Formatting a Population Study at St. Vincent de Paule Residence

In April of 1993 a study was carried out at St. Vincent de Paule Complex to statistically update the current situation of the elderly in this residence. The exercise was undertaken following a parliamentary question that sought to ascertain the number of dependent clients in this residence.

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Although the parliamentary question was directed solely towards ascertaining the number of dependent clients in the Complex, the survey compiled was more comprehensive. It included the collection of data concerning the number of residents who had a physical potential to improve further from their present state of physical health and to gain more insight of their level of activity. Before the format of the survey was drawn up, various discussions between the professionals involved were held to identify the most significant areas of assessment which would yield the most objective and significant results.

The collection of the data was carried out over a period of three days. Considering that over 1000 clients had to be evaluated, the exercise was quite intensive and hectic. The assessing team was made up of the doctor, nurse, occupational therapist and physiotherapist responsible for that particular ward.

The format of the survey was kept as simple as possible to facilitate the analysis of the data collected. Apart from the clients' particulars, the assessment sheet included the:

(1) Level of dependency
(2) Physical potential
(3) Level of activity.

Following is an illustration of the assessment sheet.

ASSESSMENT SHEET

Ward: _____ Date: _____ Page: _____

Name and Surname	Sex M/F	Age on 19.4.93	Ind.	S.D.	Dep.	B.R.	Physical Potential to Improve. Yes/No	Level of activity. No. Code	Remarks
1.									
2.									
3.									

Evaluation Criteria

(1) Level of dependency: Four categories of dependency states were identified, i.e. independent, semi dependent, dependent and bedridden. To categorise each client in this area, five functional aspects were considered- mobility, continence, transfer to/from bed, intellect and activities of daily living. (Table 1)

TABLE 1

Guidelines on state of dependancy

	Mobility	Continence	Transfer to/from bed	Intellect	A.D.L.'s
Independent	A stable gait without physical help. (Absolute Minimum) N.B. May utilise the help of a stick/tripod/ frame.	Continent and goes to the toilet. (Absolute Minimum)	Transfers Unaided. (Absolute Minimum)	Not confused. N.B. A mild confusional state not effecting an independent daily ward routine is not failing. (Absolute Minimum)	Eats and dresses unaided. (Absolute Minimum) N.B. May require weekly bathing supervision. May utilise special equipment for independent eating/dressing.
Semi Dependent	Mobile with physical help. May utilise a walking aide or be mobile on a wheelchair. (Absolute Minimun)	Continent or Incontinent.	Transfers with some help. (Absolute Minimum)	May be normal or confused but not requiring an increased level of supervision. (Absolute Minimum)	Eats unaided. N.B. May utilise special cutlery aides. (Absolute Minimum)
Dependent	Mobilised out of bed. (Absolute Minimum)	Incontinent.	Transfers with a lot of help. Not bedridden. (Absolute Minimum)	Normal or confused, including cases who require an increased level of supervision.	Dependent.
Bedridden	Bedridden.	Continent or Incontinent.	Bedridden.	Normal or confused, including cases who require an increased level of supervision.	Usually dependent.

(2) Potential to improve: No specific guidelines were chosen for this area. It was left up to the discretion of the assessors to decide upon the client's potential for rehabilitation.

(3) Level of activity: The criteria for this section were coded in a descending order:
5 being the most active clients going out of the residence regularly:
4 being mainly hospital bound but involved in various activities (e.g. at the O.T. department, hairdressing salon, Mass etc.);
3 refers to activities at ward level only (e.g. helps on ward, follows hobbies on the ward);
2 includes clients who are socially active on the ward only; and
1 the lowest level for those people who are mainly inactive and do not involve self in any activity or social interaction.

Statistics

Tables 2, 3 and 4 show the statistics emerging from the survey.

TABLE 2 Breakdown of the population according to sex.

Males	-	332 residents	(32.9%)
Females	-	677 residents	(67.1%)
Total	-	1009 residents	(100%)

TABLE 3 State of dependency (see Table 1) according to sex.

	Males	Females	Total
Independent	116 (34.9%)	252 (37.2%)	368 (36.5%)
Semi dependent	129 (38.9%)	166 (24.5%)	295 (29.2%)
Dependent	51 (15.4%)	117 (17.3%)	168 (16.7%)
Bedridden	36 (10.8%)	142 (21.0%)	179 (17.6%)
	332 (100%)	677 (100%)	1009 (100%)

TABLE 4 Breakdown of the level of activity of residents according to sex.

Level of activity	Males	Females	Total
5	75 (22.6%)	75 (11.1%)	150
4	43 (12.9%)	112 (16.5%)	155
3	86 (25.9%)	94 (13.9%)	180
2	58 (17.5%)	222 (32.8%)	280
1	70 (21.1%)	174 (25.7%)	244
	332 (110%)	677 (100%)	1009 (100%)

Inferences derived from study

Comparing these statistics to a previous study held in 1985, it was concluded that the percentage of residents less than 60 years of age has diminished from 15% to 8.9%. This can be taken to comply that this residence has reinforced its identity as a geriatric service.

It is evident from the state of dependency data that clients residing at St. Vincent de Paule can be approximately equally divided into three categories (dependent and bedridden being considered as one category), with the greatest proportion (36.5%) being the independent status.

When considering that one third of the clients are independent, it is very alarming to discover that nearly 50% of the population at St. Vincent de Paule exhibits the lowest two levels of activity implying disseminated apathy and social isolation. Several trials were made to involve clients in group activities at ward level but response was poor despite the input.

Although other statistical comparisons were carried out, only those pertinent to Occupational Therapy are utilised in this article. Data could have been more significant if it had been correlated with previous studies of the residence, but this was not always possible as the criteria used were different.

Conclusion

Referring to St. Vincent de Paule as a residence is to a certain extent a misnomer, as a good proportion of the clients have notable medical conditions that merit acute intervention. As a consequence the complex requires more financial backing to continue its service.

The study highlighted the fact that the present number of staff is inadequate to cope with the needs of the residents. Proper deployment is a very important issue to provide the best possible service by the skeleton staff available. The need for complimentary staff in the form of nursing and paramedical assistants was also stressed. Such personnel will be able to relieve the professional staff by carrying out routine duties whilst allowing the professionals to concentrate on the more acute problems.

The result of the level of activity have far reaching implications about the quality of life encountered within the residence. Although this marked inactivity could correlate with such factors as dependency, general level of physical function or possibly strictly cultural factors, it could also indicate that there is inadequate opportunity for the residents to enjoy recreation and social interaction. This situation could easily be improved by a general change in the attitude of the staff and the public. Clients should be treated as individuals and allowed a certain degree of decision making and autonomy.