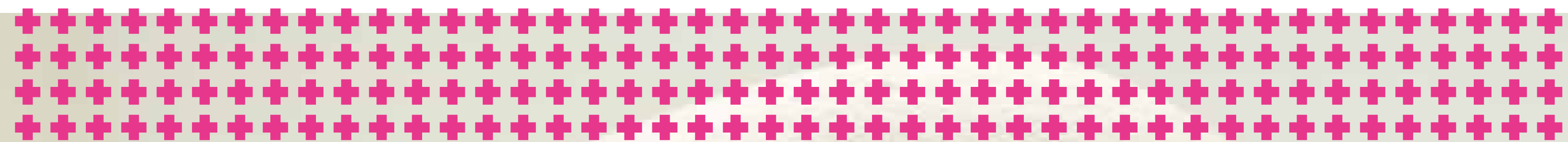
The Queen's Nursing Institute

Transition to Care Home Nursing

Section B - Working in the Care Home with Nursing Setting

Chapter 8 - Supporting Relatives and Friends with Transition of Care

A resource in the QNI's 'Transition' series, designed for registered nurses with an interest in working in a care home with nursing and for those who are already in this area of practice, who would like an update on current practice and approaches.



Section B - Working in the Care Home Setting

Chapter 8 - Supporting Relatives and Friends with Transition of Care

Completing this chapter will enable you to:

- Know more about the what relatives are looking for when making decisions about which care home to choose
- Recognise the importance of involving relatives in care decisions and the role that they play
- Understand the impact on relatives of 'the transition of care' of their loved ones
- Consider the impact of the pace and process of 'relocation to long term care' and the role of the nurse in supporting new residents

Introduction

Relatives, partners, friends and significant others have an extremely important part to play in the overall care of someone living in a care home. The role of relatives, can sometimes be overlooked by professionals as they go about their day to day duties. Often this group support their loved one to communicate with professionals to ensure that their individual needs are being met. Registered nurses and health and social care support staff working in care homes are identified as having a crucial role to play in ensuring as smooth a transition as possible through supporting new residents and their relatives in adapting and adjusting to this major change in the older person's life journey.

Problems can occur if services and support are not integrated, resulting in delayed transfers of care, readmissions and poor care. Examples of poor transitions include discharge problems (such as when people are kept waiting for further non-acute NHS care), uncoordinated hospital admissions and avoidable admissions to residential or nursing care from hospital.

Resident Transitions

Helping residents to come to terms with the move into a care home has a lot to do with the speed and the timing of the transition. If the transition happens following an emergency hospital admission and an acute episode of illness where decisions have had to be made in a rush or what is perceived as a rush, this will pose many challenges for you as the nurse trying to manage the transition. If there is a feeling all round that the resident has not been given enough time to adjust then there might be feelings of guilt, sadness, loss of social connectedness, which may initially manifest and hinder effective relationships. Even if the transition has been planned for some time you may still experience similar challenges.

The Registered Nurse Role in Transition

It will be largely down to you to be aware of the potential challenges and to manage and support residents and relatives through a wide range of conflicting emotions and feelings that can be associated with the transition into long term care.

1. You will need to be able to provide clear and coherent information for the resident and relatives at all times in order to assist them with the navigation through what will seem like a very complex system for them.

2. It will be your role to act as an advocate for the resident ensuring that you involve them in all decision making. You will need to hone your skills as a good communicator in order to undertake the advocate role and work in partnership with residents and their relatives in planning and co-ordinating the transition to long term care.

3. Establish a personal authority and assertiveness in order to influence other health and social care professionals, colleagues and residents to promote care. Being assertive means respecting yourself and other people, seeing people as equal to you, not better or less important than you. The goal of this assertive behaviour in this context is to stand up for resident's rights and act as an advocate. Being assertive does not always mean you get what you want, but it can help you achieve a compromise. You will need to develop a deeper degree of self-awareness, self-belief in your ability to convey information with confidence and conviction.

4. Pre-admission screening to provide staff with an understanding of the personal, lifestyle, cultural and geographical needs leading to improvements in the transition would be beneficial. At this stage the registered nurse can minimise the potential for negative consequences during the transition.

5. Develop some nursing practice guidelines focusing on family-centred care and how nurses support residents to deliver improvements in the transition to care for new residents and their relatives.

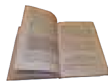
6. Consider how you communicate with new residents and their relatives and how you might improve upon this.

7. Consider developing some training for staff around the impact of resident relocation to long term care and

have an understanding of the psychological transition experienced by new residents and their relatives.

Transfer of Care Documentation

When residents are being transferred from one setting to another it is widely accepted that there is a real potential for miscommunication and for fundamental information to be either inaccurate or omitted NHSE (2016). As a nurse working with residents that will be frequently transferred from one setting to another, it will be your responsibility to ensure that the transfer is safe and appropriate and that all relevant documentation accompanies the resident.



Activity:

Find out what protocols and procedures are in place for residents in your care home. Do they use a patient transfer checklist?

Hospital Admission

In order to enhance the smooth transition of acutely unwell residents to hospital from the community and care home settings NICE (2016) developed a quality standard that covers admissions into, and discharge from, inpatient hospital settings for adults (18 and older) with social care needs. The quality standard acknowledges that family and carers play an important role and that problems occur if services and support are not integrated. Poor transitions include when people are kept waiting for further non- acute NHS care or their home care package to be finalised.

The quality statement covers the following questions where health and social care needs are directly linked to integrated ways of working:

Figure 8.1

1. Information sharing on admission
Health and social care practitioners (such as care home managers, GPs and social workers) ensure that they share existing care plans with the admitting team when they arrange a hospital admission for adults with social care needs.
2. Comprehensive geriatric assessment
Older people with complex needs have a thorough review of their needs when they go into hospital. This is completed by healthcare professionals, with specialist knowledge in caring for older people. The aim is to make a long-term plan to provide the support they need after they leave hospital.
3. Coordinated discharge
Adults with social care needs who are in hospital are given the name of the person who will be responsible for coordinating their discharge. This person will work with the adult, and their family or carers, to plan their move out of hospital.
4. Discharge plans
The discharge plan is an important part of a coordinated discharge process. To ensure adults with social care needs have a positive experience of this process, they need to understand and agree their own discharge plan, if they have the capacity to do so. If the person chooses to share the plan with everyone involved with their ongoing care and support this can lead to successful transfers and reduce the chance of hospital readmission.
5. Involving carers in discharge planning
Health and social care practitioners (such as discharge coordinators and members of the hospital based multidisciplinary team) ensure that adults with social care needs have family or carers involved in discharge planning if they are providing support after discharge.

> “ It will be down to you to be aware of the challenges and to support residents through conflicting emotions associated with the transition into long term care.

Respite

In some instances, the older person may start off by coming into the care home for regular respite admissions to either have a period of recuperation or rehabilitation following an illness, or to perhaps give their relatives or carers a break. The arrangements for respite care may be your responsibility and this is another way of preparing someone for a full-time transition into care. How these admissions are managed will be crucial in relationship building and ensuring that care needs are met.

What relatives look for when choosing a care home

The deliberation that goes into selecting a care home cannot be underestimated, looking for the best residence for a loved one is a daunting decision. By the time a person arrives at your care home they may well have been on a very long journey both physically, psychologically and emotionally. Their relatives would have been on this journey also and may have found the process quite stressful as they negotiated their way through all possible options:

- Could the older person's home be adapted to accommodate them to remain in their own home?
- What support could be available for them to remain at home?
- Consideration of all the alternatives and types of home available
- Understanding Care Needs Assessments
- Funding Issues and the complex way in which care is funded.

It is important to add that moving into a care home for some people can be a very positive experience, see the 'Further Resources' part of this chapter for tips for choosing a care home.

In Wales there is a 'Safe Discharges to Nursing Homes' group which comprises of the Practice Development Team, Discharge Coordinators from acute settings, Welsh Ambulance Service, Nursing Home Staff and Advanced Nurse Practitioners for Care Homes.

Managing Family Dynamics

Working with relatives, friends and family carers when coordinating the transition of a resident from hospital or home into long-term care requires skill and experience, and can bring out the best in some families and the worst in others. Relatives can experience a wide-ranging set of conflicting emotions and feelings based upon:

- Previous experiences of care and whether or not they felt involved in the process
- How they may have dealt with other 'health crises' in the past and managed this situation
- Tensions and disagreements amongst each other around how best to treat their relative
- Old conflicts may resurface as relationships are tested
- Feelings of 'guilt' and somehow by agreeing to long term care they have 'let their relative down'.

Scenario

Cedrick has been admitted to your home for long-term care following a stroke where he needs twenty-four-hour nursing care. Martha visits Cedrick, her husband of over thirty years, every day. They have two sons who live locally but they rarely visit. Martha has already highlighted the fact that she felt he was not cared for well in the hospital and developed a pressure sore as a result.
Martha had been caring for Cedrick at home, for nearly two years before her own health deteriorated and she could no longer care for him. Cedrick keeps asking Martha – 'when can he go home?'

Martha presents to the care home staff as very critical of his care and watches their every move as she is not convinced that they care for him as well as she could.

Martha insists on taking all Cedrick's washing home as she thinks that his clothes have been going missing, and saw another resident wearing Cedrick's cardigan one evening. Martha thinks that the staff at the home do not like her as she senses that they seem to avoid her when she visits and they do not want to discuss Cedrick's care.

Martha presents as very tired most of the time and quite tearful.

Discussion point

- How would you develop a relationship with Cedrick's family – bearing in mind their pervious experiences?
- How do you as a nurse promote autonomy and choice for Cedrick and Martha?
- How do you promote transparency?
- How do you develop a clear information giving and communication strategy for everyone involved?
- How could you reassure the whole family?
- What is it like to be Martha?

Considerations

- What are the benefits for involving family in the care of residents in your organisation?
    1. How can you be explicit in the way in which you involve relatives?
    2. Reputation of the organisation
    3. Values of the organisation
    4. Quality Assurance including regulation
    5. Complaints
    6. Fundraising

Cook has described how the older adult suffers 'a social death' once they are admitted into a long-term care home,

and it is only when the older person is supported in maintaining their own unique identity as a care home resident are they able to '..experience a life that reflects their values and priorities", rather than simply "existing in care'. (Cook G (2010)

Social isolation and loneliness has already been discussed within this resource (in Chapter Four). It is vital that care home staff are aware of the importance of social activities to create and maintain a nurturing environment. As a nurse this aspect of care may well be less familiar to you throughout your nurse training and experiences. The concept of 'Living Well' is a fundamental part of maintaining good health and quality of life and focused social activities. Care homes that actively promote and enable their residents to be involved in tailored activities routinely report a reduction in overall dependency and depression, as well as fewer instances of falls NHIR (2017).

Activity – Make a list of the types of activities that are happening in the care home you are working in.

Can you link the following statements to the activities and the health benefits of doing that activity?

- Stiff joints and muscle weakness
- Loss of appetite and trouble digesting food
- Urinary tract infection
- Incontinence
- Difficulty concentrating
- Poor sleeping patterns
- Breathing difficulties and chest infections
- Raised blood pressure
- Pressure sores
- Boredom, irritability, anxiety
- Disorientation, confusion,
- Weight gain
- Balance, posture, co-ordination
- Falls, fractures
- Self-expression
- Sense of purpose

Reflection trigger point – what would you do if?

These reflection triggers are for you to get together with your mentor and if appropriate other team members to debate possible solutions. They could be used as a basis for a discussion or even a teaching session. We are aware that the solutions to these triggers may vary from Care Home to Care Home according to local policy and procedure. We are also aware that there may be no 'right or wrong' answers to how certain situations might be tackled and therefore it will be for you as a qualified nurse to apply your thinking within the parameters of your own professional practice.

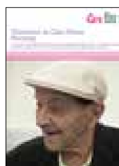
- You are working in a care home that is very structured in the way in which care is being delivered. E.g. weekly bath routines, set times for getting up, having breakfast etc. Some of the staff are reluctant to be more flexible in the way care is being given and say 'that we have always done it this way' How would you deal with this situation?

- Whilst arranging an admission for a resident to come into the home for long-term care you have a visit from the resident's partner. He has come to discuss the admission and whilst talking he breaks down and starts to cry. He feels guilty about not being able to continue to care for his loved one and feels that everything is happening quickly. He says that he feels he is unsure about whether he is making the right decision. How will you give this relative time to adjust to the prospect of this admission and what could you do to help?

> “ It is vital that care home staff are aware of the importance of social activities to create and maintain a nurturing environment.

- A new resident arrives at your organisation and her relatives accompany her. As soon as they arrive they start to demand that she be put into a room that has not been allocated, they want to have an immediate meeting with the manager and are generally unhappy about near enough all aspects of care. They start to become aggressive in their tone and are blaming you personally for all their concerns. How would you handle this situation?

- A resident has returned to your care home after a short hospital stay for an acute admission with an asthma attack. The resident returns without the dressing gown they left in and wrapped in a blanket. The letter that comes back with them outlining the admission is poorly written with limited information regarding the ongoing treatment plan and medication. What steps would you take to communicate your concerns about this?



Summary

The key points arising from this chapter has been the importance of ensuring that relatives and close family members are involved with the decision making that goes with transitioning of care. It has highlighted the role of the registered nurse in ensuring that a smooth transition occurs by pre-empting some of the potential challenges that patients and relatives face with transitioning into long term care.

Further Resources

- National Health and Wellbeing Outcomes, in Public Bodies (joint working) (Scotland) Act 2014 http://www.gov.scot/Topics/Health/Policy/Adult-Health-SocialCare-Integration/Outcomes

- Cook G (2010) Ensuring older residents retain their unique identity. Nursing & Residential Care 12(6): 290-293

- My Home Life www.myhomelife.co.uk

- Triangle of Care: Carers included – best practice in dementia care https://professionals.carers.org/triangle-care-dementia

- QNI (2015) Discharge Planning Best practice in transitions of care http://www.qni.org.uk/for_nurses/policy_and_practice/discharge_planning

- NICE Transition between inpatient hospital settings and community or care home settings for adults with social care needs https://www.nice.org.uk/guidance/ng27

- NHS Providers (2015) Right place, right time: Better Transfers of Care

- NHSE - Quick Guide : Improving hospital discharge into the care sector http://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-Improving-hospital-discharge-into-the-care-sector.pdf

- British Geriatric Society (2012) Quality care for older people with urgent and emergency care needs:

- Which, choosing a care home http://www.which.co.uk/elderly-care/housing-options/care-homes/343030-choosing-a-care-home

- Age UK (2017) Finding a Care Home https://www.ageuk.org.uk/information-advice/care/care-homes/finding-a-care-home/

- Age UK (2016) Care home checklist – Helping you choose the right care home https://www.ageuk.org.uk/globalassets/age-uk/documents/information-guides/ageukil5_care_home_checklist_inf.pdf

- NICE (2013) Mental Wellbeing of Older People in Care Homes – Quality Statement 1- Participation in meaningful activity https://www.nice.org.uk/guidance/qs50/chapter/quality-statement-1-participation-in-meaningful-activity

- College of Occupational Therapists (2015) Living well through activity in care homes – the toolkit file:///C:/Users/user/Downloads/Unit4-Care-home-Inspectors-2015.pdf

Notes on the chapter