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SOCIOLOGY | CRITICAL ESSAY

Models for community based day care for older people: A narrative review

Caroline Bulsara^{1*}, Christopher Etherton-Beer² and Rosemary Saunders³

Abstract: *Objectives:* Older Australians are choosing to live within the community and there are a number of initiatives to enable this sector of the population to do so for longer. In an effort to ensure that they remain both physically and psychologically engaged, one initiative has been to provide community based day care (CBDC). *Method:* A narrative review was undertaken through searching MEDLINE, CINAHL Plus, Scopus and AgeInfo using keywords related to facility related, target group related and purpose/program of CBDC services. *Results:* Results indicated that there is a much research investigating different approaches but little consensus regarding the optimal delivery model thereby rendering it difficult to make a direct correlation as to the most effective CBDC. *Discussion:* The review presents an overview of the array of models providing centre based day care for older people. The challenge for future service delivery is to determine which of CBDC services are most successful in catering for the needs of older community dwelling adult or are new innovative models of CBDC required.

Subjects: Community Planning and Planning Techniques; Aging and Health; Quality of Life; Community Health

Keywords: narrative review; community day care centre; older adults; wellness and elderly active ageing

ABOUT THE AUTHORS

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Christopher Etherton-Beer is an Associate Professor in Geriatric Medicine at the University of Western Australia, and a Geriatrician and Clinical Pharmacologist at Royal Perth Hospital.

The team are active in the research field of ageing well, provision of wellness models for older adults and those in cognitive decline along with engagement of wider community in enabling wellbeing in older adults. All authors are partners in large multicentre cognitive decline partnership grants nationally within Australia.

PUBLIC INTEREST STATEMENT

In Australia as around the world, significantly more older people want to remain in their own home within a community for longer. However, one key issue for many older Australians is the isolation from the rest of the community. A number of models to provide community based day care (CBDC) services are purported to enable older persons to engage with the community. This paper examines some key models and further proposes some new service models to facilitate social interaction for older community dwelling adults. The challenge for future service delivery is to determine which of CBDC services are most successful in catering for the needs of older community dwelling adults and facilitating social interaction across a number of generations.

1. Background

Alongside the ageing population increase, is the fact that many older Australians are more mobile and independent of institutional care than those from previous generations (Australian Institute for Health & Welfare, 2013). As such, there has been a drive in recent years by successive governments to have older Australians living in their own homes within the community for longer. Ultimately, the drive to assist older Australians to remain within their home for longer has stemmed from a person centred care approach to health whereby health care is provided to meet the individual needs of the person. One of the cornerstones of the patient centred approach is the involvement of family and friends in planning for the future in terms of health and care preferences.

The patient centred approach to providing supportive care for older persons encompasses a number of interrelated issues. Specifically, isolation of older persons living at home, the costs and burden of care to family and health services along with provision of support to Despite the increasing range of community support services that are provided to older Australians residing within the community the issue of isolation still remains a key challenge to older persons who choose to remain in their home and also for their families (McLaughlin et al., 2011; Pinguart & Sörensen, 2011). Along with the costs of caring another key concern is the prospective isolation of older adults given the lifestyle commitments of younger family members. Regardless of the range of options currently provided for older persons to remain within their own homes and within the community, the issue of isolation still remains a key challenge for families with older relatives and for the older person themselves (Perissinotto, Cenzer, & Covinsky, 2012). To this end, there have been a number of initiatives globally focusing on a wellness and person centred care approach to address the issue of isolation and ongoing care for older members of the community who remain in their own homes (Cornwell, Laumann, & Schumm, 2008; Crowe et al., 2015).

Initiatives such as home care services and transition care provide enabling services to ensure that older persons retain functional independence and can remain in the community for longer before being admitted to residential care. Although laudable, provision of patient and person (community) centred care initiatives such as “ageing in place” (Davey, de Joux, Nana, & Arcus, 2004), present their own set of unique challenges from a number of perspectives such as the workforce required of both health professionals and care attendants as well as coordination in the provision of services and support (Farag, Sherrington, Ferreira, & Howard, 2013; Low, Yap, & Brodaty, 2011). A number of models of social inclusion for older adults have been successful in reducing isolation and empowering this sector of the population to retain optimal quality of life and sense of wellbeing as they age. These models focus on bringing the older community member back into the community again using a number of centre based approaches. The centres also have the added benefit of relieving carers of the burden of caring along with relieving anxieties around isolation and boredom for older family members.

This paper provides a narrative review of a number of CBDC approaches to proactively provide improved quality of life for older population members across a number of key domains (emotional, physical, social). The review addresses the benefits and potential drawbacks of various models of CBDC.

2. Introduction

Demographic change is resulting in an increasing proportion of older Australians. According to the 2011 Census, there were 3 million people aged 65 years and older living in Australia (1.4 million men and 1.6 million women) with over half of this population aged 65–74 years. Proportionally, in 2011, older adults made up 14% of the Australian population in 2011, with women forming 15% of the total female population and older men constituting 13% of the total male population (Australian Bureau of Statistics, 2012).

In 2011 in Australia, most people aged 65 years and over lived in a private dwelling with a husband, wife or partner (56%). A quarter of older people lived alone in a private dwelling, making this the most common living arrangement after living with a partner. Almost one in five older people (19%) had a need for assistance with one or more of the core everyday activities of self-care, mobility and communication. The rate was higher for women than men (22% compared with 16%) and increased with age for both sexes. Activities that older adults were engaged with include volunteering (20%), providing childcare to children who are not their own, for example grandchildren (12%), and participation in the labour force (12%) (ABS, 2012).

Inconsistent terminology is used in relation to community based services for older adults. The US uses the term Senior Centre whilst in Australia and in the UK day centres, community based day care (CBDC) is often used. Stakeholders noted that there is a move away from the term CBDC, for example one large Western Australian service provider uses the term Social Centre, and also provides “Therapy Centres”. Recent literature highlighted the need to “re-brand” community services for older adults (Burns, Lavoie, & Rose, 2011; Silverstein & Wang, 2015), for example the USA literature discusses moving away from the term senior which is considered potentially off-putting for a new generation of older adults. Regardless of terminology one of the driving factors for CBDC is the person (patient) centred approach to care. The person centred approach to care encompasses relationship and input of family and friends (significant others), physical and emotional health status, abilities, personal values and interests (Innes, Macpherson, & McCabe, 2006).

3. Methods

A review of relevant academic and practice literature was facilitated through an initial search of key databases and websites. A search of key databases and websites was undertaken using specific search terms to identify relevant academic literature. The following databases were searched Medline; CINAHL Plus; Scopus and AgeInfo. Table 1 shows the terms used to search the selected databases.

In addition, a number of relevant websites were reviewed. From this initial scan, a number of documents were identified to be included in the review and covered the following topics:

- Best practice/quality standards in centre based day care for older adults.
- Different models of service/care.
- Older adult’s needs and preferences with respect to community based support.
- Specific programs and activities provided to older adults in the community.

Table 1. Keyword source to inform literature search

Service/facility related	Target group	Purpose of the service/program
Community care centre	Older adults	Health
Day care	Aged	Wellness
Day centre	Elderly	Active aging
Community service	Older people	Best practice
Centre based day care	Senior citizens	Intergenerational practice
Senior centre	Vulnerable populations	Social support
Community living	Geriatric	Wellbeing

4. Findings

There are two dominant standpoints currently evident within the sector that underpin the philosophy and values of CBDC. One is a person-centred care approach which, as previously noted, emphasises older adults' unique qualities, life history, personal preferences and characteristics. The second is the "active service" or "wellness" model which aims to build functional independence, quality of life and social participation, rather than dependence on services. There was also a broad distinction between services that focus on older adults' physical health and those that highlight support for their psychosocial wellbeing. Several service models were identified in the review thereby covering both modes of operating and specific services provided. Many services blend two or more aspects of the concepts described. There were varying degrees of evidence about the effectiveness of the models. The main operational issues identified within this study were having staff with the right knowledge and skills, having sufficient staff to meet the needs of the older adults using the service, having accessible and responsive opening times, and the provision of transport to and from the centre and offering food/meals. Another consideration for the CBDC service is having an environment that is functional, welcoming and comfortable. Broadly, considerations for the Centre's physical environment are having a welcoming atmosphere, adequate storage space, kitchen facilities, suitable toilet facilities and outside space of some kind.

5. Conceptual and service models

Varying service models are evident in the literature, each with somewhat different aims in terms of outcomes for older adults. A broad distinction is made between services with a focus on maintaining and improving the physical and functional health of older adults through therapeutic interventions and those which aim to improve psychosocial wellbeing through social interventions, although some combine both aims. Another objective of centre based services is to delay admission to residential care by enabling older adults to live in the community for longer.

Although the aims are clearly stated, it is a contentious issue as to whether these have been achieved and furthermore as to whether the aims remain relevant to current preferences amongst older community dwelling adults. It is recommended that, at a minimum, CBDC centres should review their goals and objectives annually. Review of successes and identification of areas for improvement.

Dabelko and Zimmerman (2008) note the lack of a strong conceptual model within adult day services, connecting participant needs and services to specific outcomes, making it difficult to understand what works, for whom, in what circumstances. They proposed a conceptual model for adult day services so that the "theory of change" for a service—its aims and how it is intended to work—are more clearly documented from the outset, enabling better service planning and more effective evaluation. An overview of the conceptual model is provided in Table A1.

6. Philosophy and underpinning values—CBDC service

Another consideration is determining the underlying values and philosophy of a CBDC service. A philosophy of "person centred" care is increasingly advocated as the best way to ensure a sense of well-being for older people in care settings (Evans & Vally, 2007). Within this approach, the emphasis is on the individual with their unique qualities, life history, personal preferences and characteristics.

The American National Care Forum Statement of Best Practice (Brooker, 2007) sets out a number of key principles of person-centred dementia care, which appear relevant to the broader older adult population. These are:

- Appropriate assessment, care planning and review processes.
- Valuing communication between staff and service users.
- Enabling access to services.

- Promoting wellbeing and fulfilment in whatever way is meaningful to the individual.
- Staff support and development so that a person-centred approach can be consistently applied throughout the organisation.
- Embedding a person-centred approach in an organisation.
- Creation of a homely environment through effective design of the care setting.
- Disseminating best practice.

Another philosophy identified in the literature is “relationship centred” care, where positive relationships in care settings enable staff to listen to older people, gain insights into individual needs and facilitate greater “voice, choice and control” (Owen & Meyer, 2012). This study argues that, in long-term care settings, positive relationships between older people, relatives and staff and interdependence matter more than individual autonomy. The study was based in residential care homes, rather than day care settings, however the good practice areas identified appear relevant nonetheless:

- Helping older adults maintain, or regain, their sense of personal identity through staff making significant efforts to ensure they understand what is important to older people and explore how they can accommodate individual needs.
- Involving older adults in decision-making, both in relation to their own care and the running of the centre.
- Creating community and connection through supporting older adults to engage in external community activities and where others are encouraged to come into the care home to engage in meaningful activities.

A further distinction within the literature is made between the philosophy of “wellness” or “active service”, which is contrasted with a “dependence” approach. This has emerged from research indicating that the traditional approach of doing things “for” older people creates dependency and needs to be replaced by one that seeks to enable them to do as much as possible for themselves. This “capacity building” approach focussing on optimising an individual’s functional and psychosocial independence has been found to have positive and long reaching benefits (Community West, 2008).

Ryburn, Wells, and Foreman (2008) describes the key components of the “active service” or “wellness model” as:

- An emphasis on capacity building or restorative care to maintain or promote a client’s capacity to live as independently as possible. The overall aim is to improve functional independence, quality of life and social participation.
- An emphasis on a holistic “person-centred” approach to care, which promotes clients’ wellness and active participation in decisions about care.
- Provision of more timely, flexible and targeted services that are capable of maximising the client’s independence.

Another values-based theme from the literature is that of “active ageing”. Conceptually, the World Health Organization’s (2002) definition of active ageing comprises three key pillars:

- Participation: lifelong learning, paid and unpaid work.
- Health: achieving and maintaining good physical and mental health in later life.
- Safety: ensuring the “protection, safety and dignity of older people by addressing the social, financial and physical security rights and needs of people as they age”.

Of these, enabling participation stands out as a particularly important value. For example, an Australian survey found that participation, including participation in social activities, is central to older adults' views of what constitutes successful ageing (Buys & Miller, 2006). Research examining older adults' engagement with the University of Brighton identified a desire to make a contribution as well as passively receiving services, for example through involvement in research on issues affecting older adults and mentoring young students (Moore & Hodgson, 2008). Further, research shows that older adults who volunteer report higher levels of well-being, as the self-help and transformative mechanisms inherent in volunteering provide opportunities for older adults to sustain their self-esteem and sense of well-being (Evans & Valletly, 2007).

7. Service model for CBDC

Another consideration is the specifics of the service model and whether a certain theme or focus will be adopted. As noted, there is a broad distinction between “social” and “health” service models within the literature, albeit with some blurring of this boundary. However this scoping study found a considerable number of service models in play and the sector in a period of considerable change and innovation as it seeks to meet the needs of a new generation of “baby boomers” who have different expectations and preferences from those in previous generations. Within this context the need to re-brand and reposition senior centres - including the development of “virtual” centres—and develop creative programming was mentioned both in the literature and by stakeholders—including the potential abandonment of the term “senior centres” (Aday, 2003; Moore & Hodgson, 2008; Pardasani, Sporre, & Thompson, 2009).

Beyond the “social” and “health” typology, a number of more detailed classifications of adult day services have been developed. For example, Conrad, Hughes, Hanrahan, and Wang (1993) developed a typology of six classes of day centre:

- Alzheimer’s family care.
- Rehabilitation.
- High-intensity clinical/social.
- Moderate-intensity clinical/social.
- General purpose.
- Low-intensity (e.g. senior centres).

A Canadian study (Richard et al., 2008) found that senior centres typically provided three types of intervention strategies, namely “awareness raising/education”, “physical activity” and “social activities”. The health themes most frequently covered at these centres were health habits (mostly linked to physical activity), social issues, multi-theme initiatives, mental health and physical health covering falls/injuries, Parkinson’s disease and flu/pneumonia infections. The authors note that there is scope to broaden the physical health focus to include hypertension, heart disease and arthritis.

More recent research has been undertaken in the USA to identify new senior centre models on behalf of the National Institute of Senior Centres (Pardasani et al., 2009). This study identified eight broad service classifications (Table A2 in Appendix A), with centres sometimes blending different elements in their service delivery. Some of the areas identified relate to the operational approach taken and others to the specific of services provided. A number of benefits to each model are identified, however it is important to note that this is a practice based survey rather than an academic study. Costs of CBDC service to users is another important consideration. A literature review by Pardasani et al. (2009) notes that studies have consistently shown that senior centre users have lower incomes and levels of education than the current generation of “baby boomers”.

8. Populating a centre based day care model

A key issue in developing an appropriate conceptual and service model is understanding the primary target market for the proposed CBDC service so that a service which meets their needs and preferences can be provided. Providing services of relevance to client's needs and engaging clients with service planning has been identified as a key best practice feature of CBDC (Home and Community Care, 2007; Pardasani et al., 2009). A clear theme within the literature is the importance of considering older adults as a diverse population with a range of needs, preferences and interests, rather than a homogenous group (Pardasani et al., 2009). Target market considerations include gender, generation/age, health/support needs, cultural and ethnic heritage, and socio-economic background.

Turner (2004) and Pardasani et al. (2009) both found that the majority of senior centre participants tend to be female consumers older than 75 and that participation wanes as frailty increases

9. Meeting support needs through CBDC

Weissert et al. (1989) found in a study on models of adult day care assessed the case mix of these two different groups and found that the more "socially" oriented day centres had a markedly smaller proportion of older adults requiring high levels of physical support. Another distinction relates to participants' level of cognitive ability, for example services solely dedicated to older adults with dementia and those providing separate "dementia days" to cater to the specific needs of this client group. The support needs of participants clearly has implications for staffing levels and the physical environment which are discussed later.

Another dimension to consider within the target market is participants' cultural and ethnic background, which adds another level of complexity to providing appropriate services. Barriers to accessing services amongst people from culturally and linguistically diverse background (CALD), as well as indigenous groups such as Aboriginal and Torres Strait Islanders (ATSI) in Australia include language and cultural differences, lack of culturally appropriate services, lack of access to income sources and resources, cultural insensitivity, discrimination and racism (Home and Community Care, Department of Health, 2007). However it is important not to view older adults from different cultural and ethnic backgrounds as a homogenous group. A review of literature regarding the delivery of community aged care services to people from CALD backgrounds noted that the needs of such older people are dynamic and diverse (Radermacher, Feldman, & Browning, 2009). The report recommends that services avoid a single model of service delivery, with ethno-specific services being a vital component of a responsive and effective aged care system. Examples from practice include celebrations of culturally specific days, cooking culturally specific food, international films and speakers from culturally specific groups. In Australia for ATSI clients, examples include elder storytelling, bush day, cooking Aboriginal food and visits to other Aboriginal groups (Home and Community Care, Department of Health, 2007).

Engaging older adults from culturally and ethnically diverse backgrounds also has issues for staffing and organisational costs, such as the employment of bilingual/bicultural staff and the provision of cultural awareness training. Pardasani et al. (2009) note that research has shown that the availability of an ethnically diverse staff increases the likelihood of diverse programming and the level of participation among the minority elderly. Table A2 provides an overview of the key models and their core beliefs and practices.

10. Discussion and conclusion

Collaboration is identified as one of the key characteristics of cutting-edge senior centres (Pardasani et al., 2009). Strategic partnerships between senior centres and all sectors of the community including organisations such as universities, colleges, high schools, local government and social service agencies, businesses, hospitals, healthcare providers are considered integral to their sustainability. Pardasani et al. (2009) note that such partnerships support senior centres becoming viewed as community focal points and viable, legitimate community services. Further benefits to working in

collaboration include enabling senior centres to expand their reach, enhance their influence and offer a broader cross-section of services and programs to their target market.

The area of community based care for older adults is in a phase of considerable change and innovation, as services seek to become more responsive to the needs of older adults. The importance of flexibility in the provision of services to older adults appears to be key, signalling a move away from traditional, fixed centres. Consideration also needs to be given to organisational partnerships that will support the development and delivery of the CBDC service.

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Appendix A

Table A1. Conceptual model for adult day services

Needs	Service elements	Proximal outcomes	Distal outcomes
Psychosocial domain of influence	Activities	Maximising independence/control	Emotional well-being (reduced depression and anxiety)
	Relationships with staff and other clients	Personal growth	
	Helping roles for the program and other clients	Positive relationships with others	
	Social work services (advocacy, care management, crisis intervention)	Increased sense of purpose in life	
		Increased sense of self-acceptance	
Physical functioning domain of influence	Rehabilitation therapy	Less assistance needed with activities of daily living	Physical well-being (lower health care utilisations and positive perceived health)
	Personal assistance	Less assistance needed with instrumental activities of daily living	
	Medical services (podiatry, dental services, ophthalmology, etc.)	Reduced nutritional risk	
	Nursing services (tube feeding, wound care, etc.)		
	Nutritional services		

Source: Dabelko and Zimmerman (2008, p. 85).

Table A2. Service model types

Type of model	Features	Benefits	Applicability to university priorities
Centre of excellence	Adherence to high quality standards and promotion of continuous improvement	Additional features are and the promotion of best practice, adaptability, and strategic management	Directors with higher education and/or management certificates— university based research and student learning
Community centre	Diverse and comprehensive programming offered at multiple sites through partnerships with (e.g.) libraries, schools, universities, art galleries	Intergenerational program opportunities, integrated leisure activities, an inclusive approach, serving a large segment of population	Not directly evident
Wellness centre	Use of evidence-based health promotion models and steady participation in health-related research protocols	Coordination with healthcare professionals, universities, research institutions and pharmaceutical companies	Consistent use of evaluation tools and significant collaborations, for example with local universities
Lifelong learning/ arts centre	Activities offered at multiple sites focussing on intellectual stimulation, personal growth and enhanced quality of life	Benefits of this model are: more (and new) seniors access services because of off-site location; stimulating brain-fitness program helps keep minds alert	Not directly evident
Continuum of care	Serving as a conduit to incremental care for community-based seniors and promoting independent living	Introducing community members and seniors to the senior centre; creating a foundation for a continuum of care	Not directly evident
Next chapter	Enable older adults to clarify goals for the next stage in their life, link them with resources and develop practical plans of action	Benefits of this approach are: seniors feel a sense of purpose, productivity, vitality and improved physical and mental health	Older adults are regarded as assets with an “experience dividend” for communities
Entrepreneurial	A focus on philanthropic rather than public funding. Use of strategic management tools for continuous improvement	Benefits of this approach are: increased control over funding; greater independence through self-sufficiency; increased sense of ownership	Not directly evident
Café	Retail based approach to programs. The café is the centre piece. Programs that are offered in addition to café at various sites	Benefits of this approach are: improve quality of life, provides/promotes good nutrition; social connections stave off cognitive decline	Smaller, neighbourhood-based focus
Community connector	To enable older adults to connect with networks which already exist in their local communities. A partnership between a number of aged care and disability services	Staff and volunteers in the community connector role to empower the individual to be part of the community	Not directly evident
Activity buddies	To enable older adults to remain active and engaged with the wider community. Decrease isolation and enable wellness	Organise intergenerational activities with both students and older people	University based research and student learning
IT based	A website showing older adults what support services are available in their local community	Secure, practical solution that helps connect people around someone receiving care	Wellness/preventive health, and why it's a good idea to use such services i.e. evidence from research

Source: Pardasani et al. (2009).



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