

# Better care moves: older people's 'transition' between different care settings

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# Background & Aims

- **Context:**

- Moves between care settings in later life are challenging for older people but are also sometimes unavoidable (Baxter et al, 2020)
- Social care practitioners have a significant role in supporting older people moving into and between social care settings (Sandberg et al, 2001; Asquith et al, 2005; Manthorpe et al, 2008; Ray et al, 2015; Tanner et al, 2015)
- However, practitioners may lack understanding of the needs of older people and their carers, and lack the confidence, guidance or resources in practice (Manthorpe et al, 2008; Fabbre et al, 2011; Cole et al, 2018)

- **Research objectives:**

- Investigate how social care practitioners currently support and could better support older people's moves.
- Identify the move-related experience and expectations of older people and their carers, their viewpoints on the risks and unmet transition-related needs, as well as personal examples of best practice.
- Develop practice recommendations, aligned to the needs of older people, to guide practitioners during the process of supporting older people and their families pre-, during, and post transitions.



# INTERVIEW SAMPLE

Group	Characteristics		Number	
6 Older people	Financial arrangements	Self-funder	5	
		Publicly funded	1	
	Age group	60-69	1	
		70-79	3	
		Above 80	2	
	Gender	Male	3	
		female	3	
	Health conditions	Dementia	1	
		Physical disabilities	2	
		Learning disabilities	1	
No significant conditions		3		
11 Carers	Relations	Filial carer	7	
		Partner carer	3	
		Wider family carer (e.g. grandchild, nephew)	2	
		Friend carer	1	
	Gender	Male	4	
		Female	7	
	Conditions of people they care for	Dementia	7	
		Cognitive impairment	1	
Physical disabilities		1		
Mental health issues		1		
Age range	31 – 84			
10 social care practitioners	Roles (n=5):	Local Authorities	Social worker	3
			Discharge coordinator	1
			Case manager	1
	Non-LA (n=5):	Discharge coordinator at a rehab hospital		1
		Care home manager		1
		Day centre & dementia café lead		1
		Community navigator		1
	Dementia support officer		1	

# Preliminary findings - Key themes

- **Move-related challenges**

- Older people
- Unpaid carers
- Social care practitioners

- **Move related social care practice**

- Move-related support schemes/examples
- What's needed & how to deliver in social care practice?
- Support for social care practitioners



# **Move-related challenges**

# Move- related challenges for older people

- **Decision-making support**
  - Access to info or advice
  - How to balance priorities (e.g. costs, care needs, space, close to family)
  - Forced vs. proactive moves
  - Who makes the decision & who supports?
- **Feelings / fears**
  - Fear of making move, loss of individuality, being put in place without own consent
  - Loneliness & lacking of social in new place
  - Fear of irresponsible services & mistreatment
  - Fear of moving into residential care – Covid & general
- **Practical struggles**
  - e.g. complex & stressful process, physical move requires help & advice
- **More challenging for people with protected characteristics**

“Age UK have provided me with some written papers on advising the sort of accommodation I could move to and contact, but I'm at a total loss, **I don't know what to do...** I think I've had conversations, yes, but nobody can actually suggest anything. Nobody actually says to me, I think what you ought to do is this. If somebody could actually come up with **some recommendation of what I should do that would help me.**”

– OP01, 80, Male, living with dementia

“if you're an LGBTQ person, so you wouldn't actively choose to go to them. So although physically you might benefit, for example, from an extra care or a supported care system, you probably wouldn't, and therefore it takes something quite – like a **crisis point**, like a severe illness or a fall or, you know, something that kind of takes the decision away almost, **rather than you make the decision proactively... It would be a kind of reactive, there's no other option.**”

– CP07, Dementia support project officer

# Move-Related Challenges for Family/Friend Carers

- **Decision making**

- How to involve older people in decision-making
- No other family to discuss vs. family in one mind
- Self-organised move vs. publicly funded

- **Feelings**

- Stressful & exhausted process for families
- Feeling guilty for facilitating the moves
- Cannot let them go & difficult to accept their decision of move

- **Practical struggles**

- Carers own health & respite needs
- Distance
- Health/social care professionals do not listen, care or inform carers

“The thing I think I feel most strongly about ... is how **guilty** I feel in having facilitated, assisted, encouraged, talked through, somebody going into a home, who afterwards we find the home is not what we hope it is to be.”

– OP03, 91, Female, living with physical disabilities

“I ended up recently with – showing signs of **stress**, physically... I have trouble sleeping some nights because I’m so wound up about things relating to my level of involvement versus other family members level of involvement. You start building up strange **resentments**, you start trying to understand what’s best to do. Meanwhile you’re grieving for your mother, your family member. So it doesn’t take an immediate toll on you like a car crash would, for example. It takes a slow pull from you.”

– FC01, Male, Filial carer



# Move-Related Challenges for Social Care Practitioners

- **Communications with older people & carers:**
  - Communications with people having limited capacity, disputes between older people and their families, or conflicting opinions with social care services
  - Managing expectations, anxieties & unwillingness to move
  - Difficult but have to build relationship & trust in a short time (esp crisis move)
- **Sourcing funding & financial support**
  - Ask financial status at very first meeting
  - Ambiguity in eligibility in public funding
  - Family not willing to top up
- **Practical challenges** e.g. Transport for move

“I think a lot of it is **managing people's expectations and managing people's anxieties** as well... families have got to – have **an identified contact person**, they've got to be given **all of the information about our processes.**”

– CP04, Social care discharge coordinator

“I think that it's really difficult about **eligibility** because it's – it can be I believe quite subjective and I might write something one way and a colleague might write something another way. And your manager might look at them both and might decide that that way has more weight than that way. So they might be saying, but that isn't a – you know, that is a reason.”

– CP09, Social worker

# Move-Related **Systematic** Challenges - **All**

## • **Divisions between Health and Social Care & within Social Care**

- Scattered info & insufficient cross team communication
- Health & social care staff do not understand each other
- No assigned social worker, unnecessary close & re-start social service case after hospital stay
- Services batted away requests
- COVID impacts & Discharge to Assess (D2A) pathway
- Pains of multiple moves & resistance to move again

## • **Limited capacity & staff shortage**

- **Too much (repeated) paperwork & authorisation**
- **Limited public budget & Service gap**

“They [hospital] rang me probably about ten to five to say that she was coming into the home that day. The hospital didn’t know that we were a new home, so they were going to send her out with no medication... it is very unfair to expect night staff to welcome in a new person because they haven’t got the staff to sit with that person, ease them in, reassure them...”

– CP03, Care home manager

“He went into hospital... and he was moved from A&E into an interim ward in this hospital. He was then moved into a ward for elderly men then he tested positive for Covid, so he was put in an isolation ward. And then, **with no explanation to him or me, they moved him a long way away from here to a private care home** for recuperation. And again, he was isolated and he was very distressed...I was finally allowed to visit. I got the room reorganised so it was better for him and **then they moved him again.**”

– FC05, Female, Partner carer

“we were, prior to Covid, working in the hospital, as part of the social services team... then, and obviously **with Covid**, which we've had for over two years, it's been a very different pathway for people in hospital now because **social services are not the lead in discharges, it is down to the hospital**...So it was to get people out of an acute hospital into another relevant setting. Albeit going home or into a nursing home or a residential home, and we are now picking those cases up in the nursing home, in the residential home.”

– CP04, Social care discharge coordinator

The background is a light blue gradient with several realistic water droplets of various sizes scattered across the top and bottom edges. The droplets have highlights and shadows, giving them a three-dimensional appearance.

**Move related social care practice**

# Move-related support schemes

- **Connect Well Community Navigators**
- **CQC or LA checks**
  - Good practice *“a secret shopper who received some sort of insight, that they weren’t aware of the fact that they were being tested, could be quite useful.”* OP03, 91, Female, living with physical disabilities
  - should focus more on care quality instead of notes keeping
- **LA support in facilitating move decisions**
  - 12 weeks disregard trial period – means tested

“this was just before lockdown as well, I think, he [community navigator] went and saw a gentleman who lived in one of them static caravans and went through all his options and then during lockdown, he actually had to be moved into a care home. So he was about to assist them with that as much as he could with the restrictions at the time.”

– CP02, Age UK dementia café lead

“what I try to do as a signposting agency, that’s all we are funded by [LA] and the NHS, is to help people for a limited period of time to navigate their way through the various tasks they need in order to successfully make that transition, make their own choices, decisions and just present them with information that helps them form those decisions.”

– CP05, Community navigator

“The other thing for long-term care is that we also support individuals with, if they’re eligible, again, for twelve-week disregard where we disregard the property for the first twelve weeks which does enable them to change their minds if it’s really horrendous and they can go back home and we can support whether a package of care or PA or a direct payment or whichever it is they want. So for some people they try it and then they – because then they realise it’s not for them so they can come home in that twelve-week period...”

– CP09, Social worker

# What is Needed & How to Deliver

- **Approaches:** person-centred strength-focused & more flexible approach
- **Better understanding & info of care settings & charities by ASC & HC staff**
  - info of care labour, social support, financial & other details
  - Clear, correct & short; better informed navigation info in one stop
- **Build trust & listen to older people & carers**
- **Consistent support between services**
- **Proactive & timely support, esp. decision making**
  - Empowering older people & carers
  - Practical info/support – what to bring & move itself, try a few days before moving in
- **Support carers** e.g. update for family

“I know we have to go through the right channels, but maybe an idea of the different care homes and what they actually deal with. So that then if we’re actually talking to people about moving them from home to a care home, we can actually say well, this one would suit because of this and be able to give them a bit more information about what was available at the care homes.”

- CP02, Age UK dementia café lead

“I always have an open door so they [carers] can always come in and have a chat. Making sure that our staff are generally available to chat, as well. Just reinforcing that they are doing the right thing, that they are now getting – their relationship is going back to how it should be...They’re not falling out. They are coming back. They’re going back to their daughter, or their son, niece, nephew, whatever. So it’s a positive move.”

- CP03, Care home manager

# Move-related inclusive practice

- **Ageist & Intersectionality**
- **Raise awareness of supporting diverse groups**
  - Some practitioners aim to engage more with different communities
  - How to reflect inclusive practice in needs assessments and general support
  - e.g. English not first language & Sign language; cultural differences; religious needs
- **LA commissioning consider inclusive practice - LGBTQ Affirmative care advocacy**
  - Training & awareness
  - LA role models

“we do live in an ageist society... So how much value do we place on older people generally, and then how much do we place on older people who then have other characteristics... that’s a huge challenge.” – CP07, Dementia support project officer

“I’m well aware that there are communities living in the area that I cover with whom I have little contact. Which I would like to think we can reach out to and have, you know, more engagement with for their sake, you know, as we should.”

– CP05, Community navigator

“just because somebody is a certain race or a particular religion it doesn't mean that that's necessarily important to them in that day. So it's about clarifying through our assessment process what is important to you.” – CP08, Social worker

“currently – for example, East Sussex County Council has done a specific LGBTQ needs assessment. So they're one of the local authorities that has actually really considered what the needs of the LGBTQ community might be across lots of different things, such as housing, and Brighton are certainly following suit on that as well.”

– CP07, Dementia support project officer

# Support for practitioners

- **Allowing more time to support each people**
- **Supervision and peer support for staff**
  - Discuss options with team
- **Knowledge & information**
  - Info of practical move agencies
  - Mapping of the system & organisations & process
- **Network with other professionals**
  - How to reach people & promote services

“if we've got a complex case that is proving to be stressful for one of our practitioners, we'll have what we call a **mini wash up**... there's like **mini supervisions** that happen on a daily or every other day basis on each of those cases... And as I say any sort of like issues, then I will set up a meeting with the practitioner, myself, senior, and we also include the team manager as well. So we're – all put our heads together to look at, okay then, what can we do, or what service could we use, what can we do to move this on? What can we do to make it better?”

– CP04, Social care discharge coordinator

“There was, for example, an excellent **conference** facilitated by the Alzheimer's Society a couple of months ago about specific experience of people living with dementia and in Covid times and that was really great. And the room was full of allied professional health and social workers and it was all about what we're talking about here, I believe, which is connecting things up for the sake of the individual.”

– CP05, Community navigator

# Practice guidance – draft structure of online resources

## Overview & acknowledge

- Introduction
- Why important (practitioner's talk)
- Context (service user/carers' talk): complexity of care moves and challenges for older people and carers in the process



## Roadmap of typical and diverse pathways of care moves

- Animated video
- Prompts at different stages



## How to better support older people and their carers during care moves?

- Suggestions for practitioners



## How to better support staff working in move-related practice?

- Targeted for managers and organisations



## Move-related inclusive practice

- Gap & good practice examples (esp. for LGBT+) and recommendations



## Categorised resources





If you'd like to more information, please feel free to contact Wenjing Zhang [w.j.zhang@kent.ac.uk](mailto:w.j.zhang@kent.ac.uk)

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