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Admission of an Older Person into a Care Home in Europe: Exploring the Dimensions of a 'Healthy Transition' and the Potential Role of Social Work

Abstract

Transitions in gerontological social work are poorly theorised and underresearched. Although social workers are routinely involved in transitions of older people into care homes, they tend to be treated as a functional transition from one place to another rather than as a social, emotional and psychological process for the older person and their family. Evidence suggests that a healthy transition is more likely if the older person has exerted some influence over the 'when', 'where' and 'how' of the decision, continuity between the 'old life' and the 'new' is maintained, and their concerns are acknowledged. Drawing on a theory of transition developed by Melies et al., (2000), this paper argues that social workers have the relational, communication and advocacy skills, as well as legal literacy and a rights based perspective, to help to promote healthy transitions. There is considerable potential to develop, and evidence the value of, social work's contribution to this often marginalised area of practice.

Key words: older people; care home admission; transitions; social work

Introduction

This paper will explore how social workers can help to facilitate a healthy transition for older people permanently admitted to a care home, and their family carers (carers) (see Box 1). Using a particular conceptual model (discussed later) we make the case for social work engagement with the transition process and why it is important. We draw on evidence from five European countries: the UK, Ireland, Romania, Finland, and Italy as these countries share policy contexts. The authors are University academics and are members of the European Social Work Research Association's Special Interest Group for Gerontological Social Work.

Box 1: *A note about terminology*

- ***Care homes*** refer to all types of institutional settings that offer 24-hour accommodation and care to older people, including nursing homes, residential care homes, and specialist dementia care homes.
- Family ***carers*** will be referred to as carers (not caregivers)
- ***Older people*** refers to people aged 65 years and over (unless otherwise stated)

We are looking at the transition of an older person from the community or hospital, into a care home *not* from one care home to another or from a care home to a hospice (or other setting).

Context: Older People and Care Homes

There are a range of policy imperatives across Europe that encourage older people, including those with care and support needs, to remain in their own homes. The aims of 'ageing in place' policies chime with a related policy aspiration to reduce admissions to care

homes and contain welfare costs (Luker et al., 2019). Neverthless, a small but significant proportion of older people do move into a care home every year in all of our five countries (see Table 1). The risk of admission rises steeply amongst the very old. The majority of care home residents are women aged 85 years or over: most have multiple health problems; have previously lived alone, are single, widowed, or divorced; and are poor or dependent solely on public (welfare) benefits (Dening & Milne, 2021).

Table 1: Care Home Profile

Country	**Number of older people[1] living in a care home (proportion of the total population of older people)**	**Total number of care homes (proportion of homes that are run by the private sector)**
UK (including Northern Ireland)	418,000 (4.8%)	17,079 (90%)
Ireland	30,000 (4.7%)	581 (80%)
Finland	50,074 (3.9%)	1,830 (54%)
Italy	288,000 (1.9%)	8,524 (77%)
Romania	38,228 (0.8%)	3417 (62%)

It is important to recognise that data from our five countries is collected and collated in different ways and that 'care homes' are defined and organised differently too (Aaltonen, 2015). It is noteworthy that admissions are lower for Italy and Romania. This can be explained by a combination of: powerful cultural expectations that 'the family' will provide care, that welfare benefits incentivise community based care options, the provision of home care services via the (free) health system, and the fact that in both countries the cost of residential care is very high. Despite these difference, key trends can be discerned, and patterns identified.

Risk Factors and Triggers

Risk factors and triggers take a number of forms.

Being in hospital has been identified as a Europe wide risk factor for admission to a care home although pathways into care are poorly understood. In Finland the risk of admission from hospital is double that of a community based older person and in Ireland this is the case for nearly two thirds of admissions (Health Service Executive, 2022). The profile of those admitted from hospital is clinically distinct; this population tend to be very dependent, frail and to have recently experienced a stroke, fracture and/or significant mental illness (Burton et al., 2022; Harrison et al., 2017).

Care home residents have become markedly more dependent over time. In the UK, 80% of care home residents have dementia and/or a hearing impairment; a significant proportion have depression and are frail, in pain and/or incontinent (Dening and Milne, 2021). At the point of admission, residents often have complex co-morbid conditions and unpredictable

[1] People aged 65 years and over

clinical trajectories (Forder and Caiels, 2011). This shift reflects the emphasis on community based care noted above as well as the rising costs of care home fees across Europe. There is now greater reliance on residents paying their own fees[2], either wholly or partially; this is the case in three of our sample e countries - the UK, Ireland and Romania. Paying for 'extras' such as outings and hairdressing services is common in all five.

The death of a caring spouse or partner is a well-established trigger for admission (Nihtilä and Martikainen 2008). A recent eight country study identified caregiver burden as the 'most consistent factor' associated with a move to a care home (Verbreek et al., 2012). As the challenges of caring interleave with the needs of the older person social workers are often required to balance perspectives. Care home admission is a product of the needs of the cared for person *and* the needs and capabilities of the carer, who may themselves be older and have their own health problems. Living alone with no support from a family carer is a risk factor for admission at an earlier stage in the illness trajectory (Toot et al., 2016).

Other risk factors relate to the older person's context. There is evidence, for example, that older people who are poorly socially connected are at greater risk of admission than those who are enmeshed in their community and/or have links with family members *and* friends (Hanratty et al., 2018). Unsurprisingly 'inappropriate' housing including: no or limited adaptations to accommodate mobility restrictions; drafty and inaccessible rooms; no or very expensive heating options; and poor bathroom facilities, is also a risk factor (Hoogerduijn et al., 2012)

For older people living with dementia the ability to maintain independence in activities of daily living has consistently been identified as a protective factor across Europe (Verbeek et al., 2012). A systematic review of evidence (Toot et al., 2017) concluded that it is, commonly, a *combination* of the following issues that constitute 'risk' rather than a single issue: the person's individual characteristics; the ability and willingness of carers to provide support; the availability and quality of support services; and the suitability of the person's living environment (Covinsky et al., 2003; Hoogerduijn et al., 2012; Kauppi et al. 2018).

Transition into a Care Home

There can be no doubt that moving to a care home is a significant transition for an older person often precipitated by critical events, such as a fall, over which s/he has little control. It is likely to be their last place of residence. Admission tends to be associated with the loss of a number of long-established continuities and attachments such as: a home the older person may have lived in for many years, belonging to a community or neighbourhood, relationships, pets and personal possessions (Lundgren, 2000; Sullivan and Williams, 2017).

Transitions, especially from hospital, are managed in variable and inconsistent ways (Kable et al. 2015). It is well documented that unsupported transitions can have a negative impact on an older person's wellbeing (Goodman et al. 2017). Adverse reactions, such as feeling like an 'outsider' or social disengagement, is associated with heightened risks of depression. Deterioration in health and wellbeing, loss of identity and sense of agency, and reduced

[2] A group knows as self-funders

connectivity with family and friends are common experiences (Fitzpatrick and Tzouvara, 2019).

Evidence strongly suggests that moving into a care home is much more than a physical transition from one environment to another; it involves profound psychological and emotional changes too (Sullivan and Williams, 2017). As noted, admission is likely to be preceded by at least one significant loss or change; these often co-occur giving the older person limited time to adjust. If an older person moves into a care home as an 'emergency' - for example from acute hospital - they are likely to feel they have very limited control over the decision. Their physical, emotional, practical and social resources are also likely to be severely depleted.

Before exploring the nature and dimensions of a 'positive' or 'healthy' transition into a care home it is useful to discuss the concept of transition itself.

Transitions: Concept and Models

A transition results in fundamental changes to an individual's role, sense of self, and/or identity (Melies et al., 2000). For a change to be described as 'a transition' it must be of sufficient magnitude and/or represent a 'major life event' requiring a person to develop alternative ways of managing their life or viewing their world. In the nursing literature - where 'transitions' have received much more attention than social work - the accepted definition is, 'a passage from one life phase, condition or status to another, a multiple concept embracing the elements of process, time span and perception' (Meleis, 2010: 25; Schumacher and Meleis, 1994).

Referring to the work of van Gennep, Tanner et al., (2015) suggest that a transition involves stages that are connected to moving from one status to another as well as, often, one place to another. Van Gennep highlights the importance of liminality: the experience of feeling 'betwixt and between'. He identified three types of 'liminal rites': pre-liminal rites in which the individual is removed from her/his social situation; liminal rites in which s/he is in limbo; and post-liminal rites in which s/he adjusts to a new social status. The process also involves three types of transitional experience for example, relinquishing earlier but still valued roles, ideas, and practices; creating or discovering new adaptive ways of 'acting' and of 'being'; and coping with the changed conditions (Ambrose, 2018).

Originally utlised by the nursing profession, Melies et al., (2000) developed a typology of transition which reflects the complexity and multidimensionality of a transition experience. Subsequent application of the typology to several health related transition projects led to the development of a theory of transition (See Figure 1). Underpinned by an ecological approach, it offers a useful framework for social workers whose role often intersects with the lives of older people at the point of transition. The theory highlights:

- Triggers or antecedents which make transition more likely
- Types and patterns of transition (for example, health/illness, environmental, situational)
- Properties of a transition experience (for example, temporality with no predetermined end point)

- Factors which inhibit or facilitate progression towards a healthy transition (for example, accessing reliable information, opportunities to prepare)
- Patterns of response comprising process indicators (for example, developing confidence, coping) and outcome indicators (for example, mastery, identity development/reformulation).

FIGURE 1 here

Meleis et al., (2000) highlight the importance of understanding the experiences of the individual, and their family, during the transition. This necessitates understanding personal and environmental (individual, community and societal) conditions that facilitate, or constrain, progress towards achieving a healthy transition. Research suggests that the focus of most interventions relating to transitions is on the management of the physical transition rather than its emotional and psychological dimensions and the multiplicity of factors that influence the overall experience (Tanner et al., 2015). A 'service focused transition' risks prioritising practicalities and meeting the needs of the agency. Older people are subjected to 'assessments of risk' or 'need' and decisions tend to be driven by organisational pressures such as 'delayed discharges' rather than anything relating to the older person's perspective or wishes.

Meleis et al., (2000: 26) argue that a healthy transition is determined by the extent to which a person can demonstrate mastery of the skills needed to manage their new situation and ability to reformulate a new sense of identity. Feeling confident about the rhythms and culture of the care home, being able to accept support, and understanding the challenges of 'collective' care are examples of issues over which mastery can be developed. A healthy transition is a process which happens over time, not in a single moment. This reflects the complexities of psychologically working through what has been lost and what can be preserved and adjusting to the likelihood that factors such as health and care needs, social connections and personal resources have changed and may well continue to change.

The Shape and Nature of a Healthy Transition into a Care Home

A healthy transition can facilitate a number of positive outcomes for an older person including improved health and wellbeing, better social connectivity, and increased feelings of security, comfort, and safety (Fitzgerald and Tzouvara, 2018; O'May, 2007). Research evidence from Europe, as well as the USA, Australia and Canada, suggests that a number of factors contribute to, or undermine, the achievement of a healthy transition. In this section we explore this evidence through the lens of Meleis et al.'s (2000) model. We also reflect on the extent to which the dimensions of a healthy transitions are, or could be, achieved for older people.

Personal conditions

Preparation, knowledge, and maintaining choice and control

A healthy transition is more likely if the older person exercises some control over the decision, retains an element of choice and is accorded agency (O'Neill et al., 2020a, 2020b; Ryan and McKenna, 2015). For people living with dementia, it is important that the reason for moving into the home is fully explained (Sury et al., 2013). Other contributory factors include the support they receive throughout the decision-making process and pre-admission planning

such as visiting the home and meeting the staff (Cole et al., 2018). Lee et al. (2013) identified the importance of a 'trial period'. For people living with dementia outcomes relating to well-being and 'feeling settled' are improved if s/he is allocated a 'buddy' for the first 48 hours of their stay (Sury et al., 2013).

However powerful the evidence is, significant challenges exist in achieving these aims in practice (Harrison et al., 2017). Choice can be severely constrained by care home availability - which varies significantly by country and area - and also by what the older person and/or their family can contribute financially. Choice, and engagement in decision making, is often much more limited for older people who rely on public (state) funding than it is for those who self-fund. Decisions about when an older person is admitted to a care home, and which home they move into, tend to be made by professionals, including social workers (Thetford and Robinson, 2006; Scheibl et al., 2019). People living with dementia are routinely excluded from decision-making on the grounds that they 'lack capacity' (Donnelly et al., 2018; Larsson and Österholm, 2014). Budgetary considerations are a primary driver. There is an inherent contradiction between the policy rhetoric of choice and a system driven by cost efficiencies (Reed and Stanley, 2006).

Overall, the opportunity for an older person to exert some influence over the 'when', 'where' and 'how' of the transition is consistently evidenced as positive. A healthy transition is much more likely in contexts where an older person has either chosen to move into a care home themselves or has been meaningfully involved in the decision (Gilbert et al. 2015; O'Neill et al., 2020a, 2020b). How often this is, or can be, operationalised is a key question and one we return to later.

Personal resilience, self-efficacy and acceptance

The personal resilience of an older person is highlighted as contributing to their ability to come to terms with relocation (Holder and Jolley, 2012). Being able to recognise the benefits of living in a care home promotes adjustment, for example, feeling safe and having one's care needs met (Ellis and Rawson, 2015). 'Reframing' admission as a positive decision has been specifically identified as helpful (Johnson and Bibbo, 2014).

Self-efficacy is also important (Lee, 2010). In two USA-based studies, increased self-efficacy (Johnson et al., 1998) - alongside appreciating the advantages of living in a care home - were pivotal to residents' positive adjustment. It also contributes to lower rates of depression (Greene and Dunkle, 1992). Talking about losses associated with the transition and seeking ways to manage these - for example continuing engagement with pre-admission hobbies – also supports adjustment (Brandburg et al., 2013).

Environmental and organisational conditions

Creating a sense of home after relocation

Creating a 'sense of home' post admission has a positive influence on residents' mental health and quality of life (DeVeer and Kerkstra, 2001; Rijnaard et al., 2016). There appear to be two routes to facilitating this: reinforcing connectivity with the 'old life' and the care home culture. Bringing personal possessions into the home such as furniture, books, photos and pictures is a key dimension of helping to build a bridge between the old and the new (Koppitz

et al., 2017). Dimensions of the care home culture that promote a sense of home include: the physical layout (e.g. enabling residents to organise their own personal space); mealtimes (e.g. food choices, staff and residents eating together); promotion of resident autonomy; involvement of relatives in care home life; engagement with others; taking part in leisure and social activities; and access to outdoor space.

Feeling welcomed, having confident staff managing the admissions process in a way that prioritises the older person rather than administrative tasks, and being introduced to the care home gradually, have also been identified as important to adjustment (Fitzpatrick and Tzouvara, 2019). Establishing connections with other residents promotes a 'sense of belonging'.

The quality of care is, perhaps obviously, important (Rijnaard et al., 2016). Key factors which promote effective adjustment include care which helps residents 'feel like they still matter' and which facilitates independence, agency and choice (Wada et al., 2020). Axiomatically, higher levels of 'satisfaction' with the care received is a key factor (Fitzpatrick and Tzouvara, 2019). The cultural sensitivity and competence of care provided i.e. the extent to which care staff recognise and respond to cultural needs, has been specifically associated with more effective adjustment for older people from black and minority ethnic communities. For example, provision of particular diets and/or foods (Amuji, 2020).

Healthy Transition: process indicators

A healthy transition can be conceptualised, not as a temporal set of stages, but as a process which requires ongoing adjustment. Supporting existing relationships, and the development of new relationships, are important dimensions of a healthy transition (Brownie et al., 2014). Retaining a 'connection to family' can bolster residents' ability to cope with relocation; it also promotes a sense of self and identity (Iwasiw, et al., 2003).

Maintaining links is not straightforward. There is a well known risk of isolation, and of depression, post admission which may result in the older person not wishing to see family or friends (Melrose, 2004). This can create tensions between the resident, the family and care home staff and may make it more challenging for the older person to develop new relationships; it may also compound existing feelings of isolation (Sun et al., 2021). Links can be fostered by family members helping with their relatives' personal care needs, visiting regularly and including the older person in family outings. Evidence suggests that families derive satisfaction from these roles; their involvement is an important component of the older person's experience of positive care (Ryan and McKenna, 2015).

Admission of a relative to care home is a life transition for family members too. Whilst research exploring the experiences of families is limited, evidence suggests that relatives feel more positive about admission if they consider that effort has been made to involve them in assessment processes and decision making (Afram et al. 2015; Moore and Dow, 2015; Westacott and Ragdale, 2015). This is also the case if they consider that the care home engages well with the older person and that they are receiving good quality care. Carers who have been engaged with providing intensive complex care for some time tend to find the

transition more challenging; they struggle to relinquish their caring role and find ways to redefine their 'carer identity' post admission (Larkin and Milne, 2021).

Healthy Transition: Outcome indicators

Clear indicators of a healthy transition would include the older person feeling settled and/or recognising the positive aspects of the move (Schumacher et al., 2010). Achievement of 'environmental mastery' is also important: this is defined as "a sense of self efficacy or mastery over environmental demands, which reflect a sense of control" (Knight et al., 2011, p.871). Unsurprisingly, these features are associated with a lower risk of depression (Greene and Dunkle, 1992). A longitudinal study of the first-year post admission, found that encouraging residents to 'honestly reflect' on their feelings about their experience of transition helped them to maintain their sense of self, reinforced their individuality, and promoted a sense of 'still mattering' (Iwasiw, et al., 2003).

Outcome indicators also extend to relatives and carers (Cole et al., 2018; Afram et al., 2015). Enhanced wellbeing of both carers and residents is evidenced in contexts where carers continue to provide (some) care to their relative and advocate for their needs to be met, for example, making sure they have access to their favourite TV programmes (Hainstock et al., 2017). Support groups for relatives, which are offered by some care homes, are evidenced as helpful in terms of reducing the stresses associated with the transition for both relatives and the older person themselves (Larkin and Milne, 2017).

Promoting healthy transitions into care homes: Developing the social work role

As already noted, admission tends to be viewed and treated by the 'care system' as a functional process, not as a lived or felt experience; the expedient and cost efficient management of resources take precedence. Through this lens, opportunities for an older person to be emotionally, practically and socially supported to manage the transition, are often eclipsed by organisational and/or funding priorities. As employees (usually) of the local state the role of social workers reflects these priorities. They are often involved in a formal assessment regarding care home admission and in some jurisdictions they have a statutory duty to investigate instances of abuse, including those arising in care homes (Anand, et al., 2022). They are obliged to balance a duty to promote the rights of an older person to make their own decisions and choices with a duty to ensure that they, nor their family carer, are at risk of harm; they are also obliged to be mindful about the judicious use of limited welfare resources.

It is noteworthy that almost no attention has been paid to exploring how social workers could promote a healthy transition in practice or research. Given the challenges inherent in moving into a care home and the often disempowered status of the older person, this is perhaps surprising. We consider that there are a number of key ways in which social workers could help to facililtate healthy/ier transitions. We acknowledge that whilst there is some variation between the training and roles of social workers in our five countries, they share engagement with processes of decision making around care home admission and expertise in supporting older people with complex needs and their families.

The social work skills of helping individuals, and families, to make informed, crafted choices and positive decisions is an obvious contribution. We know that older people are often placed in a care home in situations of crisis. Whilst this may challenge opportunities for thoughtful time rich discussion, engagement can take many forms; there is often a window to share information, build a rapport, and offer advice. Arguably, this is even more important in a context where 'emptying' hospital beds and performing a 'statutory duty' dominate decision making. These are especially pronounced risks for people with dementia and older people with no family. Recent research examining the role of social work with older people in England highlights the important role they play in advocating for the wishes, agency and autonomy of older people and in protecting their rights to be involved in decisions about their care (Tanner et al., 2023). This is a role that needs to be brought to bear on care home transitions.

Melies et al., (2000) identify 'preparation' as critical in promoting a (more) positive experience of transition. A key dimension of preparation is supporting the older person to voice their concerns and feelings about the move honestly, particularly their (likely) feelings of loss and fear. Identifying what is most important to them may inform ways to scaffold - at least some sense of - control over the decision and how the transition process will work. Offering tailored information is a key element: about the range of care homes available, costs and sources of financial advice, legal issues, and how the process of moving will be managed. These are all issues that social workers know about and, where offered, relieves older people and their relatives at a time of high stress; we know how challenging families find trying to navigate a complex care system (Ray et al., 2020). Engaging with a knowledgeable trusted professional is evidenced as helping to facilitate a more timely co-produced transition (The Parliamentary Ombudsman, 2020; Willis et al., 2022).

Social workers also have a role to play in challenging the nihilsitic 'last resort' and 'personal failure' narrative that dominates public discourse, referred to earlier. Admission to a care home may be the only safe choice. It is important to help the older person and their family recognise the benefits of the move, for example having an enhanced sense of security and relief for the, often exhausted, family carer (Larkin and Milne, 2021; Soitu, 2021).

Social workers remaining engaged with the older person post admission reflects the fact that the process of assessment, and relationship focused support, is an ongoing requirement of the whole process of transition. This is the case in Finland where all residents have a 'named social worker' - employed by for the local state - and also in Romania where all care homes employ a social worker (Soitu, 2021; The Parliamentary Ombudsman 2020). A detailed social work assessment highlighting an older person's strengths, resources, interests, preferences and biography - as well as their needs - helps to inform the shape and nature of the care home's care plan and approach to support. Effective adaptation to the new situation is much more likely in contexts where the older person is supported to achieve mastery and exercise agency. A key post admission role is supporting conversations between the care home staff and the older person, exploring concerns the older person may have about maintaining relationships with family members and friends and/or financial issues, and their feelings about moving to the home (Rossi, 2019).

Whilst, in a number of our sample countries (for example, England, Finland and Romania) it is a legal requirement to 'regularly review' the care and support of an older resident who is

funded by the state, this can be challenging to enforce. Reviews do not always happen and when they do they are not necessarily conducted by a social worker but a less qualified social care worker. Valuable opportunities to (re)engage with the older person's - and their family's - concerns, provide proactive advice about legal rights and funding issues, as well as monitor the quality and type of care provided, are lost. This is particularly important in contexts where the older person has no relatives or access to an advocate and/or has dementia where there may be communication issues (Afram et al., 2015).

Although it is not common for care homes to employ social workers in Romania - as noted above - this is the case. For a care home to be registered by the Romanian authorities it is mandatory to employ a social worker (Soitu, 2021). The social worker's responsibilties include contributing to the multidisciplinary pre-admission assessment of potential residents and developing individualised care plans. Post-admission, they adjust the care plan as needed and provide direct support to the older person; they also facilitate engagement between the family and the care home (The Parliamentary Ombudsman 2020). These roles help to achieve a healthy transition.

Conclusion

Moving into a care home represents one of the last transitions an older person will make in their life (Smith et al., 2023). Underpinned by an ecological approach, Melies et al's., (2000, 2010) theory offers a useful framework for exploring greater social work engagement with care home transitions. Its emphasis on a multi-factorial process challenges the current transactional approach; it also foregrounds the lived experience of the older person and their family and highlights the nature of the transition as a social, emotional and relational journey as well as a physical and practical one. Despite the fact that social work's skill set is situated squarely on this intersection of issues, no research has been done on exploring its contribution to promoting a healthy transition. Given the growing number of older people with complex needs and their families who come to the attention of social workers across our five countries, and the likelihood that an increasing proportion will need admission to a care home, our paper makes a timely contribution to making the case for a specific focus on this opaque and hidden, yet critical and complex, area of practice. Investment in research to explore the role of social workers in facilitating more positive outcomes for older residents and their families needs to be made beginning with a study in European countries that employ social workers in care homes (Pascoe et al., 2023).

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