statistical tests were done to compare the first and second sets of results, namely Chi Square Test and Pearson Correlation Coefficient. A correlation coefficient of 0.941 was obtained with a p value of 0 for the questionnaire. This indicates that respondents were consistent in their responses which could not have occurred by chance (Polit & Hungler, 1999).

3.8 Pilot Study and Modifications

A pilot study is a small scale preliminary study conducted before the main research in order to check the feasibility or to improve the design of the research (Polit & Hungler, 1999). A pilot study is usually carried out on members of the relevant population, but not on those who will form part of the final sample (Haralambos & Holborn, 1995). This is because it might influence the later behaviour of research subjects if they had already been involved in the research.

Pilot studies can be useful in a number of reasons:

- Interviews or questionnaires may be tested to make sure that they make sense to respondents;
- May help researchers develop ways of getting the full cooperation of those they are studying.
- May be used to develop the research skills of those taking part in the study; and,
- May determine the continuation of the study.

(Haralambos & Holborn, 1995).
3.8.1 Questionnaire

Seven (n=7) physiotherapists, who were excluded from taking part in the main study, were conveniently selected from the target population to participate in the pilot study of the questionnaire. The questionnaire was piloted several times. Initially it was distributed to the physiotherapists and verbal feedback was given on layout, wording, comprehension and time of completion. The revised questionnaire was re-piloted to the same physiotherapists. Although no major problems were identified, minor amendments had to be made to allow a better flow of the questions.

One of the questions asked to participants taking part in the pilot study was whether they preferred demographic data in the first part or the second part as suggested by Oppenheim (1992). All respondents preferred to start by filling the demographic data to get it over with.

The revised questionnaire was redistributed to the same physiotherapists twice with a fifteen day interval to test the reproducibility of the questionnaire over a period of time.

For the purpose of the study apart from face validity which cannot stand on its own due to its subjectiveness, the questionnaire was handed to five (n=5) experts in the field of management, research and physiotherapy who are knowledgeable in the topics of physiotherapy and older people’s care. These experts evaluated the questionnaire individually which allowed for adequate changes to be done.
3.8.2 Physical Assessment and Interview

Five (n=5) older people were conveniently selected to take part in the pilot study. The interview was not tested for test retest reliability. The mobility assessment was already being used by physiotherapists in SVPR but was included in the pilot study to check compliance of older people. No problems were encountered with the mobility assessment. Level of comprehension, and interviewer skills were tested during the piloting. Content and face validity were tested by consultation with older people taking part in the study and an expert in the field.

Following the pilot study it was decided that the use of a tape-recorder for the structured interview was to be abolished. As it was suggested by Franklin & Cutler (2000), interviewees shared valuable information with interviewers when the tape recorder was switched off. Information was probably not divulged for privacy reasons or because of personal embarrassment. Also Franklin & Cutler (2000), state that apart from invasion of privacy, tape-recording is not suitable when drawing attention to interviewee is undesirable, when the aim is to keep the interview as informal as possible and when circumstances mitigate against adequate sound recording such as a noisy environment.

Also, the demographic part of the interview which was initially in the first part was transferred to the end due to embarrassment felt by the older people while divulging such personal information to a stranger during the first few minutes of the encounter.
3.8.3 Interview

A pilot study was done to pre test the guidelines of the semi structured interview by asking three knowledgeable persons in the fields of physiotherapy and management, excluding key persons taking part in the study. No changes were needed.

3.9 Ethical Considerations

Permission was sought from the hospital administration and the Ethics Committee to be able to carry out this survey.

For the study to be carried out informed consent had to be given by all participants. Informed consent means that participants have adequate information regarding research, are capable of comprehending information and have power of free choice enabling them to consent or decline participation in the research voluntarily (Bork, 1993).

Gaining informed consent is essential but it might not be that straight forward especially from vulnerable subjects, as in the case of older people, who may be incapable of giving fully informed consent or to weigh the risk and benefit of participation. Thus, as suggested by Bork (1993), for the purpose of this study in such cases consent was given from the legal guardian and from a person whose primary interest is the person’s welfare.
A covering letter was included with questionnaires, or otherwise delivered before interviews stating the purpose of the study. It was given in two languages Maltese and English. In the case of older people who were illiterate or had poor eyesight the covering letter was read out for them and any queries clarified. Finally, it was made clear that participation was on a strictly voluntary basis and that all participants could withdraw or refuse to answer any of the questions.

Individual protection and confidentiality in relation to privacy and protection from manipulation by research was established during and after interviews and questionnaires. Respondents of the questionnaire were instructed not to put their name anywhere on the form, so that complete anonymity could be established. A blank self-sealing envelope was provided so that the completed questionnaire would arrive to the researcher closed.

In the case of the interviews with older people and key persons anonymity was not possible and appropriate confidential procedures had to be implemented. As suggested by Polit & Hungler (1999)

- an identification number was assigned to participants;
- identifying information and lists with corresponding identifying information were kept in a safe locked storage;
- Access to information was restricted to a small number of individuals on a need-to-know basis;
- Identifying information destroyed as quickly as is feasible; and
- Research information was reported in an aggregated form or with the use of pseudonyms.

Transcriptions were also coded and used only for the purpose of the study. Information derived from the application forms of SVPR has been treated in the same way as information derived from interviews.

Finally Fontana & Frey (1994), in Franklin & Cutler (?000), in their three point guide show us the importance of exercising moral responsibility toward research participants:

"To our subjects first, to the study next and to ourselves last."

3.10 Data Collection

3.10.1 The Self-Administered Questionnaire

The questionnaires which were placed in a blank white envelope were distributed personally, by hand, by the researcher to all physiotherapists or to their supervisor, in case it was not possible to reach them at work, on a normal working day. Due to the small size of units physiotherapists were all informed of the distribution and collection date of the questionnaire beforehand. The researcher called the supervisors in charge of the units before collecting questionnaires.

Questionnaires were to be collected by the supervisors in all units except for those physiotherapists working at SLH. In this case a box was available for posting.
In this way while anonymity was ensured an element of personal contact was maintained.

According to Oppenheim (1992), personal distribution as opposed to mail, gives the benefit of a degree of personal contact and ensures high response rate. In this way the major disadvantage of questionnaires could be minimised. Low response can develop a non-response bias, whereby non-respondents can have more extreme views (Polit & Hungler, 1999).

3.10.2 The Mobility Assessment & Structured Interview

As stated before, the tool consisted of a mobility assessment and a face-to-face structured interview. Participants were contacted by telephone and if they accepted to take part in the study the interview was carried out in their residence. If there was no reply the call was repeated a number of times, at different times and on different weekdays as suggested by Abramson & Abramson (1999). If the participants failed to answer the door on the day of the appointment, the researcher called again to set another appointment.

Also, if the applicants for SVPR were not the older people themselves, the main carers were contacted first. This was done to reduce any inconvenience created if the older people were unaware of the application.

The interviewer dressed neutrally for the assessment in order to minimise any bias. At no time was the profession of the assessor revealed, although it was stated
that the latter was a health professional because of the mobility assessment. The fact that interviewer was a student carrying out the study in part fulfilment of the MSc in Health Services Management course was also divulged. The participants were always informed that the assessor had nothing to do with SVPR and its admission board.

An identification card was supplied for inspection, if requested, so that the participants could confirm the identity of the researcher. The presence of a relative or carer was allowed during the interview for reassurance, due to the insecurity felt by the older people to allow a stranger in their house.

As the researcher is a physiotherapist, familiarity with the mobility assessment was already present and no further training was required.

3.10.3 Interview

The participants were contacted by telephone and by e-mail. Information about the topics to be tackled was supplied, including an outline of the questions. If they agreed to take part in the study an audio-tape recorded semi-structured interview which lasted for about thirty minutes was carried out usually at the respondent’s office.

The interview was tape-recorded as it is an efficient and accurate method to record an interview although this needs to be done unobtrusively so as not to inhibit the interviewees’ responses (Franklin & Cutler, 2000). Unlike the interview with
the older people tape recording was probably more acceptable for this group because the topics tackled were less of a sensitive nature and personal than those tackled with the older people.

3.11 Data Analysis

Both qualitative and quantitative data were derived from the questionnaires and interviews. Replies to closed-ended questions, Likert scales and ranking questions were coded and transferred to the Special Package to Social Science (SPSS), which was used to generate tables, graphs and carry out statistical tests.

Content analysis was used to analyse unstructured responses to open-ended questions in the questionnaire and interviews with the older people. Through a thorough manual analysis of each question, several themes were developed. A narrative description was chosen to form an explanatory theory, based on the experiences and understanding of the key persons' interviewed (Rubin & Rubin, 1995).

3.12 Limitations

Due to time and financial constraints, this study only examined the older people who are already awaiting admission to a Residence. This may be a major limitation, as the results obtained by this study cannot be extrapolated to other areas especially as a small sample was assessed with regards to the whole population.
Also statistical data obtained from the applications of SVPR might be manipulated and therefore not reliable in showing the real picture. The data might not have been totally accurate since it was collected manually from the available applications. Some applications could have been misplaced and it is not possible to have 100% accurate data.

The researcher had no formal training regarding conducting and analysing interviews, making the study susceptible to interpretation bias, interviewer bias and subjectivity. Recall bias relates to respondents' selective memories in recalling past events and selection bias can occur if the sample differs from those of the wider population (Bowling, 2002).

Also, the people being interviewed might suffer from evaluation apprehension which could affect adversely the results.
CHAPTER 4 - RESULTS

The following chapter illustrates the results of the dissertation:

4.1 Response Rate of Physiotherapy Questionnaire

Eighty two out of ninety nine physiotherapists returned the questionnaire. This gives a percentage of 82.8% which, considering that the questionnaire had some open ended questions which could have limited the response rate (Garson, 2002), gives a satisfactory result. Worthwhile to note is the fact that response was higher in those who worked outside St Luke’s Hospital (SLH). This could be due to the difference in the collection system. In fact, physiotherapists working in SLH had to post the questionnaire in a common box while the questionnaires of those physiotherapists working outside SLH were collected personally by the researcher.

Furthermore, Garson (2002) opines that meeting respondents at a time convenient to them, together with face-to-face encounters while assuring total confidentiality and anonymity all help to increase the response rate.

4.1.1 Demographic Description

Physiotherapists taking part in the questionnaire were required to state their gender, age and years of service since qualification. As the Units within the Physiotherapy Department are rather small physiotherapists could be easily identified. Thus, they were not requested to disclose professional background to ensure anonymity.
Data about the ages of respondents were collected by asking participants to indicate to which age group as of their last birthday they belonged to. The use of age groups was solely selected to make the questionnaire less threatening to participants since it would make them less easily identifiable.

All respondents (n= 82) provided this information. Table 1, illustrates the amount of physiotherapists who returned the questionnaire, categorised by gender, age and years of service since qualification.

Table 1: Demographic distribution of Physiotherapists

<table>
<thead>
<tr>
<th>Gender</th>
<th>Male</th>
<th>No.</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>53</td>
<td></td>
<td>64.6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age</th>
<th>No.</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>21 – 30</td>
<td>52</td>
<td>63.4</td>
</tr>
<tr>
<td>31 – 40</td>
<td>19</td>
<td>23.2</td>
</tr>
<tr>
<td>41 – 50</td>
<td>10</td>
<td>12.2</td>
</tr>
<tr>
<td>51 – 61</td>
<td>1</td>
<td>1.2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Years Qualified</th>
<th>No.</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 years or less</td>
<td>13</td>
<td>15.9</td>
</tr>
<tr>
<td>3 – 5 years</td>
<td>32</td>
<td>39</td>
</tr>
<tr>
<td>6 – 10 years</td>
<td>14</td>
<td>17.1</td>
</tr>
<tr>
<td>11 – 15 years</td>
<td>7</td>
<td>8.5</td>
</tr>
<tr>
<td>15 years and over</td>
<td>16</td>
<td>19.5</td>
</tr>
</tbody>
</table>

4.1.2 Questionnaire for Physiotherapists

The second part of the questionnaire consisted of three types of questions (See Appendix II). The first type required participants to place a tick mark in a box next to the description that matched their answer. These questions used a Likert scale, that is, each participant had to choose from five statements varying from strongly agree to strongly disagree.
The second type of questions required participants to rank statements according to their preference. Rank scores were used since some participants chose not to rank all the answers.

The third type of questions required participants to answer to two open ended questions, comments and one funnel question (Question 8).

4.1.2.1 Role of Physiotherapists versus Older people

The first three questions which were Likert type questions sought to assess the perception of physiotherapists with regards to the importance of their role in rehabilitation of older people and to what extent. Full results are shown in Table 2.

<table>
<thead>
<tr>
<th>Question</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Undecided</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Physiotherapy plays an important role in the rehabilitation of older people</td>
<td>61 74.4</td>
<td>21 25.6</td>
<td>- -</td>
<td>- -</td>
<td>- -</td>
</tr>
<tr>
<td>2. Resources in terms of physiotherapy services should be targeting older people.</td>
<td>33 40.2</td>
<td>48 58.5</td>
<td>1 1.3</td>
<td>- -</td>
<td>- -</td>
</tr>
<tr>
<td>3. Physiotherapists play an important part in the treatment of:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Incontinence</td>
<td>13 15.9</td>
<td>40 48.8</td>
<td>7 20.7</td>
<td>10 12.2</td>
<td>- -</td>
</tr>
<tr>
<td>• Immobility</td>
<td>68 82.9</td>
<td>14 17.1</td>
<td>- -</td>
<td>- -</td>
<td>- -</td>
</tr>
<tr>
<td>• Intellectual Impairment</td>
<td>8 9.9</td>
<td>37 45.1</td>
<td>19 23.2</td>
<td>15 18.3</td>
<td>2 2.5</td>
</tr>
<tr>
<td>• Instability</td>
<td>38 46.3</td>
<td>35 42.7</td>
<td>7 8.5</td>
<td>2 2.4</td>
<td>- -</td>
</tr>
</tbody>
</table>

* Highest marks are shown in bold
4.1.2.2 Need for Community Physiotherapy Services

Questions 4 and 5 which also use a Likert scale sought to evaluate the perception of physiotherapists with regards to the need of Community Physiotherapy Services (CPS) in Malta and whether they have come in contact with individuals who would have benefited from such services. One participant did not answer both these questions. Table 3 shows full results.

Table 3: Need for Community Physiotherapy Services

<table>
<thead>
<tr>
<th>Question</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Undecided</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. I have come in contact with individuals who would have benefited from CPS should there have been one available</td>
<td>40 48.8</td>
<td>38 46.3</td>
<td>1 1.3</td>
<td>2 2.4</td>
<td>- -</td>
</tr>
<tr>
<td>5. For this reason I think there is a need for CPS in Malta</td>
<td>45 54.9</td>
<td>31 37.8</td>
<td>3 3.7</td>
<td>1 1.3</td>
<td>1 1.3</td>
</tr>
</tbody>
</table>

* Highest marks are shown in bold

In question 6 participants were required to rank according to their preferences why CPS might be necessary in the Maltese setup. Figure 3 shows results according to the mean rank scores which are listed in Table 20 (Appendix IV p195).

Figure 3: Question 6 – Necessity of Community Physiotherapy Services

- It may help prevent early institutionalisation
- It may help facilitate early discharge from hospital
- It completes the physiotherapy services provided to the public
- It creates new job opportunities for physiotherapists
Within the same question participants were given the opportunity to include and rank a statement of their own choice, not written in the questionnaire and 17 (20.7%) participants chose to add further comments.

According to six participants CPS will provide quicker access to those who are ‘on a waiting list’ or are ‘unable to attend day hospitals or out-patients’, therefore reducing barriers to use service. Also another five participants highlighted the specificity of CPS with comments such as ‘provide treatment according to need’ and ‘allow carers to participate in treatment’. Another four participants commented on increasing the physiotherapist’s role by ‘motivating older people, help increase their quality of life and be independent as long as possible’.

### 4.1.2.3 Present Physiotherapy Services

The study sought to evaluate the perceptions of physiotherapists with regards to present physiotherapy service provision. Full results are listed in Table 4.

<table>
<thead>
<tr>
<th>Question</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Undecided</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>13.4</td>
<td></td>
<td>32</td>
<td>39</td>
<td></td>
</tr>
</tbody>
</table>

* Highest marks are shown in bold

In the second part of question 8 physiotherapists were required to justify their answer. The fact that 76 (92.7%) participants did justify their answers is impressive considering that open ended questions are usually considered unpopular (Oppenheim, 1992). Content analysis of their reasons is depicted in Table 5.
Table 5: Content Analysis of reasons given to justify answers to Question 8

<table>
<thead>
<tr>
<th>Theme</th>
<th>Excerpts</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strongly Agree</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gap in service Provision</td>
<td>‘Many patients are receiving in-patient treatment but not adequately followed afterwards’</td>
<td>5</td>
</tr>
<tr>
<td>Barriers to Use Service</td>
<td>‘Lacking awareness and promotion of physiotherapy services resulting in less efficient use of services’</td>
<td>4</td>
</tr>
<tr>
<td>Internal Problems</td>
<td>‘Understaffed, waste of resources, no staff motivation or respect, unqualified management’</td>
<td>4</td>
</tr>
<tr>
<td>External problems</td>
<td>‘Government transport unreliable. Physiotherapists unable to give appointments and keep time’</td>
<td>1</td>
</tr>
<tr>
<td>Personal Interest</td>
<td>‘Physiotherapists reluctant to start service because it affects their respective private practice’</td>
<td>1</td>
</tr>
<tr>
<td><strong>Agree</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gap in service Provision</td>
<td>‘Older people stop being followed halfway through their rehabilitation after discharge from SLH’</td>
<td>20</td>
</tr>
<tr>
<td>Poor Quality Service</td>
<td>‘Poor quality treatment offered to disabled, weak, frail patients who arrive in hospital very tired’</td>
<td>6</td>
</tr>
<tr>
<td>Internal Problems</td>
<td>‘Short of staff in certain areas’ ‘Few physiotherapists working with older people’</td>
<td>6</td>
</tr>
<tr>
<td><strong>Undecided</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gap in service Provision</td>
<td>‘Services do not cater for all types and conditions of older people’</td>
<td>5</td>
</tr>
<tr>
<td>Good Quality Service</td>
<td>‘Physiotherapy services satisfactory in terms of quality &amp; continuity of treatment from SLH to ZCH’</td>
<td>3</td>
</tr>
<tr>
<td>External Problems</td>
<td>‘Lack in transport and ward environment hinder treatment’</td>
<td>2</td>
</tr>
<tr>
<td>Internal Problems</td>
<td>‘Short time to see patients and large caseload’</td>
<td>1</td>
</tr>
<tr>
<td><strong>Disagree</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfactory</td>
<td>‘No long waiting lists, enough staff in wards and good treatment outcome’</td>
<td>11</td>
</tr>
<tr>
<td>Gap in service Provision</td>
<td>‘Physiotherapy services cover all areas except a small percentage requiring CPS’</td>
<td>5</td>
</tr>
<tr>
<td>External Problems</td>
<td>‘Some patients have no transport and loose good services’</td>
<td>1</td>
</tr>
<tr>
<td>Internal Problems</td>
<td>‘Frequency of treatment and duration can be compromised due to caseload’</td>
<td>3</td>
</tr>
<tr>
<td><strong>Strongly Disagree</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfactory</td>
<td>‘We offer out-patient services, visits to state homes and home visits’</td>
<td>2</td>
</tr>
<tr>
<td>Gap in service Provision</td>
<td>‘Community home visits can be improved’</td>
<td>1</td>
</tr>
<tr>
<td>External Problems</td>
<td>‘Acute in-patient care is problematic due to administration, management and nursing services’</td>
<td>1</td>
</tr>
</tbody>
</table>
Chapter 4 – Results

4.1.2.4 Impact on Private Physiotherapy Services

In question 10 participants were required to state their level of agreement as to whether CPS will have a negative impact on private physiotherapy services. Full results are shown in Table 6. One participant did not answer question 10.

Table 6: Impact on Private Physiotherapy Services

<table>
<thead>
<tr>
<th>Question</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Undecided</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>10. CPS will have a negative impact on the current private physiotherapy services</td>
<td>No.</td>
<td>Perc.</td>
<td>No.</td>
<td>Perc.</td>
<td>No.</td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>12.2</td>
<td>35</td>
<td>42.7</td>
<td>15</td>
</tr>
</tbody>
</table>

* Highest marks are shown in bold

4.1.2.5 Requirements for Community Physiotherapy Services

Several questions tackled this issue within the questionnaire. To be able to set up a CPS it is very important to identify the target population.

4.1.2.5.1 Who should Benefit from Community Physiotherapy Services

In question 7 participants were required to rank who in their opinion should be targeted in a CPS. Figure 4 shows the mean rank score results (numerical values are shown in Table 21, Appendix IV, p195).

Five participants added further reasons of who should be targeted in a CPS. These comments were all related to limitations to access be it due to family reasons such as ‘living alone’ or ‘cannot be accompanied by carers’ and for environmental reasons such as a ‘three storey flat with no lift and patient not mobile’.
Figure 4: Question 7 – Who should be targeted when considering Community Physiotherapy Services

4.1.2.5.2 Community Physiotherapy Services Provider

In question 13 participants were also required to rank who they perceived to be in the best position to provide CPS. One participant did not answer this question. Figure 5 shows the mean rank score results (See Table 22, Appendix IV, p195) whereby it is clear that CPS should be either provided by an autonomous Community Physiotherapy Section or else be spread over all Departments or Units.

Two participants further commented that CPS should be ‘provided even in Gozo’ and that it should be ‘provided by qualified people in a well organised and supervised system’.
Figure 5: Question 13 – Who should provide Community Physiotherapy Services?

- Provided only by St Luke’s Hospital Physiotherapy Department
- Provided only by physiotherapists working at St Vincent De Paul Residence
- Spread over all Departments/Units each supplying its own Community Service independently according to speciality
- Provided by an autonomous Community Physiotherapy Section responsible only for the national delivery of community services
- Provided by a Private Physiotherapy Organisation through subcontracting

4.1.2.5.3 Who should refer older people

As access to a service is particularly important, physiotherapists were required to rank who in their opinion should refer older people for a CPS as shown in Figure 6 (See Table 23, Appendix IV, p196). Four participants did not answer this question. According to participants, the physiotherapists themselves are preferred to select their own patients.

The 16 participants who offered other options as to who should refer patients for CPS also stated that an assessment should always be carried out by physiotherapists irrelevant who the referee is. They mentioned that the older people, their carers and members of the multidisciplinary team, including those working within the community, General Practitioners and social workers should be able to contact CPS.
4.1.2.5.4 Physiotherapists and Working Conditions

As physiotherapists are important for the development of a CPS, participants were asked to what extent they agree that working in a CPS would be interesting and whether physiotherapists working in a CPS should be specialised, work flexible hours and use their own transport. Full results are shown in Table 7.

Table 7: Physiotherapists and Working Conditions

<table>
<thead>
<tr>
<th>Question</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Undecided</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>11. It would be interesting to work in a CPS</td>
<td>35</td>
<td>42.7</td>
<td>36</td>
<td>43.9</td>
<td>6</td>
</tr>
<tr>
<td>12. Physiotherapists working in a CPS should:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Be specialised</td>
<td>14</td>
<td>17.1</td>
<td>40</td>
<td>48.8</td>
<td>9</td>
</tr>
<tr>
<td>• Work flexible hrs</td>
<td>24</td>
<td>29.3</td>
<td>43</td>
<td>52.4</td>
<td>5</td>
</tr>
<tr>
<td>• Use own transport</td>
<td>5</td>
<td>6.1</td>
<td>9</td>
<td>10.9</td>
<td>14</td>
</tr>
</tbody>
</table>

* Highest marks are shown in bold
4.1.2.5.5 Requirements for an efficient and effective Community Physiotherapy Service

Physiotherapists were also requested to state in their opinion what the requirements for an efficient and effective CPS are, in an open ended question. 78 (95.12%) participants answered Question 9. Content analysis of results is shown in Table 8.

Table 8: Question 9 - What would be the requirements for an efficient and effective Community Physiotherapy Service?

<table>
<thead>
<tr>
<th>Theme</th>
<th>Excerpts</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Set Guidelines</td>
<td>'Adequate referral system and set criteria'</td>
<td>27</td>
</tr>
<tr>
<td></td>
<td>'Guidelines, professional standards, policies, procedures and mission statement'</td>
<td></td>
</tr>
<tr>
<td>Teamwork</td>
<td>'Good teamwork, communication with interdisciplinary team in the community and in hospital'</td>
<td>22</td>
</tr>
<tr>
<td>Monitoring Systems</td>
<td>'Increase accountability through monitoring and record keeping'</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>'Feasibility studies, quality assurance procedures and independent clinical audit'</td>
<td></td>
</tr>
<tr>
<td>Support Staff</td>
<td>'Qualified management offering support for staff on all levels even safety measures'</td>
<td>13</td>
</tr>
<tr>
<td>Promotion of Service</td>
<td>'Education of public, promotion and lectures about physiotherapy services'</td>
<td>5</td>
</tr>
<tr>
<td>Responsibility</td>
<td>'New unit within Physiotherapy Department dedicated solely to CPS'</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>'Team leader among physiotherapists responsible for all system'</td>
<td></td>
</tr>
<tr>
<td>Human Resources (Physios)</td>
<td>'Trained motivated staff who can carry out visit as planned, keeping time and treat effectively'</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td>'Continuous Professional Development'</td>
<td></td>
</tr>
<tr>
<td>Experienced</td>
<td>'Physiotherapists with experience in various fields of Geriatrics'</td>
<td>4</td>
</tr>
<tr>
<td>Work Conditions</td>
<td>'Flexible working hours to suit patients'</td>
<td>9</td>
</tr>
<tr>
<td>Transport for Physiotherapists</td>
<td>'Efficient and reliable transport services provision, fuel remuneration, own transport'</td>
<td>3</td>
</tr>
<tr>
<td>Location</td>
<td>'Storage and availability of an arsenal of small equipment, walking aids and weights'</td>
<td>5</td>
</tr>
<tr>
<td>Geographic Divisions</td>
<td>'Geographical divisions of areas according to demand'</td>
<td>4</td>
</tr>
</tbody>
</table>
4.1.2.5.6 Disadvantages of Community Physiotherapy Services

Participants were asked to list any inconveniences that might be encountered during implementation of CPS, by physiotherapists and older people respectively.

Table 9: Question 14 - Do you foresee any inconveniences associated with working outside hospital?

<table>
<thead>
<tr>
<th>Theme</th>
<th>Excerpts</th>
<th>No</th>
</tr>
</thead>
</table>
| Organisational & External Problems | ‘Government with current employment policy, red tape regulations and private physiotherapy issues’  
‘There needs to be a system and cultural change to limit abuse, both political and physiowise’ | 15 |
| Finding Resources              | ‘Financial and human resources problem’  
‘Difficulty in provision of equipment’ | 14 |
| Problems in Organising Service | ‘Problem in setting the time that should be worked and amount of patients seen’  
‘Difficult to establish criteria, determine monitoring services, audit, quality control and accountability’ | 13 |
| Transport                      | ‘Problem in deciding on ideal type of transport to be provided and financial insurance’ | 6  |
| Teambuilding                   | ‘Multidisciplinary team effort, difficulty in team building and in liaison with team’ | 3  |
| Time Consuming                 | ‘Decreased amount of patients one can see in a day as they require long treatment sessions’  
‘Traffic in peak hours and parking problems’ | 16 |
| Lack of resources               | ‘Lack of resources such as equipment and knowledge’ | 15 |
| Isolation                      | ‘Work alone, risk isolation without peer support and may require help during treatment’ | 12 |
| Safety Issues                  | ‘Abuse from patients’  
‘Legal issues’  
‘Inadequate environment. Plinths, beds not variable height, pets, house layout’ | 9  |
| Transport Modality             | ‘Transport modality. Problem if use own car as there is more risk for accidents’ | 6  |
| Isolation                      | ‘If housebound socialises less. Institutionalised in own home’ | 13 |
| Invasion of privacy            | ‘Might be afraid to open door and let a stranger into the home’  
‘Security issues, theft claims’ | 9  |
| Less opportunities             | ‘Not benefit from all treatment available’  
‘If discharged from hospital early and forced to face life that may not be able to cope with’ | 5  |
| Inconvenience                  | ‘Wait for physiotherapists: late due to travelling’  
‘If still attend hospital for other appointments, can be uncomfortable’ | 3  |
Content analysis of results is shown in Table 9. Out of the 72 (87.8%) participants who answered the first part of question 14, 12 (14.63%) did not answer the question, 22 answered no and the rest gave quite an extensive response regarding problems that might arise.

While 74 (90.24%) participants answered both the second and third part of the Question, 56 (68.3%) answered yes, that they did foresee inconveniences for physiotherapists, 15 (18.3%) answered no while 10 (12.1%) did not answer the question. Likewise in the third part of the question, 32 (39%) answered that they did foresee a problem, 42 (51.2%) answered no and 8 (9.8%) did not give an answer.

4.1.2.6 Further comments

At the end of the questionnaire 24 (29.3%) of the participants added various comments on the subject. Some of the participants stressed the importance of promoting ‘awareness regarding the role of physiotherapists and their skills to all parties especially General Practitioners to channel referrals appropriately’ while ‘maintaining autonomy to assess patient, decide on mode of treatment and when to stop’. While some participants commented that ‘it is high time that such service is started in Malta’ others commented that it is ‘time that patients donate a percentage of cost so that health workers are paid properly.’
4.2 Analysis of Application Forms of St Vincent De Paul Residence

The total number of application forms for St Vincent De Paul Residence (SVPR) in February 2005, amounted to 819. Of these applications, 167 (20.3%) were awaiting evaluation by the Admission Board of SVPR. Of the rest of the applicants, those under the age of 60 years (n=21-2.5%), those already in a home (n=140-17%), those who were in SLH (n=22-2.68%) and those who applied before 1999 (n=47-5.73%) were excluded from the analysis.

Thus, a total of 332 (40.53%) application forms which were registered between 1999 and 2005 of older people aged 60 years and over were analysed. Table 10 shows the number of applicants who applied between 1999 and 2004. In 2005 only one applicant who was already resident in a home was available and thus was excluded from the study.

Table 10: Distribution of applicants for SVPR according to year of application

<table>
<thead>
<tr>
<th>Year of application</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999</td>
<td>17</td>
<td>5.1</td>
</tr>
<tr>
<td>2000</td>
<td>27</td>
<td>8.1</td>
</tr>
<tr>
<td>2001</td>
<td>63</td>
<td>18.9</td>
</tr>
<tr>
<td>2002</td>
<td>75</td>
<td>22.5</td>
</tr>
<tr>
<td>2003</td>
<td>99</td>
<td>29.7</td>
</tr>
<tr>
<td>2004</td>
<td>52</td>
<td>15.6</td>
</tr>
</tbody>
</table>

4.2.1 Gender and Age Distribution

From the 332 application forms, 105 (31.5%) were males and 228 (68.5%) were females. Figure 7 shows the distribution of applicants according to the different age groups as mentioned in the literature review. Noteworthy, is the fact that the largest portions of applicants are in the ‘old old’ age group.
4.2.2 Marital Status

While 122 (36.6%) were widows or widowers, 106 (31.9%) applicants were married, 91 (27.4%) were single and 14 (4.2%) were separated. Figure 8 shows the distribution of the Marital Status of the applicants.

Figure 8: Marital Status of Applicants
4.2.3 Locality

Distribution by locality shows that 26 (7.8%) applicants live in Sliema, another 26 (7.8%) live in Birkirkara, 23 (6.9%) live in Paola, 19 (5.7%) live in Qormi, 16 (4.8%) live in Hamrun, 15 (4.5%) live in Valletta and another 15 (4.5%) live in Zebbug. The rest of the applicants are scattered in other localities around Malta. Figure 9, shows the distribution of applicants according to the District (See Appendix I) where they live. It can be concluded that the largest amount of applicants live in the Northern and Southern Harbour Districts.

![Figure 9: Distribution of applicants according to District](image)

4.2.4 Detail about Applications

From 332 applicants, 72 (21.7%) were in-patients who were consequently discharged home. Of these, 62 (86.1%) were patients at SLH, 8 (11.1%) were residents at Zammit Clapp Hospital (ZCH), one (1.4%) at Mount Carmel Hospital (MCH) and 1 (1.4%) at Sir Paul Boffa Hospital (SPBH). Table 11 shows the
distribution of applicants who were in-patients in SLH and afterwards discharged home.

Table 11: Distribution of applicants for SVPR according to the Wards in SLH

<table>
<thead>
<tr>
<th>Wards</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>39</td>
</tr>
<tr>
<td>Surgical</td>
<td>9</td>
</tr>
<tr>
<td>Orthopaedic</td>
<td>9</td>
</tr>
<tr>
<td>Neurosurgical Unit</td>
<td>2</td>
</tr>
<tr>
<td>General Dependency Ward</td>
<td>1</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>1</td>
</tr>
<tr>
<td>Psychiatric Unit</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>62</strong></td>
</tr>
</tbody>
</table>

4.2.5 Medical History and Diagnosis

311 (93.7%) applicants stated that they suffered from a medical condition and documented a variety of medical histories. Due to the heterogeneity in documentation of medical conditions by different Medical Practitioners, certain conditions were grouped. Heart problems consisted of Ischemic Heart Failure, Congestive Heart Failure, Atrial Fibrillation, Myocardial Infarction and Valvular Heart Disease. Respiratory conditions included Chronic Obstructive Pulmonary Disease, Asthma, Pulmonary Fibrosis and Bronchiectasis. While eyesight problems varied from Glaucoma, Cataracts and Blindness, Circulatory problems included Peripheral Vascular Disease and chronic Deep Vein Thrombosis. Also mental problems included Schizophrenia, Schizo-affective disorders and Paranoia.

Figure 10 shows the distribution of the 12 most common medical conditions presented by applicants. Furthermore, it is to be noted that four applicants were diagnosed as being ‘elderly’ or to be suffering from ‘old age’. 
4.2.6 Communication Abilities

The majority of applicants had good communication abilities. Table 12 shows distribution of the applicants’ hearing, speech and vision ability in terms of good, fair or poor.

Table 12: Communication Abilities of applicants

<table>
<thead>
<tr>
<th></th>
<th>Good</th>
<th>Percentage</th>
<th>Fair</th>
<th>Percentage</th>
<th>Poor</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hearing</td>
<td>239</td>
<td>72</td>
<td>66</td>
<td>19.9</td>
<td>27</td>
<td>8.1</td>
</tr>
<tr>
<td>Speech</td>
<td>262</td>
<td>78.9</td>
<td>54</td>
<td>16.3</td>
<td>16</td>
<td>4.8</td>
</tr>
<tr>
<td>Vision</td>
<td>216</td>
<td>65.1</td>
<td>89</td>
<td>26.8</td>
<td>27</td>
<td>8.1</td>
</tr>
</tbody>
</table>

4.2.7 Mental State

In this section the applicants had to be assessed with regards to orientation, memory, presence of hallucination, paranoid ideas and their behavioural state. 308 (92.8%) applicants did not suffer from hallucinations or delusions while 313
(94.3%) did not suffer from paranoid ideas. Table 13 illustrates grades of orientation to time, person, place, memory and behavioural state of applicants.

Table 13: Orientation, Memory and Behavioural State of applicants

<table>
<thead>
<tr>
<th>Always</th>
<th>Occasionally</th>
<th>Rarely/Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oriented</td>
<td>No.</td>
<td>Percentage</td>
</tr>
<tr>
<td>267</td>
<td>80.4</td>
<td>48</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Well-preserved</th>
<th>Impaired</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>No.</td>
<td>Percentage</td>
<td>No.</td>
</tr>
<tr>
<td>Memory</td>
<td>242</td>
<td>70.8</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Normal</th>
<th>Apathetic</th>
<th>Agitated</th>
<th>Aggressive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioural State</td>
<td>No.</td>
<td>Percentage</td>
<td>No.</td>
</tr>
<tr>
<td>230</td>
<td>69.3</td>
<td>73</td>
<td>22</td>
</tr>
</tbody>
</table>

### 4.2.8 Activities of Daily Living

Figure 11 shows six different activities of daily living according to capabilities of applicants to carry out such tasks.

Figure 11: Activities of daily living
The majority of the applicants could carry out the first three activities of daily living that is, eating, dressing and bathing independently. On the other hand the majority of the applicants were unable to prepare meals, do housekeeping and go shopping.

4.2.9 Mobility

The Medical Practitioners were required to mark the appropriate statement which best describes the capabilities with regards to mobility of the applicants as shown in Figure 12. While 133 (40.1%) of the applicants were capable of walking unaided for short distances, a slightly lesser number, that is, 108 (32.5%) were able to get in and out of bed without help.

Figure 12: Mobility
4.2.10 Continence

Figure 13, shows the level of continence. 249 (75%) of the applicants were capable of going to the bathroom, 57 (17.2%) were incontinent of urine and 33 (9.9%) were incontinent of faeces. The applicants who used a commode or bed pan (n=30-9%) probably have a mobility problem rather than a continence problem.

![Figure 13: Continence](image)

4.2.11 Need for Nursing Care

247 (74.4%) required minimal or simple custodial care while 146 (44%) required care for personal hygiene. Half the applicants (n=167) required help in drug administration. Figure 14 shows the results related to nursing care required.
4.2.12 Social State

While 150 (45.2%) applicants lived alone, 149 (44.9%) lived with someone else and 14 (4.2%) lived alone occasionally. Furthermore, 140 (42.2%) applicants slept alone. Moreover 127 (38.3%) applicants received daily frequent visits, and 56 (16.9%) received less than one visit per week. Figure 15 shows four different carer categories that offered help to the applicants. It is well noting that while 254 (76.5%) applicants received help from relatives, only 11 (3.3%) benefited from community or hired help.
4.2.13 Reasons Why the Applicant is Unable to Continue Living in the Community

Deterioration of physical and mental conditions was the main reason given by 216 (65.1%) applicants, for being unable to live in the community. The fact that both applicants (n=171-51.5%) and carers could not cope (n=173-52.1%) were two major factors for applying for SVPR as shown in Figure 16.

Figure 16: Reasons why applicants are unable to continue living in the community

4.2.14 Further Analysis

Going shopping was the most effected activity of daily living. Thus the relation between shopping and ability to walk long or short distance was analysed. It would have been expected that people who could walk long distances could be able to go shopping without assistance but this was not the case. This can be seen in Figure 17 which shows the number of older people who can carry out these activities.
Chapter 4 – Results

4.3 Interview with Older People

Out of 152 older people who applied for SVPR in the years 2003 - 2005, 55 (36.2%) respondents accepted to take part in a face-to-face interview and mobility assessment. Of the rest, 10 (6.7%) were found to be deceased when contacted, seven (4.6%) were already in homes, 27 (17.8%) did not answer the telephone, 15 (9.9%) were hospitalised or very ill and 38 (25%) refused to take part in the study. The latter was mainly due because the potential participants were apprehensive of carrying out the interview in their home.
4.3.1 Demographic Description

Participants were required to divulge their gender, marital status, living conditions and social support as shown in Table 14. 17 (30.9%) older people received support from persons not in the immediate family or not living next door. Of these, eight (47%) were receiving support from siblings, another eight (47%) were receiving support from nephews or nieces and one (6%) was receiving support from a friend.

Table 14: Demographic distribution of Older People

<table>
<thead>
<tr>
<th>Gender</th>
<th>No.</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>22</td>
<td>40</td>
</tr>
<tr>
<td>Female</td>
<td>33</td>
<td>60</td>
</tr>
<tr>
<td>Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>15</td>
<td>27.3</td>
</tr>
<tr>
<td>Married</td>
<td>18</td>
<td>32.7</td>
</tr>
<tr>
<td>Widow/er</td>
<td>21</td>
<td>38.2</td>
</tr>
<tr>
<td>Separated</td>
<td>1</td>
<td>1.8</td>
</tr>
<tr>
<td>Living Condition</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alone</td>
<td>19</td>
<td>34.5</td>
</tr>
<tr>
<td>With partner</td>
<td>16</td>
<td>29.1</td>
</tr>
<tr>
<td>With siblings</td>
<td>11</td>
<td>20</td>
</tr>
<tr>
<td>With children</td>
<td>8</td>
<td>14.5</td>
</tr>
<tr>
<td>With someone else</td>
<td>1</td>
<td>1.8</td>
</tr>
<tr>
<td>Social Support</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Partner</td>
<td>6</td>
<td>10.9</td>
</tr>
<tr>
<td>Children</td>
<td>27</td>
<td>49.1</td>
</tr>
<tr>
<td>Neighbours</td>
<td>5</td>
<td>9.1</td>
</tr>
<tr>
<td>Someone else</td>
<td>17</td>
<td>30.9</td>
</tr>
</tbody>
</table>

4.3.1.1 Locality

While six (10.9%) older people lived in Qormi, five (9.1%) lived in Valletta and another five (9.1%) in Senglea. Since the localities where the other older people lived are quite scattered around the Island, these were grouped into Districts (See Appendix I) as shown in Figure 18. Similar to the applicants of SVPR the participants come from the Southern and Northern Harbour Districts.
4.3.1.2 Age

The older people were asked to give their age since their last birthday. Figure 19 shows the age distribution of the older persons over 60 years of age in three categories. From the table it can be noticed that 60% (n=33) of the participants were between 75 and 84 years of age, that is the majority are 'old old' people. This result is similar to that derived form the application forms of SVPR.
4.3.1.3 House Layout

While no one of the applicants had lifts, 32 (58.2%) lived at ground floor level, 11 (20%) lived on the first floor. Five (9%) lived on the second floor and two (3.6%) on the third floor. Five applicants lived in a two storey house. One of these applicants changed house every week as this persons’ relatives could not keep this person with them for more than a week each.

4.3.2 Face to face Interview

In this part of the interview the participants had to answer 12 questions, which were read out and filled in by the researcher according to the participants’ preferences.

4.3.2.1 Reason for Applying for Admission in a Residential Home

In the first question participants were asked why they felt the need to apply for SVPR. Table 15 shows content analysis of the results.

<table>
<thead>
<tr>
<th>Theme</th>
<th>Excerpts</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family</td>
<td>‘I need a lot of help from my relatives and they might not cope soon’</td>
<td>21</td>
</tr>
<tr>
<td>Loneliness</td>
<td>‘I feel lonely’</td>
<td>16</td>
</tr>
<tr>
<td>Old Age and Immobility</td>
<td>‘I am becoming old and doing activities slowly and with difficulty’</td>
<td>7</td>
</tr>
<tr>
<td>Peace of Mind</td>
<td>‘I wanted to be on the waiting list when need arises’</td>
<td>6</td>
</tr>
<tr>
<td>Illness</td>
<td>‘I was very ill and needed help when I applied but now have improved’</td>
<td>4</td>
</tr>
<tr>
<td>Bad Living Conditions</td>
<td>‘The condition of my house is bad and very dirty’</td>
<td>3</td>
</tr>
</tbody>
</table>
Chapter 4 – Results

4.3.2.2 Physiotherapy Services

Interesting to note that only 23 (41.8%) of the participants had benefited from physiotherapy services. Of these only one opted for private physiotherapy services. From the others, 19 (82.6%) received physiotherapy services from SLH; five (21.7%) benefited from physiotherapy service while being in-patients at SLH; two (8.7%) were then followed at the Out-Patients Department and 11 (47.8%) attended directly the Out-Patient Physiotherapy Department at SLH. Also one participant attended a Health Centre and another two received physiotherapy while they were patients at ZCH.

Participants stated that they were referred for physiotherapy treatment to be treated after falls, CerebroVascular Accident, Amputee Rehabilitation, Arthritis, fractures and knee operation. Two participants still attend for rehabilitation regularly.

19 (82.6%) participants were satisfied with physiotherapy services, another was not and three (13%) did not know. The latter did not see any difference in their condition. 13 (56.5%) participants used Hospital provided transport. Ten (43.5%) used their own transport or were accompanied by a relative.

Participants were also asked whether they were satisfied with the transport provided when attending for appointments. 32 (58.2%) did not know the answer as they have never used the service. On the other hand, 17 (30.9%) were satisfied with the hospital transport and six (10.9%) were not. The fact that the service is
free of charge and that transport picks them up from home and takes them back were some of the most praising comments. On the other hand, some reasons for lack of satisfaction included long waiting and travelling time.

4.3.2.3 Other Community Services

Of the participants, 26 (47.3%) stated that they were benefiting from community services. Of these 18 (69.2%) were benefiting from Home Help, eight (30%) from MMDNA nurses, 7(26.9%) had Telecare, one received home visits from nurses at ZCH and one receives support from a Social Worker. Figure 20 shows the distribution of community services received by the participants.

Figure 20: Community Services
4.3.2.4 Physiotherapy Service Provision

Participants had to answer certain questions relating to time and place of physiotherapy service provision. 43 (78.2%) participants would still prefer to receive physiotherapy treatment at home in the morning. Three (5.5%) participants preferred the afternoon sessions while five (9.1%) participants preferred the evening. Four (7.3%) participants did not know. Table 16 shows the answers given to Questions 8 and 9.

Table 16: Answers for Questions 8 & 9 in interview with older people

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Do not know</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>Percentage</td>
</tr>
<tr>
<td>If the delivery time of the present physiotherapy service had to be extended to after three o'clock in the afternoon would you consider attending for out-patients?</td>
<td>16</td>
<td>29.1</td>
</tr>
<tr>
<td>If you were receiving community physiotherapy and your therapist had to suggest some sessions at the outpatient department would you accept?</td>
<td>30</td>
<td>54.5</td>
</tr>
</tbody>
</table>

4.3.2.5 Community Physiotherapy versus Admission to SVPR

31 (56.4%) participants did not think that CPS could help them live longer in the community. On the other hand 15 (27.3%) participants were uncertain and nine (16.4%) participants agreed that this service could help them and their families. In the second part of the question, participants had to justify their answers. Table 17 shows content analysis of the results divided according to answers in the first part of the question.
Table 17: Question 10 - Do you think that CPS can help you stay longer in your home? Justify.

<table>
<thead>
<tr>
<th>Theme Excerpts</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physiotherapy can help</td>
<td>‘Physiotherapy can help with physical problems’ ‘Physiotherapy already helped me feel better’</td>
</tr>
<tr>
<td>Home is better</td>
<td>‘It is more convenient living at home. All help is welcome’</td>
</tr>
<tr>
<td>Too late</td>
<td>‘Now I need a lot of help and am feeling weak’</td>
</tr>
<tr>
<td>Lack of awareness</td>
<td>‘I have no idea how physiotherapy can help me’</td>
</tr>
<tr>
<td>SVPR better</td>
<td>‘I still prefer to go to a home’</td>
</tr>
<tr>
<td>Home better</td>
<td>‘I’m getting old but home is always home’</td>
</tr>
<tr>
<td>Lack of awareness</td>
<td>‘I don not know how physiotherapy can help Cannot say what will need in the future’</td>
</tr>
<tr>
<td>Loneliness</td>
<td>‘I do not want to live alone’</td>
</tr>
</tbody>
</table>

In the last question participants were asked whether there was anything else that could help them live longer at home. Content analysis of these answers is show in Table 18.

Table 18: Question 11 - Is there something else that can help you live for longer in the community or help you reconsider your decision to go to a residential home?

<table>
<thead>
<tr>
<th>Theme</th>
<th>Excerpts</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Help &amp; Support</td>
<td>‘Full time care and support’ ‘Someone to help me, offer support and check on me’</td>
<td></td>
</tr>
<tr>
<td>No need to go to SVPR</td>
<td>‘Now I want to stay home. I applied when I was sick but now am feeling better. Feels better being on waiting’</td>
<td></td>
</tr>
<tr>
<td>Company</td>
<td>‘More company might help me reconsider my decision’</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>‘Time is ticking and I’m looking forward to go to a Home’</td>
<td></td>
</tr>
<tr>
<td>Bad Living Conditions</td>
<td>‘The condition of my house is bad and very dirty’</td>
<td></td>
</tr>
<tr>
<td>Access to services</td>
<td>‘More access to services and more information’</td>
<td></td>
</tr>
<tr>
<td>Independence</td>
<td>‘If I will become independent’</td>
<td></td>
</tr>
</tbody>
</table>

4.4 Mobility Assessment

This part of the interview consisted of a mobility assessment carried out by researcher.
4.4.1 Wheelchair Management

Only five (9%) participants used a wheelchair at the time of the interview. Of these, one participant could manage the wheelchair independently another two needed minimal help, while the rest were totally dependent on their carers.

4.4.2 Balance

Balance was tested both in the sitting and standing position. Figures 21 and 22 show the balance of participants in the sitting and standing positions respectively. From the figures one can conclude that most participants were able to carry out the tasks required independently. On the other hand five (9%) participants were not able to stand up.

Figure 21: Balance in Sitting
4.4.3 Bed Mobility

Most participants were capable to achieve the activities mentioned in Figure 23, which show the capabilities of participants of moving in bed. The participants with weakness of the upper part of the body, had the most difficulty in carrying out the activities.
4.4.4 Sitting

Figure 24 shows the ability of participants to transfer to and from the sitting position. While the majority of the participants carried out the activities independently, a significant portion required assistance.

Figure 24: Sitting positions

4.4.5 Transfers Abilities

Figure 25: Transfer abilities
Figure 25 shows the capabilities of participants to transfer from one place to another. Even though most participants were able to carry out transfers, the percentage decreased from an average of 85.9% in sitting balance to an average of 51.5%. More participants seemed to need help in this category.

4.4.6 Ability to Walk and Stair Management

A total of 50 (90%) participants were capable of walking and 37 (67.3%) participants managed to go up the stairs. Figure 26 shows the capabilities of participants to carry out these tasks.

Figure 26: Walking and Stair Management abilities

4.4.7 Types of Aids Used when Walking and when Going Up the Stairs

While nine (16.4%) participants needed a stick to walk, no one needed a Gutter Frame or Crutches. Also 30 (54.5%) participants were not applicable for this
activity. Furthermore, 37 (67.3%) participants were not applicable for using an aid while going up the stair.

While none of the participants used walking frames, rollators, gutter frames or crutches to go up the stairs, eight (14.5%) participants used physical help of one person to manage the stairs. Figure 27 shows the type of aids used by participants to walk and go up the stairs. Noteworthy, is the fact that if participants could not manage these activities or did so independently they were classified as not applicable.

Figure 27: Type of Aid used to walk and go up the stairs
4.5 **Further Analysis**

Figure 28 shows the relationship between those applicants who have benefited from physiotherapy treatment and their perception regarding the ability of CPS in prolonging their stay in the community. Noteworthy is the fact that there is no difference in the answers between those who have received physiotherapy treatment or not. In fact most applicants answered no.

![Figure 28: Relationship between utilisation of physiotherapy services and perception of participants on the potential of Community Physiotherapy Services.](image)

The relationship between those applicants who have benefited from physiotherapy treatment and used the hospital transport with their satisfaction regarding the transport has also been analysed. The results show that most of the applicants that have used the hospital transport are satisfied with it. In fact while nine applicants who have used the service were satisfied with the service four were not. This has also been shown to be statistically significant with a p value of 0. Statistical significance has been tested by using Fischer's exact test as shown in
Table 19. This type of test has been used instead of the Chi-Square because it is Non-parametric due the homogeneity of the data available.

<table>
<thead>
<tr>
<th></th>
<th>Value</th>
<th>Exact Sig. (2-sided)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fisher's Exact Test</td>
<td>30.162</td>
<td>.000</td>
</tr>
</tbody>
</table>

4.6 Age of Patients treated by Physiotherapists

Following collection of data from registers of different units in the Physiotherapy Department in SLH, Figures 29 and 30 show the age distribution of patients treated by physiotherapists as in-patients and out-patients respectively. Some of the data was missing from the registers. For this reason a large amount of data was collected and thus it was assumed that the distribution of data both present and absent was similar.

As seen in Figure 29 it can be concluded that the largest number of older people treated by physiotherapists in SLH are situated in the Medical Wards. In fact a much lower number of older people attend for out-patients.

Noteworthy is the fact that physiotherapists did not treat patients according to their condition. In fact, the number and frequency of treatment sessions, type of treatment and number of physiotherapists treating one patient in one session varied from one case to another.
Figure 29: Age distribution of Inpatients treated by Physiotherapists in SLH

Figure 30: Age distribution of Inpatients treated by Physiotherapists in SLH
4.7 Present Community Physiotherapy Service Provision

Following personal communication with physiotherapists responsible of units in SLH, SVPR and ZCH information regarding present CPS and other services for older people was obtained.

4.7.1 Physiotherapy Services in SLH

Physiotherapy services in SLH offer home visits for those patients, usually older people who might require home adaptations, assessment at home and where advice for the carers and the patient is deemed relevant. These home visits are limited in number as they have to be included within the physiotherapists’ case load or schedule. Also chauffeur transport provided by SLH is sometimes inappropriate as the physiotherapists might have to go for a home visit at a time when they are very busy. In 2004, 24 home visits were carried out by the Medical and Neuro-rehabilitation team. So far 12 visits have been carried out till March 2005.

4.7.2 Physiotherapy Services in ZCH

In ZCH there is a team approach and home visits are usually carried out with the Occupational Therapists and the Social Workers. These therapists also use the transport supplied by ZCH but even if it is time consuming, a better programming of the time of the home visit is achieved.

4.7.3 Physiotherapy Services in SVPR

The only CPS present in the public sector is supplied by physiotherapists in SVPR. Even though on a small scale due to limitation of resources, community
services offered include treatment in the home of the older people and visits to Day Centres which include health promotion, advice and rehabilitation. An SVPR physiotherapist also offers treatment for older people living in their home and sometimes physiotherapists from both SLH and ZCH refer patients for CPS.

4.8 Interviews with Key Persons

This study explores the need of CPS for older people in Malta. Thus, the perception of key persons involved with these older people offers another perspective worth noting. To ensure anonymity key persons when quoted are shown in code from P1 to P8.

One of the issues discussed in the interviews was whether Malta is prepared for the challenge in caring for the increase in number of frail older people. Mixed responses were obtained. P2 and P6 opined that ‘While global ageing and our changing demography is evident in many countries’, ‘Malta was always in the forefront’ and was one of the first countries that ‘addressed this issue by creating a Parliamentary Secretary for the Care of the Elderly’ (P2, P6, P5, P8) ‘in 1987’ (P5, P8) ‘the opening of ZCH in 1991’ (P6, P2) and a ‘Department for Elderly and Community care which is responsible for providing community services for the elderly’ (P8) such as ‘Home Help, Meals on Wheels, Handyman and Telecare and Incontinence service (P8, P6, P2). P5, states that this was something good because they (Policy makers), started thinking specifically for older people and this is how the service started because they identified certain needs’ of these people. P5 further stresses that while this is all true ‘we have been stuck for the past fourteen
years and we’ve reached a status quo’ and ‘services are not being improved and increased’.

In fact P1 opines that ‘if we are preparing for the challenge we’re not doing it fast enough’ and P4 states that ‘it should not have been a crisis in the first place but now we are not prepared for the challenge.’

While other key persons focused more on service provision for older people P7 mentioned that the focus should be on ‘the elderly of the future’. P7 further opines that this should be achieved through ‘prevention and promotion of healthy ageing with the aim of improving the general state of health of our people who are the age of thirty, thirty five, forty to fifty.’

P7 further opines that the needs of older people especially in health service provision are known or can be projected. This key person states that ‘we are prepared in other areas, we know what we’re going to face in the healthcare sector’, ‘by analysing how the elderly are using health services today’ ‘we are going to get to extrapolate and have a look at what’s it going to look like in twenty years time’ and ‘when we get a picture of how the burden is going to look like than we will have to see how we are going to intervene trying to reduce this burden’.

While P3 states that ‘the needs are there, glaring’, P1 opines that ‘I think we are not recognizing the changing needs’ of the older people. ‘All we have to do is look at the situation that we have every winter, with increased number of elderly being
admitted' to SLH, 'and the increase in number of elderly persons who remain in hospital because they cannot be discharged home for social reasons' (P1).

P7 states that needs of the older people are 'complex issues' and P5 states that 'there is a whole spectrum of needs. You can look at the social aspect, the medical aspect and as happens with many older people there are a combination of both'. Also, P6 states that older people are not a 'homogenous group' and that they have 'bzonnijiet differenti minn xulxin (different needs from each other)'. This key person also stated that we 'can pinpoint the needs of the elderly' in that they will need more medical care and more rehabilitation. Other key persons mentioned 'family issues' (P8, P6, P7). P7 opined that 'traditionally Malta has always cared for itself with the family environment' 'and today they can still support each other because there are still remnants of the past, with seven or eight children' but 'in twenty years time it's going to be difficult'. Also, 'with women moving in the labour force less people will be available for caring for the elderly (P6, P8).

While P5 opines that 'the needs of the elderly are not being addressed sufficiently in many ways'; P7 further suggests that 'we do not have a proper service within the community level, integration of services (health and social services) in the community are lacking so basically the families are not very well supported. This opinion was supported by other key persons (P8, P5, P4, P7, P1). P6 also states that what 'we do not know is the expectations of elderly which will be change with change in culture'.
All participants agreed to a certain degree that the shift of care should be more towards community services. P3 states that 'I strongly believe that the elderly should be kept as long as possible in the community'.

Still, P3 states that community services are 'an expensive proposition and as expensive as, if not more as institutionalisation'. On the other hand, while P6 agrees with P3, this key person further opines that 'it is a trial worth trying, that is, evaluate its cost effectiveness. Ikollok nies jokkupaw is-sodod u l-kura akuta tohodlok bejn sittin u tmenin lira kuljum. Trid taghmel il-bilanc (having people occupying beds and acute care, costs between sixty to eighty Maltese Liri a day. You have to calculate the balance). While P4 agrees that 'community services are expensive' this person further states that they are expensive in the short term and that 'in the long term they are cheaper but people see the short term.'

Also P1 states that 'we have to be realistic in that old people have got multiple pathologies with which they are affected when they come to hospital or even if they don't'. This key person further opines that apart from health problems older people might have 'social problems such as being looked after by carers who are old themselves', 'they might need security, company or a higher level of care. P1 as supported by P8 and P2 states that 'institutional care will always be needed'.

While to some extent P5, P6 and P7 agree with P1, they suggest that 'institutional care should be last resort' to be utilised in the 'last six months of life'. In fact, both P5 and P7 agree that a 'pre-admission assessment to SVPR' carried out
by the interdisciplinary team’ including physiotherapists can help prevent early institutionalisation and access to treatment.

Still P5 further opines that while everyone encourages community services, ‘the emphasis seems to be more on institutional care’, ‘we might see more beds in SVPR which has been around for over hundred years’, ‘a home in Mellieha is opening soon’ ‘there have been plans to open more’, ‘and soon we might reach a situation were there will be a waiting list for private homes.’. While P4 agrees with P5, this key person further opines ‘no community services are being established and that comes from top management and policy makers’.

All key persons recognised the importance of physiotherapy both for the care and rehabilitation of older people but also recognised physiotherapists’ role in the community. Also, P1 recognises the importance of physiotherapists as ‘a major factor in keeping elderly kicking rather than alive’, that is, ‘it’s more a matter of improving quality of life’.

Furthermore, all applicants also recognise that physiotherapists should not work alone, in fact P2 states that ‘in the case of the elderly it’s never a one man show.’ All key persons recognize the importance of the multi or interdisciplinary team namely ‘doctors, nurses, occupational therapists, speech therapists, chiropodists and social worker’. In fact, P4 suggested that it ‘would be ideal if we come to a stage were we have a community service team from Geriatrics’, ‘but someone has to manage the team.’
The importance of General Practitioners (GP) was also considered to be able to make CPS more accessible to older people (P1, P4). P4 mentioned the ‘GP access Clinic in the United Kingdom where GPs have direct access to the service’. This issue brought about the fact that physiotherapists should have ‘their autonomy respected’. P4 opines that ‘it could be the social worker, the family, the doctor’ ‘who referred a patient for treatment’ ‘but the physiotherapist should decide on type of treatment, whether patient needs it or not, what type of intervention’ is required ‘when to discharge the patient, next contact date or whatever’.

Conversely P1, states that ‘if a physiotherapist assesses an older person who has got difficulty in mobilising what makes the physiotherapist decide whether the elderly person is a candidate for community services or not’. For this reason P4 suggests ‘that is why before you actually start the service you must have your operational policies so that you are guided by your manager’s or departmental operational policies and you stick to those’ ‘they know why a patient should be referred’. ‘So the physiotherapists are not afraid that they are going to work on guidelines and criteria and managers can control their staff more and can actually audit their service and its output more by going through operational policies’.

Also for this reason, P1, P2 and P4 agree that physiotherapists working in a community services should be experienced, not necessarily specialised in gerontology but have worked with older people. P1 further state that from a ‘human resource point of view you might have the number but not the competence’, ’not everybody can do it’. This key person further opines that ‘very few people are
capable of treating patients in the community’, ‘you need maturity, trustworthy, competent, know what they are doing and flexible.’

While P8 suggested that one should ‘first improve in-house services’ before starting a new service P4 states that ‘I don’t agree, I mean improvement is on-going’. ‘What I stress on is that you have to have a very sound basis of what you’re going to do. You must never let one service fall for the sake of another to be built’.

Still P1 and P4 suggest that an ‘independent unit solely responsible for CPS’ should be supplied. This to prevent overlap of resources and competition. P1 states that ‘it would be foolish to replicate service’ and ‘the level of expertise goes down’. P4 further opines that ‘I do not think it will be economical to have different departments’ and ‘what if you have a Stroke patient with a fracture? Who’s going to take care of him?’ ‘but I would agree to have a specialized unit in elderly’

According to P1 ‘we have to decide where we want our resources to emerge from.’ ‘From an acute hospital, Health Centres, ZCH, SVPR. They could emerge from all areas’ P1 further opines that ‘we should see who does it best’. To decide from where community services should emerge one must consider transport as well. P4 states that ‘just because Florence Nightingale did not invent this (transport) we still have not got it (the solution).
CHAPTER 5 – DISCUSSION AND ANALYSIS

The aim of this study was to explore the need for Community Physiotherapy Services (CPS) for older people in the community. Due to the complexity of the issues under study, both qualitative and quantitative measures were used by collecting original information and adapting what was already available as suggested by Wright, Williams & Wilkinson (1998).

5.1 Need for Physiotherapy Services

The stakeholders chosen to give their perception regarding the need for CPS were physiotherapists working within the public service, key persons who can contribute in the implementation or not of such services and the older people themselves.

5.1.1 Physiotherapists

From the self-administered questionnaires, physiotherapists, showed both extensive knowledge about CPS and also enthusiasm for the prospect of setting up such service. In fact five physiotherapists commented that 'it is high time that such service is started in Malta especially when considering the problem faced by St Luke's hospital (SLH) overcrowding'.

From the physiotherapists taking part in the study 78 (95.1%), strongly agreed (n=40-48.8%) or agreed (n=38-46.3%) that they have come in contact with individuals who would have benefited from CPS. To a slightly lower percentage
physiotherapists strongly agreed (n=45-54.9%) or agreed (n=31-37.8%) that there is a need for CPS in Malta.

All Physiotherapists (n=82-100%) taking part in the study strongly agreed (n=61-74.4%) or agreed (n=21-25.6%) that they play an important role in rehabilitation of older people. Moreover, 81 (98.7%) strongly agreed (n=33-40.2%) or agreed (n=48-58.5%) that physiotherapists should be targeting more this group. Indeed the importance of physiotherapists in rehabilitation of older people has already been shown previously in the literature review (Squires & Livesley, 1993). Furthermore according to Young & Dinan (2005), not only does regular physical activity play an important part in preventing disease but frail older patients with multiple disabilities may also derive functional benefits from graded physical training.

In the questionnaire, physiotherapists were requested to identify whether physiotherapy has an affect on the 'Giant of Geriatrics' which refers to the pattern recognition of a set of signs and symptoms, namely immobility, instability, incontinence and intellectual impairment, that may have as their cause any disease process (Bennet & Ebrahim, 1992). These symptoms were chosen instead of listing diseases due to the multiple pathologies that older people present with and due to the holistic nature of physiotherapy treatment.

Immobility was deemed the most factor to be affected by physiotherapy rehabilitation with all physiotherapists who strongly agreed (n=68-82.9%) or agreed
(n=14-17.1%) that they play an important role in the treatment of immobility. While the disastrous effects that immobility can have on older people is extensively mentioned in literature (Barer, 1998, Chap. 110) so is the efficacy of physiotherapy rehabilitation for improving physical function and perceived health status (Cochrane, 1998).

Instability was deemed the next most affected factor with regards to physiotherapy rehabilitation with 73 (89%) physiotherapists who strongly agreed (n=38-46.3%) or agreed (n=35-42.7%) with this fact. A fall in a frail older person often marks the transition from independence to dependency (Day, Fildes, Gordon, Fitzharris, Flamer & Lord, 2002) so prevention and rehabilitation are of utmost importance.

Physiotherapists strongly agreed (n=13-15.9%) or agreed (n=40-48.8%) to a lesser extent (n=53-64.7%) regarding the importance of rehabilitation for incontinence. This could be due to the fact that there is no Physiotherapy Continence Service in Malta and rehabilitation is carried out indirectly through rehabilitation of immobility or adaptation of the environment. According to Pushpangadan and Burns (1996) incontinence may have both medical and social consequences such as isolation.

Only 45 (55%) of physiotherapists strongly agreed (n=8-9.9%) or agreed (n=37-45.1%) on the importance of their role vis-à-vis older people suffering from
intellectual impairment. Conversely, Mesa (2005), states that physical activity can increase cognitive function and positive behaviour of older people.

When asked to rank why CPS is important, physiotherapists gave the highest two scores to the fact that CPS may help prevent early institutionalisation and may facilitate early discharge from hospital respectively. Furthermore, physiotherapists further commented that CPS is important when there are barriers to use service or when access needs to be quick. Because of the specificity of such service as it ‘provides treatment according to the older people’s needs’ there is enhancement of the physiotherapists’ role through motivation of older people due to increased quality of life and independence.

5.1.2 Key Persons

Following the interviews with several key persons, it resulted that the latter unanimously recognised the need for CSP. Furthermore, they not only acknowledged the fact that this service can help older people stay longer in the community but also can help improve their quality of life. Amid all this, comments that no ‘no health community services are being established’ were also obtained.

Noteworthy is the fact that all the key persons agreed on the important role of physiotherapists in rehabilitation of older people and in prolonging their stay in the community but also stated that they should be working as part of a team especially in the community.
One key person also stressed the importance of prevention and promotion of healthy ageing of the future generation of older people. Although CPS for the older people might have no connection with this role, this statement calls for further evaluation regarding the role that physiotherapists might have in prevention and promotion of health within the community setting.

### 5.1.3 Older People

Regarding the need for CPS, older people did not share the opinions mentioned above, especially when asked whether CPS might help them stay longer in the community.

As stated by some of the older people themselves they are unaware of the benefits of physiotherapy rehabilitation as they ‘have no idea how physiotherapy can help’ them. This shows that while older people knew what being admitted to a residential home meant, they were unaware of what role physiotherapy could play in improving their situation. Thus, this could have been an uninformed decision from their part which also served as a barrier to access physiotherapy services.

Also, four older people commented that they ‘want to stay home as much as possible but at the moment do not need physiotherapy and cannot say what will need in the future’. In fact Sorensen (1998) suggests that individuals may actively avoid preparation, especially when they are unfavourable, about needing to receive or to provide care. Consequently, their ability to process potentially threatening or potentially useful information about future care need may be threatened.
From the application forms of St Vincent De Paul Residence (SVPR), it was found that some of the older people who applied, were initially patients in Hospitals, mainly SLH but that afterwards were discharged home. In fact some of the older people taking part in the interview stated that ‘I was very ill and needed help when I applied but now have improved’

This might show not only that these older people prefer to live at home, in the community but that there is a gap in the healthcare system which means that instead of offering adequate support when these people find themselves in a crisis, leaves them to choose the inevitable. In fact, 49 (23%) of older people who were flagged as ‘social cases’ in SLH in 2004, were discharged home and it is well noting that most of them (19) were between 75 and 84 years of age (Janulova & Distefano, 2005).

Furthermore, most of the older people who applied for SVPR, together with those who have been interviewe...
received some form of community or hired help. The older people that took part in the interview also stated that 90% of the care was supplied from relatives. Also, 47.3% received some form of community services.

Worth mentioning is the fact that 65% of both the applicants of SVPR and those accepting to take part in the study were widowed or single. Furthermore, 45% of all the applicants lived alone, similarly for 34% of the interviewees. According to Moriarty & Levin (1993), those people requiring most help usually live in the same household as caregivers, if they are available. The fact that a considerable portion of the older people requiring help, do live alone might show that with the appropriate support these people will be able to stay for longer in the community.

Following analysis of the mobility assessments, 16 (29%) were independent in all the activities. On the other, hand the other participants 39(71%) all manifested some form of mobility limitation. In fact, as can be seen in Section 4.4, most of the problems were manifested during locomotion especially while going up the stairs.

As shown in Section 4.2.9, Figure 11, while the majority of older people could eat, dress and wash by themselves, most of them could not or needed assistance in shopping, housekeeping and meal preparation. Also as illustrated in, Figure 17 (Section 4.2.14) 133 (40.1%) older people could walk short distance out of which only one could go shopping independently. This fact could indicate that there might be both physical and cognitive problems involved. On the other hand, this might show the need for more objective pre-admission assessments for those requesting to
be admitted to SVPR as suggested by Dimech & Fiorini (2003). The formulation of such assessment could help detection of problems early on and directing older people towards services which they really need.

The three highest graded reasons given by applicants why they were unable to continue living in the community was due to deterioration of physical and mental conditions (65.1%) and because both carers (51.5%) and older people (52.1%) could not cope with the situation. As already mentioned, physiotherapists have an important role in rehabilitation and in their advice regarding adaptation for more independent living conditions (Squires & Livesley 1993).

During the mobility assessment carried out by the researcher, when carers were present, numerous deficits in handling techniques were noticed. Both the older people and the carers admitted that they had no previous knowledge in handling techniques.

Furthermore, even though some of the older people might have benefited from physiotherapy, they were never referred and some of those who used a walking aid were never thought how to use it properly by a physiotherapist. On the other hand it was noticed that there were older people who, with the use of an aid or some adaptations in the home might have become more independent. In fact according to Lansey, McCreadie & Tinker (2004), locomotion disabilities have a major impact on the feasibility of adaptation of living environment.
Chapter 5 – Discussion and Analysis

The lack of awareness about community services available in Malta, was striking. Even though some of the community services have existed for the past fifteen years and it is quite easy to apply for them; yet an older person still stated the need to have someone help to clean the house when this person could have applied for Home Help. Also, while some older people stated that they were feeling lonely and wanted company no attempt was made by them or their relatives to apply to attend one of the fourteen Day Centres available in Malta. Furthermore, lack of awareness with regards to physiotherapy services was also noticed by physiotherapists.

The low utilisation of community services has also been shown in other countries (Noelker & Bass, 1989 in Moriarty & Levin, 1993). It has been suggested that these services are only sought when caregivers have exhausted their physical and emotional resources and also advised that information about these services should be improved.

5.1.3.2 Carers

The two most frequent reasons supplied by older people taking part in the interview for applying for SVPR were because of family reasons and loneliness. Comments that relatives cannot cope show that it is very important to address the needs of carers and enable them to take care of the older people for as long as possible. In fact 21 (38.2%) older people as a reason for applying for SVPR stated that ‘I need a lot of help from my relatives and they might not cope soon’.
This statement shows that the older people’s perspectives are more likely to consider the implications of care on their families whereas health professionals focus more on the older person as suggested by Baker and Pallett-Hehn (1995).

Both physiotherapists and key persons recognised that the social support for the older people is going to decrease and that community services will play an important role in supporting the older people in the future. Physiotherapists also acknowledged the importance of involving carers in rehabilitation.

As mentioned before, it is not just the medical needs of the older people that should be targeted but also their social and psychological needs. Thus, the development of health and social support services might not have induced older people not to apply unnecessarily or prematurely for SVPR in the first place.

5.2 Present Physiotherapy Services

The present physiotherapy services are quite comprehensive in the delivery of service. According to the Annual Report of Institutional Care (Cachia, 2004), in SLH, there were 8,134 new adult cases and 39,995 follow-up visits performed by the Physiotherapy Out-Patient Service. Also 8,286 patients were given a total of 68,351 treatments in the various wards.

In the Physiotherapy Department there is no section specialised solely in Gerontology. Likewise in SLH there is no such section like the one that exists in Paediatrics (Fiorini & Mallia, 2003).
From the analysis of patients being treated at SLH, it can be concluded that physiotherapists working in Medical Wards are those whose caseload consists of older people between 75 and 84 years of age. This is the same age group of older people who is of most interest in this study. Physiotherapists working in Surgical Wards have also treated a large proportion of ‘old old’ people between January and March of 2005. The reason for this is because one of the Surgical Wards was converted to a Medical Ward to limit the effect of ‘overcrowding’ which occurs at that time of the year.

The fact that most of these older people are not followed by physiotherapists on an out-patients basis which is evident from the large discrepancy in number according to age group, between in-patients and out-patients, might suggest that either these older people are fully rehabilitated when they are discharged from hospital or that there is an inadequate follow up system or that these people, for various reasons, refuse to attend for out-patients.

In fact, three physiotherapists commented that ‘Few physiotherapists are working on rehabilitation of the older people as out-patients when discharged home and many patients await ZCH in SLH for rehabilitation only’.

Slightly more than half (n=43-52.4%) physiotherapists agreed (n=32-39%) or strongly agreed (n=13.4%) that present physiotherapy services are not satisfactory. Irrespective of their answer a gap in service provision with regards to older people was identified in all levels of agreement. Conversely those who disagreed with this statement stated that there are ‘no waiting lists, enough staff in the wards and good
'treatment outcome' together with provision of 'out-patient services, visits to state homes and home visits' 

Lack of staff, the environment where physiotherapists work, hospital transport and other departments such as nursing services which might not be directly affected by Physiotherapy administration were also considered to hinder the quality of service delivery.

In out-patients, the gap in rehabilitation of older people was shown and reduced by the extension of the Neuro-rehabilitation Out-Patients Unit. This section apart from treating people with neurological deficits, also treats older people who's condition does not fall under any of the other out-patient services in SLH such as for example, deterioration of general condition.

The two other Physiotherapy Departments that cater specifically for the care of the older people are those situated in Zammit Clapp Hospital (ZCH) and those in SVPR. While physiotherapy in ZCH is specifically geared for rehabilitation of the older people, due to the limited number of beds, which according to one key person 'haven't changed in the last fourteen years', older people have to wait for a long time at SLH to be transferred to ZCH. On admission to ZCH all older people are assessed by physiotherapists and treated according to their needs. Some of the patients are also followed on an out-patient basis or are referred directly to Out-Patients from Consultants in the Day Hospital. Home visits are again encouraged in this set-up, which further emphasises the need for CPS.
The fact that physiotherapists in SVPR have recognised and started, amid limitations, a CPS, which supply not only treatment in the home but visits to Day Centres and treatment in residential homes creates a further paradox. The message that seems to be delivered is that treatment in the community is not only essential but should be imminent.

It is also worth noting that physiotherapists working at Health Centres although they are situated in the most favourable set-up do not offer specialised treatment for the older people probably due to limited resources.

As in all other organisations, in the Physiotherapy Department according to two key persons ‘there is always room for improvement’. While a key person suggested that ‘we should improve the present services before setting up a new service’, another did not agree because if so ‘a new service will never be implemented’. This key person also stressed that a new service must never reduce the standards of the original service but must compliment it and not be a burden.

5.3 Community Physiotherapy Service Model

For CPS to be implemented as any other new service, it requires both financial and human resources.

5.3.1 Financial Resources

Financial resources will always be required for setting up a new service. Both physiotherapists and key persons recognised this fact. This study indicates that the
setting up or not of a CPS is solely dependent on the allocation of financial resources by policy makers for this project.

In Malta, the public healthcare system is free at point of use. According to World Health Organisation Europe (WHOE) (2004), it provides comprehensive coverage and promotes equity, while having to deal with insufficient funding. Public health expenditure in Malta is 13% of the total Government expenditure which amounts to 8.8% of the Gross Domestic Product (GDP) (WHOE, 2004). While this is considered to be high compared to other European Countries, the construction of Mater Dei Hospital which takes up a large portion of the health expenditure, takes priority over all other projects.

The fact that the Maltese healthcare system has been rated to be highly comprehensive and equitable (WHOE, 2004), even if it is a positive thing, does not help in deciding to set up another new service if the Maltese healthcare system is deemed to be in a good situation. Furthermore, allocation of funds in Malta come from the Minister of Finance and therefore the healthcare system has to further compete with other sectors not related to health but which might be looked at to be more necessary by the public, politicians, policy makers and the media.

As there have been no demands by older people and their families for services which they are not aware of in the first place, there has been no pressure made on policy makers and politicians to support the setting up of Community Services except during speeches and in conferences. In fact as stated before, while on paper
the emphasis is on community care services, the opening of new Homes for older people is being witnessed (Cachia, 2004), which are more acclaimed by the Maltese society who can easily identify with this need.

On the other hand, building new Homes for the older people and providing the adequate resources for them to function properly might be more expensive than the introduction of community services.

Even though the need for CPS is not directly felt by the older people and their families, the effect that it might have on other aspects of the healthcare service is well noted. As mentioned in the literature review, CPS can help reduce the stay in hospital of certain patients who might require only rehabilitation. With an adequate support system CPS could also help older people be more independent and stay for longer in the community. In this way it would be creating opportunity costs and allow for better use of both hospital and institutional beds. Social costs for the family could also be alleviated with CPS.

Even though CPS can be expensive while setting up the service, in the long term they are cost-effective while catering for the needs of the older people (Anderson, 2000) and improving the continuity of the healthcare service and increasing equity.

5.3.2 Human Resources

Allocation of human resources is important for setting up of a new service. As written by a physiotherapist the most important thing for an effective and efficient
CPS are ‘physiotherapists’. This might generate different reactions. It all depends on the type of management approach. In a CPS, physiotherapists are on their own and find themselves in unusual settings where they have to take immediate decisions. But this could be welcomed by physiotherapists. While some of the physiotherapists listed this fact as a potential problem for physiotherapists it did not stop them from showing their interest in working in the homes of the older people. In fact Partridge & Warren (1977) found in their study that physiotherapists actually enjoyed the lack of supervision and those who felt isolated made informal contacts with colleagues working either in hospital or the community.

Both physiotherapists and key persons agreed that physiotherapists working in CPS should be either specialised or have experience in working with older people. The most recently employed physiotherapists presently working with the Ministry of Health Elderly and Community Care (MHECC) have at least three year experience. This experience coupled with willingness to increase their knowledge, if well utilised, makes these professionals one of the most invaluable resource of the Organisation.

While recruitment of physiotherapists might be difficult, one key person stated that ‘it is not the amount that counts but the skill’. Thus, in case of a CPS, one of the possible solutions recommended is ‘reallocation and reorganisation of resources’.
Another solution could be to ‘buy services not professionals’. Conversely, another key person stated that unless carefully monitored, no feedback regarding the quality of service being provided can be obtained.

Another option suggested to both physiotherapists and key persons was the possibility to have an independent CSP through sub-contracting, like in the case of the Memorial District Nursing Association (MMDNA). Physiotherapists considered it as a third possible option of five while key persons did not comment on it.

5.3.3 Environmental Factors

Physiotherapists mentioned that the environment found in the home of the older person might not be ideal due to non-variable height beds, corridors, furniture, relatives and pets. Likewise, the hospital environment is also not ideal for treatment with fixed cot beds, hospital furniture in the middle and in corridors, limited space and people running around as mentioned by physiotherapists themselves. Given these scenarios it is better to treat the patient in his or her environment amid its disadvantage than in an unnatural setting that also is not ideal. As stated by a key person ‘one home visit can be more beneficial than all the treatments carried out in hospital’

Furthermore, according to Partridge and Warren (1977), all treatment can be adapted to the patient’s home except hydrotherapy unless the patient has a pool. With the advances of technology, the new equipment especially electrotherapy
come in portable sizes with more than one function. Thus, a small twenty by twenty centimetre machine, both battery and mains operated, could provide all the electrotherapy one requires.

The only problem that arises is where the equipment can be stored and how they are going to be carried around. Physiotherapists have suggested the division of CPS in districts so that better management of caseload could be obtained with less running about and looking for parking. For this reason utilisation of Health Centres which are scattered around the Island, could be considered for storage of equipment and might be also considered as a base for physiotherapists from where to work. One key person stated that ‘If you have different districts, it is logical for physiotherapists to have a place to leave their bag in the morning and pick it up in the evening’.

5.3.4 Accessibility and Autonomy

As stressed by P1 it is imperative that fast access to CPS is achieved otherwise it would loose its purpose. Physiotherapists taking part in the study have identified barriers to access to the present physiotherapy services and also delayed access to certain services such as ZCH from SLH.

Even though physiotherapists preferred that they should be the ones to refer older people for CPS, all other options were considered, including relatives and older people themselves. Also as suggested by key persons and by physiotherapists
by providing information, increasing the awareness and allowing direct access of General Practitioners to community services including CPS would facilitate access.

Physiotherapists were very concerned with the autonomy they should have when assessing and treating older people. This has been confirmed by a key person and also by literature (Partridge & Warren, 1977). All these sources state that while anyone can refer the older people for physiotherapy, it should be the physiotherapist following a thorough assessment that should decide the need for treatment, type, duration, frequency and when to stop treatment.

For this reason, both physiotherapists and key persons stressed the importance for operational guidelines and criteria on who should benefit from CPS. Furthermore these criteria could be used by managers to monitor both physiotherapists and the outcomes.

The concern that physiotherapists would be treating the wrong patients was also shared, as reported by Clark (1977), when introduction of CPS was considered in 1970 in West Berkshire, United Kingdom. In fact, at first opposition came down to the fact that physiotherapists would end up providing a long standing palliative treatment for chronic ailments. Following the implementation of CPS, it was clear that this was not the case.
5.3.5 Multidisciplinary Team

Both physiotherapists and key persons recognised the fact that physiotherapists cannot work alone especially in the community. Stone (1987) states that a multidisciplinary approach enables patients to be viewed from all aspects. As stated before in the literature review most CPS abroad are provided as part of a Community Rehabilitation Team and in fact most of the recent studies on community care include all the rehabilitation team not just physiotherapists.

With regards to a multi-disciplinary team approach, a key person stated that if the different professions work together 'they have to be under one manager' 'but it does not have to be Doctor led'.

5.3.6 The Impact on the Private Sector

Regarding the effect of a possible CPS on the private physiotherapy services, 45 (54.9%) physiotherapists agreed (n=35-42.7%) and strongly agreed (n=10-12.2%) that CPS will have a negative impact on the private sector. As stated by a physiotherapist 'Personal interests are causing conflicts in physiotherapy sector. Request for physiotherapy is high but the general feeling is that physiotherapists are reluctant to start this service because it affects their respective private practice'.

This could be so because the public sector as described by Von Brockdorf (1991), is not a competitive sector as it is free of charge and the only things that might induce individuals to turn to the private sector for services is because it is
more convenient in the time of delivery of service and the option of the physiotherapist going to the home of the patient.

The fact that most of the older people are unaware of the role of physiotherapists in rehabilitation also shows that there is a large group of people that while they may benefit from Physiotherapy Services are not using the service irrespective of who is providing it.

Therefore this group of people is still unexploited from both fields. Thus through ‘awareness and promotion of Physiotherapy services in the Community’ might indirectly increase the use of private physiotherapy services.

5.3.7 Categories of Older People

Partridge and Warren (1977) list the main presenting problems of patients using CPS as those suffering from pain, joint stiffness, abnormality of movement, problem of gait and walking, generalised immobility, respiratory problems and those having contractures. From these it can be noticed that specific conditions were not mentioned but the actual disability or limitation was. While some the older people taking part in the interview, did manifest some of these problems, it was not deemed possible to categorise patients requiring CPS either according to symptoms or condition.

Gleeson et al (1989), states that in deciding who should benefit from CPS, physiotherapists should keep in mind the needs of the patient in relation with the
environment and support available. As supported by literature, physiotherapists and key persons, it should be stated that CPS should not be supplied to all the older people requiring treatment. According to physiotherapists the three most eligible cases requiring CPS are when a journey to hospital can counter balance the benefit of treatment, when the acute nature of the condition is better treated at home and when the family needs advice on how to cope with older people and their problems.

5.3.8 Hospital Transport Facilities

Both the present Hospital Transport Services for patients and any transport modalities to be used by physiotherapists in CPS seem to be of concern. While 17 (30.9%) older people seem to find hospital transport satisfactory, physiotherapists do not share the same views. One comment by a physiotherapist states that ‘Government transport is not reliable. Physiotherapists are unable to give appointments and keep time.’

5.3.9 Who Should Provide Community Physiotherapy Service?

When asked who should provide CPS, physiotherapists gave first preference to two different forms of Services. Both an autonomous CPS section responsible only for the national delivery of Community Services and a CPS spread all over the Physiotherapy units each supplying independent services were selected. Key persons on the other hand agreed that it ‘would not be economical’ if there was more than one department doing the same thing. Also as stated by a key person, as
a percentage of older people suffer from multiple pathologies, it would be difficult to assign these people to one speciality of physiotherapy.

5.3.10 Characteristics of Community Physiotherapy Services

Different issues such as transport and hours worked were also considered in this study. Different modes of transport are mentioned to be used in literature varying from going by walk to using one’s own transport. While physiotherapists in SVPR use their own transport, 53 (64.6%) physiotherapists taking part in the study disagreed (n=27-32.9%) or strongly disagreed (n=26-31.7%) that they should do so. While concern about risks of accidents, traffic and parking problems were mentioned by physiotherapists, concerns about provision of fuel remuneration or allowances were also listed. In fact the choice of adequate transport measures were considered by physiotherapists to be important both during the implementation of CPS. Another option could be the use of transport supplied by the Organisation as supplied by MMDNA. Due to financial resource limitations, this option was not considered by any of the key persons.

67 (81.7%) physiotherapists agreed (n=43-52.4%) or strongly agreed (n=24-29.3%) that those working in CPS should work flexible hours to be able to accommodate older people and their needs. While 43 (78.2%) older people still prefer visits to be made in the morning, probably as they are used to hours of the present delivery of service, those that wanted their relatives who worked in the mornings to be present during treatment stated that they preferred CPS in the afternoon (n=3-5.5%) or in the evening (n=5-9.1%).
In the study older people were asked whether they would consider attending to the Out-Patients Department if so requested by their physiotherapists if they were initially receiving treatment at home. 54.5% (n=30) answered in the affirmative while 38.2% (n=21) could not answer this question.

5.4 Limitations of the Study

All limitations inherent in carrying out research in general, and in using a cross-sectional survey in particular, would apply to this study. These include possible faults in sampling, coding, tabulating, and data processing (Garson, 2002).

Sampling bias occurs when not all members of the population of interest have a calculable chance of being selected in the sample (Bowling, 2002). The fact that a lot of older people refused to take part in the study can be considered as a bias. On the other hand these people have shown similar characteristics as those of all the applicants of SVPR.

The fact that the tools utilised were constructed by the researcher and that multiple tools were used might also act as a bias and lead to misinterpretation of results. For this purpose a pilot study was carried out to limit such bias. Moreover, literature utilised for the design of these tools was quite extensive.

Another bias is the interviewer bias. To limit any influence on the person being interviewed the interviewer trained to appear and speak in neutral non-judgmental manner as suggested by Bowling (2002).
Recall bias relates to the respondents' selective memories in recalling past events, experiences and behaviour (Bowling, 2002). This could have been the case while interviewing older people.

Other limitations are those inherent in using Likert-type attitude questions and rank order questions. These include the difference between what people say and what they do, and the lack of reproducibility since the same total score may be obtained in many different ways (Oppenheim, 1992).

5.5 Recommendation for Further Research

This study explored perceptions of physiotherapists employed by the Ministry of Health, Elderly and Community Care (MHECC), older people who applied for SVPR and key persons also employed by the MHECC. With the availability of more time and resources, a more comprehensive study could have included all physiotherapists working in Malta and Gozo both in the public and private sector. Moreover the perceptions of older people presently benefiting from physiotherapy services and of those who have just applied or are considering applying for a residential home might also have been beneficial. Obtaining the views of other health professionals and key persons especially those working in the primary healthcare setting might help identify more problems within the community.

For this reason action research is more advisable for this type of study. The emphasis of action research is to promote development, raise awareness, empower and initiate collaborative investigation between trained researchers, professionals
and lay persons with the help of designated mediators (Bowling, 2002). The aim of action research is to achieve improvement by auditing processes and critically analysing events.

In this way the actual implementation of the service can be experienced and feedback from all involved parties given. Also advantages and disadvantages of the services together with improvements to be made can be objectively monitored.
CHAPTER 6 – CONCLUSIONS AND RECOMMENDATIONS

6.1 Conclusions

From the study it can be concluded that if there is a need for CPS, it is normative in nature, that is, it is only perceived by professionals and not by the older people themselves (Bowling, 2002).

Malta has always been in the forefront in care of the older people but not in the delivery of integrated health and community care services. The formation of the MHECC seemed to facilitate this integration but no pressure is being done by physiotherapists, the public and the media for such a service to be implemented.

6.1 Recommendation for Management

The current and projected increase in cost of care means that healthcare providers have to identify innovative methods of delivering care that reduce costs while maintaining health outcomes.

Whether a Community Physiotherapy Service (CPS) will be implemented or not, some changes seem to be required to prepare our Healthcare System for the drastic increase in older people in the coming decades. Both short term quick-fix solutions and long-term planning with no action are not the answer.

Moreover, the Physiotherapy Department will also be required to improve delivery of services through bridging of gaps in service provision, removal of
barriers to service use through promotion of physiotherapy services and development of adequate services according to needs.

If CPS is set up, financial costs will differ depending on the activities and changes required. These costs will depend on whether reorganising of existing staff and establishments is carried out and whether the increased demands on CPS and social services could be absorbed within the existing set up.

While skills, knowledge and a willingness to manage the change are important at the individual managerial level, it is the local political and health economy context that influence the collective engagement of physiotherapy in public health activities.

In Malta policy implementation decisions are shaped at a Government level by a range of power interests. Managers therefore have to seriously engage in the political arena. They need political support from those who can make financial decisions in the local health service. They also need allies and collaborators both within and outside their own discipline and organisation including older people and their families.

A number of findings both from the literature review and from the study can be used by different managers to improve present services and to project other services. The literature offers extensive information about CPS in other countries
and about its cost effectiveness. While models and needs of CPS in one country might not be applicable for Malta, still certain guidelines could be utilised.

The fact that a CPS has already been initiated in SVPR and to a smaller extent is being done in other departments in the form of home visits show the need for a formal service to be initiated.

Organisational change can bring about chaos, but with a positive cultural change and participation of physiotherapists in the setting up of a new service cannot be overemphasised. Physiotherapists have shown that they are highly knowledgeable about Community Services and willing to learn. This can be considered as an asset to the organisation.

As suggested by physiotherapists, proper planning of the CPS is necessary with setting up of operational guidelines both to be used by physiotherapists and by managers for monitoring and auditing purposes. Adequate recording systems should also be available to monitor the activities of physiotherapists especially if they work on flexible hours.

Also communication systems between different professionals should not be left to chance but should be facilitated beforehand together with promotion of the service to increase awareness about physiotherapy from older people and other professionals themselves.
Providing transport vehicles for physiotherapists can be very expensive but to provide a chauffer driven car also has its drawbacks. An alternative might be to hire cars from external sources or to provide mileage remuneration to cover for fuel, wear and tear and insurance coverage.
REFERENCES


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References


one year follow up of patient outcome, resources use and cost.  
Cerebrovascular Diseases, 12, 131-138.


APPENDIX I

Standards of Clinical Practice of the Association of Chartered Physiotherapists with a Special Interest in Elderly People

&

Districts of Malta
KEYPOINT 1: AUTONOMY
The patient's need to regain or maintain personal autonomy and to aim for increasing personal responsibility for recovery should be recognised.

KEYPOINT 2: EXAMINATION AND ASSESSMENT
There should be accurate examination, assessment and recording of each patient's physical state, taking into account individual psycho-social and environmental needs and followed by continued re-assessment and review.

KEYPOINT 3: GOAL SETTING
Agreed individual goals should be established with each patient and any carers. These should include timescales, be realistic, and be subject to on-going review, discussion and modification.

KEYPOINT 4: INTERVENTION
In responding to the strengths and needs of older people and their carers, physiotherapy interventions consist of a mix of giving advice, teaching and treatment. All involve evaluation and sharing skills in order to enable patients to recover or maintain maximum possible functional activity and comfort.

KEYPOINT 5: TEAM-WORKING/CONTINUING EDUCATION
Working closely together and sharing knowledge/skills with all those concerned with the patient's management and support is essential for intervention to be effective, efficient and 'patient-friendly'. This team approach should be applied to physiotherapy as well as multi-disciplinary teams.

KEYPOINT 6: WORKING WITH CARERS
The key role of carers in undertaking the crucial responsibility of supervising or assisting patients' activities of daily life must be acknowledged. It follows that carers should be consulted about and, if appropriate, involved in all aspects of physiotherapy intervention.
KEYPOINT 7: HEALTH EDUCATION

Realistic, supportive physiotherapy education strategies give older people and their carers the opportunity to help themselves to achieve optimal levels of health whether they are healthy, have reversible problems or permanent disability.

KEYPOINT 8: QUALITY ASSURANCE

Evaluation of intervention with individuals and specified groups of patients is necessary to determine whether it has been effective and efficient. This should be followed by corrective action if necessary.

KEYPOINT 9: ENVIRONMENT/HEALTH AND SAFETY

The physiotherapy service needs appropriate safe facilities which are accessible and welcoming. In addition to any specialised equipment, a wide range of safe basic items of equipment such as walking aids must be available for issue to patients. Liaison with any other departments or agencies which issue this equipment is an essential physiotherapy activity.
DISTRICTS OF MALTA

MT  REPUBLIC OF MALTA
MT0  REPUBLIC OF MALTA
MT01  MALTA Island
MT011  SOUTHERN HARBOUR DISTRICT

MT01101  VALETTA (CITTA UMILISSIMA)
MT01103  BIRGU (CITTA VITTORIOSA)
MT01104  ISLA (CITTA INVICTA)
MT01105  BORMLA (CITTA COSPICUA)
MT01108  ZABBAB
MT01117  FGURA
MT01118  FLORIANA
MT01129  KALKARA
MT01133  LUQA
MT01134  MARSA
MT01145  PAOLA
MT01157  SANTA LUCIJA
MT01162  TARXIEN
MT01165  XGHAJRA

MT012  NORTHERN HARBOUR DISTRICT

MT01206  QORMI
MT01214  BIKRKARA
MT01221  GZIRA
MT01227  HAMRUN
MT01241  MSIDA
MT01246  PEMBROKE
MT01247  PIETA
MT01252  SAN GILJAN
MT01253  SAN GWANN
MT01258  SANTA VENERA
MT01259  SLEMA
MT01260  SWIEQI
MT01261  TA’XBIEX

MT013  SOUTH EASTERN DISTRICT

MT01310  ZEJTUN
MT01315  BIRZELBUGA
MT01320  GUDJIA
MT01326  GHAXAQ
MT01331  KIRKOP
MT01335  MARSASKALA
MT01336  MARSAXLOKK
MT01340  MQABBA
MT01349  QRENDI
MT01351  SAFI
MT01367  ZURRIEQ
Appendix I

MT014 WESTERN DISTRICT

MT01402 MDINA
MT01407 ZEBBUG (MALTA)
MT01409 SIGGIEWI
MT01412 ATTARD
MT01413 BALZAN
MT01416 DINGLI
MT01428 IKLIN
MT01432 LIJA
MT01450 RABAT (MALTA)
MT01468 MTARFA

MT015 NORTHERN DISTRICT

MT01524 GHARGHUR
MT01537 MELLIEHA
MT01538 MGARR
MT01539 MOSTA
MT01544 NAXXAR
MT01555 SAN PAWL IL BAHAR

MT02 GOZO AND COMINO

MT026 GOZO AND COMINO

MT02611 RABAT (GOZO)
MT02619 FONTANA
MT02622 GHAJNSIELEM AND COMINO
MT02623 GHARB
MT02625 GHASRI
MT02630 KERCEM
MT02642 MUNXAR
MT02643 NADUR
MT02648 QALA
MT02654 SAN LAWRENZ
MT02656 SANNAT
MT02663 XAGHRA
MT02664 XEWKIJA
MT02666 ZEBBUG (GOZO)
APPENDIX II

Measuring Tools used in the Study
Intervista u eżami fiżiku ghall-anzjani

*L-ewwel Parti*

1. Ghalfejn hassejt il-bżonn li tapplika ghal dar residenzjali?

2. Qatt ibbenefikajt minn servizzi ta’ fiżjoterapija?
   - [ ] Iva
   - [ ] Le
   - [ ] Ma Nafx

3. Jekk Iva:
   - Meta, fejn, kemm il-darba u ghal kemm?

4. Inti sodisfatt/a bis-servizzi ta’ fiżjoterapija prezenti?
   - [ ] Iva
   - [ ] Le
   - [ ] Ma Nafx

5. Użajt it-trasport provdut mill-isptar biex tattendi ghall-appuntament?
   - [ ] Iva
   - [ ] Le
   - [ ] Ma Nafx

6. Inti sodisfatt/a bit-transport provdut meta tattendi l-‘out-patients’?
   - [ ] Iva
   - [ ] Le
   - [ ] Ma Nafx

7. Bhalissa qieghed/a tibbenefika minn xi servizzi ơhra?
   - [ ] Iva
   - [ ] Le
   - [ ] Ma Nafx

8. Jekk iva, speċifika:

9. Kieku kellek tibbenefika minn servizz ta’ fiżjoterapija fil-komunita x’hin tal-ġurnata tippreferi li jsir?
   - [ ] Fil-ghodu
   - [ ] Wara Nofsinar
   - [ ] Fil-ghaxija
   - [ ] Xorta
8. Kieku s-servizz ta’ fiżjoterapija kellu jiġi estiż għal wara t-tlieta ta’ fil-ghaxija, tikkonsidra tattendi fid-dipartiment ta’ l-‘out-patients’?

☐ Iva      ☐ Le      ☐ Ma Nafx

9. Kieku kellek tirċievi servizz ta’ fiżjoterapija fil-komunita u t-terapista tieghek tissuġerilek li tattendi għal xi sessjonijiet fl-‘out-patients’ tahseb li kont taċċetta?

☐ Iva      ☐ Le      ☐ Ma Nafx

10. Tahseb li servizz ta’ fiżjoterapija fil-komunita jista jghinek tibqa tghix għal iżjed żmien f’darhek?

☐ Iva      ☐ Le      ☐ Ma Nafx

- Ghalfejn?

11. Hemm xi haġa ohra li tista thajrek jew tghinek tibqa tghix għal iżjed żmien fil-komunita jew li terġa tikkonsidra id-deċizjoni li tapplika għal dar residenzjali?
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Interview & Mobility Assessment of the Older People

Part 1

1. Why did you feel the need to apply for long term care?

2. Have you ever received any physiotherapy service?
   - Yes
   - No
   - Do not know

3. If yes:
   - When, where, how many times and for how long?
   - Are you satisfied with the present services?
     - Yes
     - No
     - Do not know
   - Did you use own transport/supplied transport?
     - Yes
     - No
     - Do not know

4. Are you satisfied with the present transport services supplied when attending for physiotherapy out-patients?
   - Yes
   - No
   - Do not know

5. Do you presently benefit from any other service?
   - Yes
   - No
   - Do not know

6. If yes, Specify:
7. If you had to receive community physiotherapy, what time of day would you prefer?
   - Morning
   - Afternoon
   - Evening
   - Any

8. If the delivery time of the present physiotherapy service had to be extended to after three o'clock in the afternoon would you consider attending for outpatients?
   - Yes
   - No
   - Do not know

9. If you were receiving community physiotherapy and your therapist had to suggest some sessions at the out-patients department would you accept?
   - Yes
   - No
   - Do not know

10. Would a physiotherapy community service help you live for a longer period at home?
    - Yes
    - No
    - Do not know
    • Why

11. Is there any thing else that can help you live for a longer period in the community or reconsider your application for a residential home?
Part 2

Mobility Assessment to be carried and filled by researcher

Marking:
N/A: if column is not applicable
  1. independent
  2. verbal prompting
  3. minimum help required
  4. uses aids
  5. maximum help required

Wheelchair Management:
Manages:  Sides
          Brakes
          Leg-rests
          Foot-plates

Manoeuvres wheelchair:

Balance:

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<td>Unsupported</td>
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Bed Mobility:
Rolling:
Moving up in bed:
Sitting up in bed:
Getting into bed:
Sitting:
Sitting to standing: 
Turning to sit: 
Standing to sitting: 

Transfers:
Bed to chair: 
Chair to bed: 
Chair to toilet: 

Gait:
Ability to walk: 

Stair Management:
Ability to go up the stairs: 

**Type of aid used during:**  
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<td>Stick:</td>
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<td>Tripod/Quadripod:</td>
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<td>Walking-frame:</td>
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<td>Crutches:</td>
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Comments:
________________________________________
________________________________________
________________________________________
Part 3

Gender: Male □
Female □

Age last Birthday: __________

Status: __________

Living condition: Lives alone □
Lives with spouse □
Lives with siblings □
Lives with children □
Other □

Social Support: Partner □
Children □
Neighbours □
Other □

Locality: __________

Living premises layout: Number of floors __________
Stairs __________
Lift __________
Questionnaire for Physiotherapists

Do not write your name anywhere on the questionnaire.

Part 1

Kindly answer the following questions by placing a tick mark in the box next to the description that matches your answer.

Gender: Male □ Female □

Age: 21-30 □ 31-40 □ 41-50 □ 51-61 □

Years qualified: 2 years or less □ 3-5 years □ 6-10 years □ 11-15 years □ 15 years and over □
Part 2

Kindly answer the following questions by placing a tick mark in the box [✓] next to the description that matches your answer or as otherwise instructed.

1. Physiotherapy plays an important role in the rehabilitation of older people.

   [ ] Strongly Agree [ ] Agree [ ] Undecided [ ] Disagree [ ] Strongly Disagree

2. Due to the demographic shift in the population a dramatic increase in the number of older people resulted. Resources in terms of physiotherapy services should be targeting this group.

   [ ] Strongly Agree [ ] Agree [ ] Undecided [ ] Disagree [ ] Strongly Disagree

3. According to Andrew (1992) the Giants of Geriatrics can affect the quality of life. Physiotherapists play an important part in the treatment of:
   - Incontinence
     [ ] Strongly Agree [ ] Agree [ ] Undecided [ ] Disagree [ ] Strongly Disagree
   - Immobility
     [ ] Strongly Agree [ ] Agree [ ] Undecided [ ] Disagree [ ] Strongly Disagree
   - Intellectual Impairment
     [ ] Strongly Agree [ ] Agree [ ] Undecided [ ] Disagree [ ] Strongly Disagree
   - Instability
     [ ] Strongly Agree [ ] Agree [ ] Undecided [ ] Disagree [ ] Strongly Disagree
4. I have come in contact with individuals who would have benefited from community physiotherapy services should there have been one available

<table>
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<th>Strongly Agree</th>
<th>Agree</th>
<th>Undecided</th>
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<th>Strongly Disagree</th>
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5. For this reason I think there is a need for community physiotherapy services in Malta.

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<th>Strongly Disagree</th>
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6. If you agree, why do you think community physiotherapy is necessary?

(Rank factors from 1 onwards. Give 1 to the factor which you deem most necessary, 2 besides the next and so forth)

- It completes the physiotherapy services provided to the public.
- It may help facilitate early discharge from hospital.
- It may help prevent early institutionalisation.
- It creates new job opportunities for physiotherapists.

Other

7. Who do you think should be targeted when considering a community physiotherapy service?

(Rank factors from 1 onwards. Give 1 to who should be targeted most, 2 besides the next and so forth)

- All older people requiring out-patient physiotherapy.
- All older people who have mobility problems or are wheelchair bound.
- All older people requiring transport.
- When a journey to hospital can counter-balance the benefit of treatment.
- When a family needs advice on how to cope with elderly and their problems.
- When daily treatment is required.
- When acute nature of the condition is better treated at home.

Other
8. The present physiotherapy services are not satisfactory.

- Please justify your answer:

9. What would be the requirements for an efficient and effective community physiotherapy service?

10. Community physiotherapy services will have a negative impact on the current private physiotherapy services.
11. It would be interesting to work in a community physiotherapy service.

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<th>Agree</th>
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12. Physiotherapists working in a community service should:

- Be specialised.

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- Work flexible hours.

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- Use own transport.

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13. Community physiotherapy services should be:

*(Rank factors from 1 onwards. Give 1 to the service which you deem the best choice, 2 besides the next and so forth)*

- Provided only by St Luke’s Hospital Physiotherapy Department.
- Provided only by physiotherapists working at St Vincent De Paul Residence.
- Spread over all Departments/Units each supplying its own Community Service independently according to speciality.
- Provided by an autonomous Community Physiotherapy Section responsible only for the national delivery of community services.
- Provided by a Private Physiotherapy Organization through subcontracting.
- Other
14. Do you foresee any inconveniences associated with working outside hospital?

- Implementation of the service

- For you as a physiotherapist

- For the older people

15. Who in your opinion should refer older people for a community physiotherapy service?

(Rank factors from 1 onwards. Give 1 to your preferred choice, 2 besides the next and so forth)

☐ Physiotherapists.

☐ Consultants employed by the Ministry of Health, Elderly and Community Care.

☐ General Practitioners.

☐ Other Health Professionals.

☐ Other

Other Comments:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Thanks for your participation
Outline of Interview for Key Persons 1

1. As stated in the Annual Report 2004 of the Department of Institutional Health, Malta will be facing a major challenge in caring for the frail sick older people in the coming two decades. Do you think that we are ready for this challenge?

2. What is being done by your division to prepare for such an event?

3. Are the needs of the Maltese older people identified and are they being addressed sufficiently?

4. During the last years we have witnessed the expansion of St Vincent DePaul Residence and applications for the new Homes of the Elderly. Does this imply that Institutional Care is the solution or should the balance of care be shifted to the community?

5. Do you think that physiotherapists do or can contribute in the preservation of the older people’s independence and thus prolonging their stay in the community?

6. Presently Physiotherapy Services are concentrated more in the acute setting, i.e. in Hospitals. Is there a possibility of Physiotherapy Services being shifted and supplied from a community setting?
Outline of Interview for Key Persons 2

1. As stated in the Annual Report 2004 of the Department of Institutional Health, Malta will be facing a major challenge in caring for the frail sick older people in the coming two decades. Do you think that health service providers are ready for this challenge?

2. What is being done by your division to prepare for such an event?

3. Are the needs of the Maltese older people identified and are they being addressed sufficiently?

4. During the last years we have witnessed the expansion of St Vincent DePaul Residence and applications for new Homes of the Elderly. Does this imply that Institutional Care is the solution or should the balance of care be shifted to the community?

5. Do you think that physiotherapists do or can contribute in the preservation of the older people's independence and thus prolonging their stay in the community?

6. Presently Physiotherapy Services are concentrated more in the acute setting, i.e. in Hospitals. Is there a possibility of Physiotherapy Services being shifted and supplied from a community setting? Are there enough human resources available?

7. Should improvement of present physiotherapy and other related health services be carried out before any new service is developed?

8. In the case of such service provision, should an autonomous Community Physiotherapy section be responsible for the national delivery of community services or should it be spread over all Departments/Units each supplying its own community service independently? Why?

9. From a questionnaire distributed to physiotherapists employed by the Ministry of Health, Elderly and Community Care, most physiotherapists pointed out that, following a thorough assessment, they should decide who is to benefit from community services irrespective of who refers older people for treatment. Do you agree?

10. With the implementation/delivery of Community Physiotherapy Services new problems such as means of transportation, insurance, legal and ethical issues and access to equipment could crop up. Comment.
MINISTERU
GHALL-POLITIKA SOĊJALI
(Dipartiment tas-Sigurtà Soċjali)

Numru tal-Każ: ..............................................

TALBA GHAD-DHUL FIR-RESIDENZA SAN VINĊENZ DE PAULE
1. ĖWWEL PARTI (timtela mill-Welfare Officer)

A. Dettalji dwar l-Aplikant
1. Isem l-Aplikant ........................................................................................................
2. F'każ fejn l-Aplikant tkun mara, kunjom xbubitha .............................................
3. Indirizz ....................................................................................................................
4. Numru tat-Telefon .................................................................................................
5. Stat: * ĠUVNI / XEBBA
       MIŻŻEWWEĠ / MIŻŻEWĠA
       ARMEL / ARMLA
       SEPARAT / SEPARATA

(* aghmel ċirku madwar il-twegiba t-tajba)
6. Data tat-Twelid .................................................................
7. Post tat-Twelid ........................................................................................................
8. Numru tal-Karta ta' l-Identità ..............................................................................

B. Dettalji dwar il-Familja ta' l-Aplikant
1. Isem u kunjom missier l-Aplikant ........................................................................
2. Isem omm l-Aplikant u kunjom xbubitha .............................................................
3. F'każ fejn l-Aplikant ikun raġel miżżewweġ, isem martu u kunjom xbubitha ....
4. F'każ il l-Aplikant tkun mara miżżewġa, isem żewġha ...........................................
5. Isem u kunjom ta' l-egreb membru tal-familja jew ta' l-aġent ta' l-Aplikant ...
6. L-Indirizz u n-numru tat-Telefon ta' dan il-membru tal-familja/aġent .........
7. F'każ li jkun membru tal-familja, kif jigi mill-Aplikant ......................................
C. Dettalji dwar dhul minn Pensjonijiet jew skemmi ohra taht l-Att tas-Sigurtà Soċjali

1. Numru tal-pensjoni (inkludi l-ammont li jirċievi l-Applikant)

2. Tip ta' benefiċċji ohra li jirċievi l-Applikant minbarra l-pensjoni

3. Fejn l-Applikant mhuwiex qiegħed jirċievi xejn taht l-Att tas-Sigurtà Soċjali, agħti n-numru tas-Sigurtà Soċjali

D. Dikjarazzjoni ta' min jaghmel it-Talba

Niddikjara li d-dettalji moghtija minni f'din l-Applikazzjoni ġew moqrija lilli u huma kollha minnhom.

.................................................................................................................................

Firma ta' l-Applikant

(F'każ fejn it-Talba ma ssirx mill-Applikant)

.................................................................................................................................

Firma ta' l-Applikant

Iserm u Kunjom id-Dikjarant

Indirizz

Numru tal-Karta ta' l-Identità

Kif jiġi mill-Applikant

.................................................................................................................................

Iddikjarat quddiem, fl-Uffiċju Distrettwali tad-Dipartiment tas-Sigurtà Soċjali ta'

........................................... ...........................................

Data Firma tal-Welfare Officer

NOTA: L-Applikant huwa mitlub lilli jibghor kopja taċ-ċertifikat tat-twelid, u fejn japplika, kopja taċ-ċertifikat taż-Zwieġ.
MINISTRY FOR SOCIAL POLICY
Office of the Parliamentary Secretary for the Care of the Elderly

Cae Number: ............

TQALBA GHAD-DHUL FIR-RESIDENZA SAN VENCENZ DE PAULE

Request for Admission to St Vincent de Paule Residence

IT-TIENI PARTI (timtela mit-Tabib)

PART WO (to be completed by a Medical Doctor)

TICK THE CORRECT ANSWERS, example ✓

1. Applicants’ Personal Data

1.1 Applicant’s Name ...........................................................................................................

1.2 Address .......................................................................................................................

1.3 Identity Card Number ....................... 1.4 Telephone Number .................................

2. Details about the Application

2.1 Is this the first Application? – YES ☐ – NO ☐

2.2 If the answer to question 2.1 is NO, give the Date and Reference Number of the first application ....

2.3 This Application is for: – PERMANENT ADMISSION ☐ – TEMPORARY ADMISSION ☐

2.4 If the Application is for Temporary Admission, indicate:

2.4.1 The required dates: FROM .................................................. TO .......................................

2.4.2 The reasons for such a request

3. Medical History and Diagnosis

4. Drug Treatment

5. Communication Abilities:

<table>
<thead>
<tr>
<th></th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1 Hearing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.2 Speech</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.3 Vision</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
6. Mental State

6.1 Orientated
(Time, Place and Person)  
- ALWAYS  
- OCCASIONALLY  
- RARELY/NEVER

6.2 Memory  
- WELL PRESERVED  
- IMPAIRED  
- POOR

6.3 Hallucinations/Delusions

6.4 Paranoid Ideas

6.5 Behavioural State:  
- NORMAL  
- APATHETIC  
- AGITATED  
- AGGRESSIVE

7. Activities of Daily Living

<table>
<thead>
<tr>
<th>Activity</th>
<th>Independent no assistance needed</th>
<th>Performs the activity with assistance</th>
<th>Unable to do the activity him/herself</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.1 Eating</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.2 Dressing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.3 Bathing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.4 Housekeeping</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.5 Meal preparation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.6 Shopping</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7.7 Mobility:  
7.7.1 WALKS LONG DISTANCES UNAIDED  
7.7.2 WALKS SHORT DISTANCES UNAIDED  
7.7.3 WALKS WITH A WALKING AID  
7.7.4 WALKS WITH PHYSICAL ASSISTANCE  
7.7.5 GETS IN AND OUT OF BED WITHOUT HELP  
7.7.6 GETS IN AND OUT OF BED WITH HELP  
7.7.7 WHEELCHAIR/ARMCHAIR BOUND  
7.7.8 BEDRIDDEN

7.8 Continency:  
7.8.1 GOES TO THE TOILET  
7.8.2 USES A BED-SIDE COMMODE/BED-PAN  
7.8.3 HAS A URINARY CATHETER/PENILE SHEATH  
7.8.4 INCONTINENT/OCCASIONALLY INCONTINENT OF URINE  
7.8.5 INCONTINENT/OCCASIONALLY INCONTINENT OF FAECES
8. Need for Nursing Care

8.1 MINIMAL/SIMPLE CUSTODIAL CARE
8.2 DRUG ADMINISTRATION
8.3 CARE FOR PERSONAL HYGIENE
8.4 FEEDING
8.5 SIN CARE (e.g. pressure areas)
8.6 BLADDER/BOWEL CARE

9. Social State

9.1 Lives alone:  – ALWAYS  NEVER
                 – OCCASIONALLY

9.2 If the Applicant lives ALWAYS or OCCASIONALLY alone, give the following details:

9.2.1 Sleeps alone  – ALWAYS
                     – OCCASIONALLY
                     – NEVER

9.2.2 Received visit:  – LESS THAN ONE VISIT PER WEEK
                        – DAILY/FREQUENT VISITS

9.3 Who are the Carers?  – RELATIVES
                         – FRIENDS/NEIGHBOURS
                         – COMMUNITY/Hired HELP
                         – NO CARERS

10. Reasons Why the Applicant is Unable to Continue Living in the Community

10.1 DETERIORATION OF PHYSICAL/MENTAL CONDITION
10.2 FELLING LONELY
10.3 RECENTLY BEREAVED
10.4 DOES NOT WANT TO BE A BURDEN ON OTHERS
10.5 UNABLE TO COPE ALONE
10.6 CARERS CANNOT COPE
10.7 HOUSE UNSUITABLE TO MEET THE APPLICANT'S NEEDS
10.8 HOUSE IN POOR CONDITION
10.9 HOMELESS

Other remarks ...........................................................................................................
11. If the Applicant is presently hospitalised, state:

Where ..........................................................  Ward ...........................................  Consultant ..............................................

Date: ......................................................................................................................

DOCTOR'S SIGNATURE

Name in BLOCK LETTERS ................................................................. Telephone Number ...
Address ..............................................................................................................
SOCIAL WORKER REPORT

HOME VISIT/OUT-PATIENT ASSESSMENT

STATE OF DEPENDENCY:  
- INDEPENDENT □
- SEMI DEPENDENT □
- DEPENDENT □
- BED RIDDEN □

URGENCY FOR ADMISSION:

DATE OF ADMISSION: .............................................

OTHER REMARKS
APPENDIX III

Consent Letters & Letters to Participants
Appendix

Formula ta' Kunsens

Jiena hawn that iffirma/t/a, b’karta ta’ l-identità numru u li noghod

qieghed/qieghda niehu sehem fi studju li qed taghmel Ms. Sharon Young bl-isem Analizi tal-bonn ta’ servizzi ta’ fizoterapija ghall-anzjani fil-komunità. L-Għan u d-dettalji ta’ l-istudju spjeghomli l-istess Sharon Young li wkoll iċċaratli xi misťoqsijiet li ghamilt. Ġhal dan il-għan niddikjara illi jiena cittadin/a Maltija u li għalaqt tmintax (18) –il sena. Nifhem illi r-riżultati ta’ dan l-istudju jistgħu jintużaw għal skopijiet xjentifiċi u jista jiġi ppublikat rapport bil-miktub; jekk isir hekk b’ebda mod ma nista nkun identifikatha, individwalment jew bhalà parti minn grupp, mingħajr il-kunsens tieghi bil-miktub skond l-Att dwar il-Protezzjoni u l-Privatezza tad-Data (Kap. 440 li gie fis-sehh fit-22 ta’ Marzu, 2002).

Nifhem ukoll li ma għandi l-ebda dmir li niehu sehom f’dan l-istudju u dan qed nagħmlu minn rajja u b’mod volontarju. Jien nista, meta rrid, ma nkomplix niehu sehem fl-istudju, u mingħajr ma nagħti raġuni.

Jiena mhux qed nithallas sabiex niehu sehem f’dan l-istudju.

Firma tal-partecipant/a __________________________

Isem tal-partecipant/a __________________________ (b’ittri kbar)
Consent Letter

I ________________ the undersigned, bearing identity number ________________ and residing at ------------------------------------ am taking part in a study carried out by Ms. Sharon Young named A Needs assessment of Community Physiotherapy Services for the elderly. The purpose and details of the study were explained to me by Ms Young and any questions answered. I understand that the results of the study may be used for scientific purposes and that the results achieved from this study in which I am participating may be reported or published; however, I shall not be personally identified in any way, either individually or collectively, without my express written permission according to the Data Protection Act (Act 440 dated 22nd March, 2002).

I understand also, that I am under no obligation to participate in this study and am doing so voluntarily. I may withdraw from the study at any time, without giving any reason.

I am not receiving any remuneration for participating in this study.

Signature of participant ________________

Name of participant ________________ (block letters)
Letter of Participation for Physiotherapists

Dear Colleague

I am currently carrying out a research project which aims to investigate the need for physiotherapy community services for older people. The study is being carried out under the auspices of the Institute of Health Care, University of Malta.

The questionnaire is being addressed to all physiotherapists working with the Ministry of Health, Elderly and Community Care, and aims to obtain the perceptions of physiotherapists regarding the need of community physiotherapy service for older people. As you can appreciate, the project depends entirely on your participation. The questionnaire takes about 15 minutes to complete and is completely anonymous.

Should you encounter any problems with your answers, please contact your Superior, who will pass on your queries to me without revealing your identity.

If you don’t mind discussing your queries with me, you may contact me at the Physiotherapy Department, St Luke’s Hospital at 25951351/2.

Kindly place your replies in the envelope provided and hand to your respective Superior by not later than ________________.

I appeal for your help and assistance. I am sure that you understand that the results of this study will shed important light on the perception of physiotherapists regarding the need of community physiotherapy services for the older people.

Thanking you for your assistance,

Yours Sincerely,

Sharon Young
Ittra ta' parteċipazzjoni għall-fiżjoterapisti

Għażiż/a kollega

Attwalment qiegħda nahdem fuq proġett ta' riċerka, illi l-ghan principali tiegħu huwa li jinvestiga l-bżonn ta' servizzi ta’ fiżjoterapija għall-anzjani fil-komunità.


Jekk tiltaqa’ ma xi problema waqt li tkun qed timla’ l-kwestjonarju nforma lis-Superjur/a tieghek; il-problema tieghek tiġi mghoddija lili mingħajr ma tiġi żvelata l-identità tieghek.

Jekk inti ma tiddejjaqx titkellem direttament mieghi, allura nistiednek iċċempilli d-Dipartiment tal-Fiżjoterapija ta’ l-Isptar San Luqa fuq in-numru 25951351/2

Jekk jogħġbok, poġġi t-twegibiet tieghek ġo envelop apposta li għandek issib fil-pakkett u ghaddieh lis-Superjur/a tieghek mhux iktar tard minn ____________.

Nitlob l-ghajnuna u l-assistenza tieghek. Ċerta illi inti tifhem li r-rizultat ta’ dan il-proġett jagħtina haľna aktar informazzjoni dwar il-perċezzjonijiet tal-fiżjoterapisti fuq il-bżonn ta’ servizzi ta’ fiżjoterapija għall-anzjani fil-komunità.

Grazzi ta’ l-assistenza tieghek

Dejjem tieghek

[Signature]

Sharon Young
Letter of Participation for the Older People

Date:

Dear ____________,

I am a student reading for a Masters Degree in Health Services Management at the Institute of Health Care, University of Malta. I am currently conducting a research project entitled 'A Needs Assessment of Community Physiotherapy Services for the Elderly'.

Being an applicant awaiting admission to St Vincent de Paul Residence you have been selected to participate in the study. The study is purely academic and is not being conducted in the name of St Vincent de Paul Residence nor will it have any effect on your application.

The interview will consist of answering a set of questions regarding the need for physiotherapy service in the community for older people, together with a mobility assessment.

If you choose to participate, your name will be kept strictly confidential and will be known only to myself. You will be free to refuse to answer any of the questions. I also assure you that if the study is published no reference will be made to your identity.

Please find attached a formal consent form, which you are required to sign, if you decide to participate in the study.

Yours faithfully

[Signature]

Sharon Young.
Appendix III

Ittra ta’ parteċipazzjoni ghall-anzjani

Data:

Għażiża___________.


Permezz ta’ din l-itra nixtieq nitolbok il-permess sabiex inkun nista’ nintervistak. Din l-intervista hi maqsuma f’żewġ partijiet. L-ewwel parti tinkludi għadd ta’ mistoqsijiet marbuta mal-bżonn ta’ servizzi ta’ fisjoterapija ghall-anzjani fil-komunità, u t-tieni parti se tikkonsisti minn eżami ta’ mobilita.


Grazzi ta’ l-ghajnuna siewja tieghek.

Għoddni Dejjem Tieghek

Sharon Young.

194
Letter to participation for key persons

Dear Sir/Madame,

I am currently carrying out a research project which aims to investigate the need for community physiotherapy services for the older people. The study is being carried out under the auspices of the Institute of Health Care, University of Malta.

For this purpose I would like to ask permission to carry out an interview with your good self. The interview is being addressed to all persons in an administrative position who may play an important role in the implementation or otherwise of community physiotherapy services for the older people. As you can appreciate, the project depends entirely on your participation. The interview which will be tape recorded, will take about 30 minutes.

Please note also that individual protection and confidentiality in relation to privacy and protection from manipulation by research will be established during and after interview. Transcriptions will be coded for the purpose of anonymity and used only for the purpose of the study.

Noteworthy also that participation will be on a strictly voluntary basis. If you agree to these conditions, you still will be free to refuse to continue all or part of the interview.

Thanking you for your assistance,

Yours sincerely,

Sharon Young
APPENDIX IV

Results of Rank Order Questions
Used in Physiotherapy Questionnaire
### Table 20: Question 6 - Need for Community Physiotherapy Services

<table>
<thead>
<tr>
<th>If you agree that there is a need for CPS, why do you think it is necessary?</th>
<th>Mean Rank Score</th>
<th>Preference</th>
</tr>
</thead>
<tbody>
<tr>
<td>It may help prevent early institutionalisation</td>
<td>4.12</td>
<td>1</td>
</tr>
<tr>
<td>It may help facilitate early discharge from hospital</td>
<td>3.88</td>
<td>2</td>
</tr>
<tr>
<td>It completes the physiotherapy services provided to the public</td>
<td>2.70</td>
<td>3</td>
</tr>
<tr>
<td>It creates new job opportunities for physiotherapists</td>
<td>2.30</td>
<td>4</td>
</tr>
<tr>
<td>Other</td>
<td>0.43</td>
<td>5</td>
</tr>
</tbody>
</table>

### Table 21: Question 7 – Target Population for Community Physiotherapy Services

<table>
<thead>
<tr>
<th>Who should be targeted when considering CPS?</th>
<th>Mean Rank Score</th>
<th>Preference</th>
</tr>
</thead>
<tbody>
<tr>
<td>When a journey to the hospital can counter-balance the benefit of treatment</td>
<td>6.30</td>
<td>1</td>
</tr>
<tr>
<td>When acute nature of the condition is better treated at home</td>
<td>6.13</td>
<td>2</td>
</tr>
<tr>
<td>When a family needs advice on how to cope with elderly and their problems</td>
<td>5.57</td>
<td>3</td>
</tr>
<tr>
<td>All older people who have mobility problems or are wheelchair bound</td>
<td>4.52</td>
<td>4</td>
</tr>
<tr>
<td>When daily treatment is required</td>
<td>3.80</td>
<td>5</td>
</tr>
<tr>
<td>All older people requiring transport</td>
<td>3.26</td>
<td>6</td>
</tr>
<tr>
<td>All older people requiring out-patient physiotherapy</td>
<td>2.19</td>
<td>7</td>
</tr>
<tr>
<td>Other</td>
<td>0.35</td>
<td>8</td>
</tr>
</tbody>
</table>

### Table 22: Question 13 – Community Physiotherapy Providers

<table>
<thead>
<tr>
<th>CPS should be:</th>
<th>Mean Rank Score</th>
<th>Preference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spread all over Departments/Units each supplying its own CPS independently according to speciality</td>
<td>4.38</td>
<td>1</td>
</tr>
<tr>
<td>Provided by an autonomous Community Physiotherapy Section responsible only for the national delivery of CPS</td>
<td>4.38</td>
<td>1</td>
</tr>
<tr>
<td>Provided by a Private Physiotherapy Organisation through subcontracting</td>
<td>2.99</td>
<td>2</td>
</tr>
<tr>
<td>Provided only by physiotherapists working at SVPR</td>
<td>2.7</td>
<td>3</td>
</tr>
<tr>
<td>Provided only by SLH Physiotherapy Department</td>
<td>2.21</td>
<td>4</td>
</tr>
<tr>
<td>Other</td>
<td>0.04</td>
<td>5</td>
</tr>
</tbody>
</table>
## Table 23: Who should refer Older People for Community Physiotherapy Services?

<table>
<thead>
<tr>
<th>Who should refer older people for CPS?</th>
<th>Rank</th>
<th>Mean score</th>
<th>Preference</th>
</tr>
</thead>
<tbody>
<tr>
<td>It may help prevent early institutionalisation</td>
<td>4.02</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>It may help facilitate early discharge from hospital</td>
<td>3.05</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>It completes the physiotherapy services provided to the public</td>
<td>2.73</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>It creates new job opportunities for physiotherapists</td>
<td>1.89</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>0.5</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX V

Approval Letters by the Relevant Authorities
Dear student,

Please refer to your application submitted to the Research Ethics Committee in connection with your undergraduate dissertation entitled:

**A NEEDS ASSESSMENT OF COMMUNITY PHYSIOTHERAPY SERVICES FOR THE ELDERLY**

At the last meeting of the Research Ethics Committee held on 12th October, 2004, members reviewed and approved the above-mentioned Protocol.

You are kindly requested to submit to the Research Ethics Committee a brief report on completion of your research.

Yours sincerely,

[Signature]

Professor V. Ferrito
Chairman
Research Ethics Committee
Institute of Health Care

cc: Mr Michael Bezzina, Supervisor
Data Protection

SHARON YOUNG
ST. RAPHAEL
TRIQ IZ-ZUGRAGA
B'KARA BKR09
4th November 2004

Ms Sharon Young
192/1 Drie Hoek
Triq il-Karmnu
B‘Kara

I would like to inform you that I have no objection for you to conduct your studies within St Vincent de Paul Residence and have access to data from the Medical Records Section. Please ensure that strict confidentiality is maintained at all times.

Please contact Ms Valerie Briffa Tel No 21227211 or send e-mail on valerie.briffa@gov.mt once you know the dates of your visit so that the necessary arrangements could be made.

Furthermore, once your study is finalised, I would like you to send us a copy so that we can include it in our library.

Wishing you every success in your studies.

Dr Ronald Fiorentino M.D Dip. Ger
Medical Superintendent
Appendix V

Sharon Young
192/1 Drie Hoek
Triq il-Karmnu
B'Kara
23rd August, 2004

Mr M Bezzina
Director of Elderly & Community Care

Re: Permission to Undertake Research Study

I am currently reading for a Masters Degree in Health Services Management with the Institute of Health Care, University of Malta. For my dissertation I shall be conducting a needs assessment of community physiotherapy services for the elderly. For this purpose I request permission to be able to undertake this study.

Please note also that individual protection and confidentiality in relation to privacy and protection from manipulation by research will be established during and after interviews and questionnaires. Transcriptions will be coded and used only for the purpose of the study.

Noteworthy also that participation will be on a strictly voluntary basis. If participants agree to these conditions, they will be asked to sign a printed consent form before being given the questionnaire to fill in.

A timely response would be truly appreciated.

Yours Sincerely

Sharon Young

[Signature]

Approved:

[Signature]

Director

Elderly & Community Care
Appendix V

Sharon Young
192/1 Drie Hoek
Triq il-Karmnu
B’Kara
23rd August, 2004

Ms M Muscat
Manager Physiotherapy Services
St Luke’s Hospital

Re: Permission to Undertake Research Study

I am currently reading for a Masters in Health Services Management with the Institute of Health Care, University of Malta. For my dissertation I shall be conducting a needs assessment of community physiotherapy services for the elderly. For this purpose I request permission to be able to undertake this study.

The study will consist of an interview of elderly persons in the community, an interview with key persons who may be important in the implementation or otherwise of community physiotherapy services and a questionnaire which will be distributed to all physiotherapists employed with the Ministry of Health, Elderly & Community care. For this purpose I require the list of all physiotherapists. I will use this data solely for sampling purposes.

Please note also that during the study, individual protection and confidentiality in relation to privacy and protection from manipulation by research will be established during and after interviews and questionnaires. Transcriptions will be coded and used only for the purpose of the study.

Noteworthy also that participation will be on a strictly voluntary basis. If participants agree to these conditions, they will be asked to sign a printed consent form before being given the questionnaire to fill in.

A timely response would be truly appreciated.

Yours Sincerely

Sharon Young
Appendix V

Sharon Young
192/1 Drie Hoek
Triq il-Karmnu
B’Kara
23rd August, 2004

Ms ML Grech
Principal Physiotherapist
St Vincent de Paul Residence
Luqa

Re: Permission to Undertake Research Study

Dear Madam,

I am currently reading for a Masters in Health Services Management at the Institute of Health Care, University of Malta. For my dissertation I shall be conducting a needs assessment of community physiotherapy services for the elderly. For this purpose I am asking permission to incorporate a part of the assessment form utilised by St Vincent de Paul Physiotherapy Department, in an interview for the elderly. The assessment will be used solely for the fulfilment of the study.

Please note also that individual protection and confidentiality in relation to privacy and protection from manipulation by research will be established during and after interview. Transcriptions will be coded and used only for the purpose of the study.

Noteworthy also that participation will be on a strictly voluntary basis. If participants agree to these conditions, they still will be free to refuse to continue all or part of the interview.

A timely response would be truly appreciated.

Yours sincerely

Sharon Young
Sharon Young  
192/1 Drie Hoek  
Triq il-Karmnu  
B'Kara  
23rd August, 2004

Mr Frank Bartolo  
Medical Superintendent  
St Luke's Hospital

Re: Permission to Undertake Research Study

I am currently reading for a Masters in Health Services Management with the Institute of Health Care, University of Malta. For my dissertation I shall be conducting a needs assessment of community physiotherapy services for the elderly. For this purpose I request permission to be able to undertake this study.

Please note also that individual protection and confidentiality in relation to privacy and protection from manipulation by research will be established during and after interviews and questionnaires. Transcriptions will be coded and used only for the purpose of the study.

Noteworthy also that participation will be on a strictly voluntary basis. If participants agree to these conditions, they will be asked to sign a printed consent form before being given the questionnaire to fill in.

A timely response would be truly appreciated.

Yours Sincerely

Sharon Young
To: Mr Tonna  
I/c Leaves Section

Thru': Dr F Bartolo  
Medical Superintendent  
St Luke's Hospital

Re: Permission to Undertake Research Study

Dear Sir,

I am currently reading for a Masters in Health Services Management at the Institute of Health Care of the University of Malta. For my dissertation I shall be conducting a needs assessment of community physiotherapy services for the elderly. For this purpose I require all the names of physiotherapists employed with the Department of Health, together with details of their place of work. I will use this data solely for sampling purposes.

A timely response would be truly appreciated.

Yours sincerely

Sharon Young