Carrying out Assessment & Transfer of Residents in Leeds

Assessment & Closure Protocol

October 2016

Reviewed: May 2021

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1. *Overview*

As part of the Leeds City Council Better Lives Strategy there has been a series of service transformations since 2011, some of which have included closures of services and transfers of care from one service to another.

This document has been used to guide and support the actions of the council in ensuring the safety and wellbeing of people as they undergo these changes. The document and its contents have guided the steps of the staff who have supported people through this process. This review has been undertaken in April 2024 and reflects the experience that we have had during previous changes, as well as the changes that have taken place in respect of the way in which our social work and other services are delivered.

In social work, we take a strengths-based approach, focussing on the person and their family and community and looking at their outcomes and aspirations. We take account of a person's history, experience, gifts and assets. We work in a person-centred way, with the preferences and aspirations of individuals identified and acted upon. We undertake a conversation with the person and their family, consistent with the Care Act 2014, arriving at a position where we have a really good understanding of the individual's care and support needs, with their views and wishes at the centre.

Supporting materials will be provided during the assessment process to allow the individual and family/carers to understand the process and the range of services that are currently available, maximising choice and allowing the individual to make an active positive decision about their future care provision.

As potential options for the services include closure, or repurposing a short stay recovery / rehabilitation service, the process will take this into account and investigate alternative services available for the individual concerned. Any decision made on the future provision of a service will be made known to residents, family / carers and staff before any press/public announcement.

Information will be provided that enables people living or residing at the services and / or those acting on their behalf, to understand the outcome of their assessment of need and identifies an alternative to their current service that is best able to meet their assessed needs.

The timing of assessment of residential service users has been challenged in other Local Authorities previously, notably in Coventry (see reference 1) where it was raised that individual assessments should have been undertaken before, not after, the decision to close residential homes was taken. In this case a judge reflected that there was no legal obligation to carry out individual assessments before the homes are closed, or even before the decision to close them is taken.

Due to the impracticalities of carrying out individual assessments for all service users, Coventry was justified in proceeding by taking samples of the population who were entitled to its services, assessing how these people would be affected by closure and then extrapolating the results to gauge the overall impact. This was

followed by individual assessments before any individual's service was changed, to minimise risk of adverse effects on the service user.

The assessment and transfer of any residents who live with dementia will be carefully planned as the majority of studies suggest that adequate preparation would help minimise any adverse effects on vulnerable movers (see reference 1 *and section* 10 below on the Specific needs of people with dementia*).*

General Information on best practice in relation to closures of services is available at:

http://www.birmingham.ac.uk/Documents/news/BirminghamBrief/AchievingClosureReport.pdf

This process is informed by the legislative framework, our commitment to a strengths and asset-based approach and the learning from other places such as Coventry as well as our experience of managing change.

2. Care and Support Planning process

Appendix 2 of this document outlines the process from consultation, through assessment to potential transfer. This is based on the unit either being recommended for closure or repurposing as a recovery / rehabilitation short stay service.

On conclusion of consultation and a decision made on the future of the service, the specifically allocated social work team, comprising of a Team Manager and Social Workers, will arrange for a keyworker / social worker to visit the individual (and where applicable their family / carers) in order to work out with the person and their family what their care and support needs are. The conversations will take place in a way in which the person needs it to take place to ensure that their care needs are understood, and at a pace that supports their communication needs. The conversations will allow a range of needs to be considered and allow the individual to raise any concerns with the keyworker. The staff group at each unit will be involved from the earliest stage possible as they will be working directly with the service users and will need accurate, up-to-date information.

The keyworker will receive support from the Social Work Team Manager and will include all members of the individual's clinical and care support team, including their GP, District Nurse and other professionals involved in their care.

The materials provided and any outputs from the process including the Conversation Record, Care and Support Plan, and Risk Assessment carried out, will be tailored to the individual's needs (e.g. advocacy, clarity and context of information, details of other services available).

Ensuring the health and well-being of all individuals throughout will be of central importance and a Risk Assessment and Management process will be an integral element, also ensuring that Safeguarding issues that arise are dealt with. The risk assessment should balance safety and effectiveness with the right of the individual

who uses the service to make choices, considering their capacity to make those choices and their right to take informed risks.

A keyworker will be allocated to ensure the process is centred on the person as an individual and considers all aspects of their individual circumstances, and their immediate and longer-term needs.

A detailed conversation record and care plan will be developed with the individual and/or those acting on their behalf, (reflecting family / carers needs where appropriate). The care plan should allow flexibility for change in response to changing needs and reflect dignity and choice. It will promote the individual's well-being by taking account of all their needs, including physical, mental, social, personal (relationship), emotional and financial needs.

Continuity in care and support will be maintained as a result of effective communication between all of those who provide it – before and after transfer, including transfer of relevant documentation and liaison between the previous staff and the staff at the new home/day service, as well as GPs. This is covered further in the 'closure' section later in this document.

The provisions of relevant legislation such as the Mental Capacity Act 2005 and the Mental Health Act 1983 will be considered wherever appropriate.

4. Family, friends, social contacts – what matters to me

The keyworker will try to understand where friendships exist between the individual and other service users / staff and try to ensure that if the service changes, these friendship groups can be maintained as far as possible.

Connections to the local community and community groups will also be considered to ensure these are maintained if the individual accesses a different service.

The keyworker has a duty under the Care Act 2014 to 'assess need' in its broadest sense and this process should identify a range of factors including an individual's history and should identify any previous "loss" experienced by the resident which may have a bearing on the present situation as well as any current mental or physical health vulnerabilities.

Stress factors must be understood as a social event and not simply as an individualised mental health problem. Emotional attachment to a room can create a sense of being "at home" - (Groger, 1995) and closure of homes can cause residents, staff and families/ carers to experience sadness and loss. Each person's experience is unique. Some may want to move immediately and risk too abrupt a decision to move while others may drag their heels and hope that something "will turn up".

5. Financial assessment

The individual's financial situation will be assessed to ensure that the service they currently access, and any alternative services they may access in the future are within their budget.

Individual budgets will be explained and explored with each individual.

General and financial advocacy will be available for individuals who lack capacity to make an informed choice.

6. Advocacy

Independent advocacy will be made available to everyone affected by a change in their current residential or day care service provision. The identified social worker will be responsible for ensuring advocacy support is available when required.

There may be occasions when older people find it hard to get their views across and it can feel like other people are making decisions for them. Independent advocates work with the older person to help them come to their own decisions, to help them get heard and to protect them from abuse.

Independent advocates are trained people who will help a person make their own decisions about things that are important to them and that will affect how they live their life. They will do this by making sure that the person has all the information that they need to make their own decision and then they will make sure that the person's decision is communicated to anyone else that may be involved. This could be professionals, family or friends. They will also ensure that the person's human rights are always observed and that they are treated fairly under the law. They will work for the individual and their loyalty will be to them and them alone.

The Mental Capacity Act 2005 applies to people who lack the mental capacity to make a particular decision, which is decision and time specific. The Act states that in certain situations, an Independent Mental Capacity Advocate (IMCA) must be appointed to help people who lack capacity to make a decision and have no one else to speak on their behalf. This could happen when an NHS body wants to provide 'serious medical treatment' or there are plans to provide the person with long-term accommodation in hospital or a care home. We will ensure that advocacy support is available whenever it is needed.

Advonet: https://advonet.org.uk/

Mind: What is advocacy? | Mind, the mental health charity - help for mental health problems

Age UK: http://www.ageuk.org.uk/leeds/

7. Outcomes

A new and detailed Care and Support Plan will be produced in conjunction with the individual and any family, friends or carers that they choose to be involved to support them. This document will provide clear statements of future care needs and of the preferred way this care should be provided in any new care setting. It will specify in detail the ways the individuals care and support should be provided to ensure that their personal dignity, independence, abilities and control over services is maximised.

Time should be given for the individual to make an informed decision about the future care they will receive.

Relatives should be kept fully informed of all significant developments by telephone or letter and any individual communication requirements (e.g. language) clearly identified at the beginning of the process.

8. Transfer

Where an alternative service is identified for the individual, arrangements will be made for them to visit to ensure the service meets their needs. During previous phases of the Better Lives programme, it was found that people often liked having familiar staff accompanying them on their visit to an alternative service and this should be considered where requested. It is crucial that early engagement is made between the keyworker, the transferring service and the new service. The keyworker should have access to relevant information about the alternative services and an awareness of resources available across the city (e.g. if there is a place available in a recommended service). This should ensure the individual is given a range of realistic options.

On visiting an alternative service, the individual should have the opportunity to review the facilities and meet key staff including the unit manager to discuss any questions or concerns they may have. The prospective service provider should see this as an important priority and dedicate time and resource to the visit and the conversation with the person.

If an individual moves to a new service, it is vital that it is fully coordinated with the staff in the new service, who must have all the relevant care and support information, including the Conversation Record, Care and Support Plan and all relevant information prior to the move. A review date should be set (not longer than six weeks after the transfer) and is the responsibility of the unit manager to arrange. Ideally the individual should be monitored on an on-going basis to ensure suitable outcomes are achieved both following the move and progressing into the future. The keyworker will maintain in contact post-move and will schedule formal 3 month and 12-month reviews to ensure the person has settled into their new service.

If the move is to an independent sector or voluntary service, Adults and Health Directorate will enter into a tripartite Care Homes Individual Service Agreement with the home and the service user, in accordance with the Community Care policies with the same processes and follow-up reviews taken.

9. Closure

Upon a decision to close a unit, we will ensure that the process of understanding needs and planning the move to a new service takes place with care and positivity. Reed et al (2000) refer to the choices available to people as 'pull factors' (resident active choices) and 'push factors' (external events). In the instance of home closure, the "push" factor of external events causes stress. This can be minimised by providing support and information on other suitable services for the individual and arranging for visits and stays in alternative services. Further detail is outlined in the 'transition' section below.

Other ways to minimise stress factors include ensuring that:

- The move is person-centred. All needs and wants of the individual must be catered for where possible.

- Friendship groups are identified and moves take place within these groups where possible.

- Support to be provided on the day by familiar staff, family and close friends who should accompany the person during the move and encourage them to discuss their feelings.

- Short term support from familiar staff can be provided to support a settling in period to the new unit and enhance the individual's wellbeing.

- Suitcases are used to transport luggage (never black bags) and packing is carried out discreetly. Where a service user does not have suitcases, these should be provided for them. To maintain familiarity of surroundings, furniture should be moved with the resident where possible and desired.

- Running up to closure of a residential home, a minimum core of 10 residents is required to prevent deterioration in morale (reference 3).

- Up-to-date knowledge of an individual's medical condition and their fitness to transfer are essential. Arrangements for registering with a new GP must be made well in advance of the transfer date. The current GPs should be involved in planning the transfer of individuals and for particularly vulnerable or high-risk individuals should liaise with the prospective GP prior to the transfer taking place. For individuals who require nursing intervention, a request should be made for a nursing care plan to be made available to the receiving nurse team prior to transfer. Where applicable, prior to completion of the transfer, it must be assured that nursing care is in place and individuals should have at least 7 full days medication on transfer.

- Moving in winter is avoided, if possible, though if users/relatives want to move during winter, this would be accommodated, and a risk management plan identified to minimise risks.)

- Continued reassurance that there are alternative services/ homes should be provided. The suitability of alternative services and potentially positive outcomes of these services should also be outlined.

- Moving an individual to an alternative service or home that is likely to close imminently should be avoided.

- Standards of care and safe staffing levels should be maintained in the home that is closing to ensure continuity of familiar service and routine.

- Social workers and staff in the service that is closing should have enough time available to ensure that a person-centred approach is maintained throughout the process.

10. Key groups

Some individuals may be exposed to greater risks if transferred, including:

- *People with severe dementia (See section 11* on the Specific needs of people with dementia*)*

- *Extremely frail people who have co-existing medical illnesses (e.g. heart and lung disease, previous breakdown etc).* This list is not exhaustive and to minimise risk, medical examination should take place during the assessment and immediately prior to proposed transfer. This will indicate whether a resident or day centre user is fit to transfer and the requirement for any additional precautions.

- *Residents who need specialist equipment. A r*eview of equipment needs (including any assistive technology) of people transferring to a new home or day service should be undertaken. No one will be moved until the receiving home or day service has the required equipment and where necessary staff are trained in its use.

- *Residents with special dietary needs and those who need assistance with eating.* Individuals should be identified in the assessment process and their support and risk management plans written up to reflect the assistance required. Named care staff from the receiving home or day service should be briefed and trained on any skills which may be required.

11. Care and Support Planning and Closure - Specific needs of people with dementia

Many people worry that moving care homes for people living with dementia, could result in worsening of their condition or even lead to reducing the person's life expectancy, though there's no definitive evidence for this (www.alzheimers.org.uk) Research indicates that following best practice is however crucial to achieving successful outcomes.

As outlined by the Alzheimer's Society (www.alzheimers.org.uk), it is important that care for people with dementia is centred around the person as an individual and should not focus on their illness or on abilities they may have lost. With this in mind, if there is a requirement to transfer residents from one home to another, it should be possible to use the same principals and processes outlined in the Assessment and Closure Protocol, which points to the most effective ways of supporting people through a change of this type. However, there are also some dementia specific considerations which need to be taken into account when a person living with dementia is faced with a change of accommodation.

Warchol, K (2013, *'Transfer trauma- A real issue for many individuals with dementia'*) refers to the stress experienced by someone with dementia when changing living environments as 'transfer trauma'. She states that it is: 'usually temporary in nature and relieved as the individual builds friendships, gains trust, and develops a sense of purpose and belonging in their new community'. Much dementia care research suggests that it is through our relationships with others that well- being is maintained or restored. The quality of these relationships is therefore considered a key factor in ensuring that a person settles in their new home.

In their paper, '*Moving Persons with Dementia?'* Struble and deLaski-Smith (1997) identify a number of measures that can be taken prior to, during and after the move to ensure that any stress associated with a move is minimised. Dementia UK and Care Quality Commission also provide guidance on this.

Advice on moving into a care home - Dementia UK

https://www.cqc.org.uk/publications/themed-work/beyond-barriers-how-older-people-move-between-health-care-england

Choice and control

People don't lose the right to take part in decisions about their lives just because they have dementia (www.alzheimers.org.uk). They should continue to be included in plans and decisions about their care and helped and supported to make choices (unless it can be shown that they are unable to make them).

To increase choice and control, where appropriate a number of visits to alternative homes should be carried out with the resident given the choice of their preferred home. However people living with dementia in residential care might be very frail and there may be a need to achieve a balance between the information gathered from multiple visits, the impact on the person's well-being and the persons understanding and ability to communicate what they do and don't like.

Struble et al (1997) suggest that it is important for staff and family members to maintain an optimistic and supportive attitude throughout the transfer process to encourage the person living with dementia to see it as a positive change.

Ageing in place

If it is determined that the person is going to move, then it should be ensured that the number of future moves they may need to make is minimised. This is because each move will be stressful, so due care should be taken to ensure that the person is not moved to an alternative home which is likely to close in the near future or will not meet future needs of the individual.

Planning the move

Planning is a key activity that can support the success of a move. Members of the social work team need to be pro-active in making early contact with all agencies involved in the care and support of the individual with dementia. It will be particularly important for the assessment team to work closely with any other involved professionals to gain a clear understanding of the needs and wishes of each individual.

The social work team will ensure early involvement with the occupational therapists in the Disability Support Team to identify if the person has all the equipment they require. This may include such items as profiling beds, crockery, cutlery, drinking aids etc. The social work team will also ensure that temporary equipment is available, should an overnight stay be required to support decisions about the move.

Struble et al (1997) suggest that the bulk of the planning for the move is carried out between staff and family well in advance of the move, before discussing this with the person living with dementia. The person should only be engaged in discussions 2-4 weeks before the move to ensure that they are not caused unnecessary stress too far in advance of the move.

Consideration needs to be given to specific rituals or routines that the person may have (e.g. person prefers to shower before breakfast, or have a drink at a specific time, going to bed and getting up routines), food likes and dislikes etc. Staff at the new home should be made aware of these to ensure that the person can maintain their routine and feel comfortable in their new surroundings. A person's life story work can be used to support this transition. As this belongs to the person this should accompany them in any change of residence, as it contains key information that can be used to support their well-being and identity. If there is no life story work completed or in progress this should be commenced at the earliest opportunity. Life story work will greatly assist the new care team to develop relationships and an understanding of the person.

The home that the person is moving to should be given details of the person's interest/ background to identify whether any potential friendships can be formed within the resident group. Dementia UK suggest that there are several ways that Life Story work can be practiced and can be completed in many formats - or a combination of formats that works best for the individual. These may include books, collages, video recordings and personal profiles, memory boxes and Apps.

The accommodation should be personalised with belongings and key objects that represents the person's life and interests.

Timing and health

On the day

The move should take place during the day, and it is suggested that the best time for the move to take place is in the morning while the person is 'fresh and functioning at their highest level' (Struble et al, 1997). Also, by moving in the morning it should allow a family member, or carer, to support the move and stay with the resident until they have settled. It is also possible that individual traits may point to other more optimum times for such activity. The person that knows them best may provide such an insight. There should be sufficient staffing to ensure that the person receives individualised attention on the day, that the care and support plan in the home can be completed and staff can be informed of and aware of the content of that plan, including any risk assessments that are required. Dietary needs, personal care needs and preferences should be communicated quickly and accurately.

Following transfer- the first few months

Staff at the new home should spend more time with new residents to get to know them during the first month or longer if necessary. Consistency of care staff in the receiving home is particularly important.

Impact on the individual

Every care will be taken to minimise risk and stress caused by the move by following the processes outlined in the Assessment and Closure Protocol. However, it is inevitable that residents with dementia may experience a wide range of emotions when transferring to a different living environment. As such, it is vital that throughout the process a person is treated with dignity and respect and that they feel involved in their care and support provision. This includes their right to expect those caring for them try to understand how they feel and make time to offer support rather than ignoring or humouring them (Alzheimer's Society UK).

12. Transition process

- A suitable period of planning for transition is necessary – most advice is to give approximately 6 months. Williams and Netten (2003) suggest transition to closure generally takes 3 to 6 months.

- The period planned for the relocation should be long enough to avoid people feeling rushed or pressurised but not so protracted that individuals become more likely to suffer depression or their motivation and well-being is affected. The timing of all transfers should be an agreed process with individuals, family and staff and based on individual need, risk and complexity.

- A maximum of 2 residents to move on any one day and a minimum of 2 days will elapse in which there are no transfers from the home. A maximum of 2 people would normally transfer in any week.

- If groups of friends express a wish to move together and suitable staffing arrangement including travelling support can be arranged, then this will be explored as it may be beneficial to the residents for them to move and travel together.

- A Transfer plan will be developed by the key worker with input from the individual, their family and care staff who know them well. This will include arrangements such as:

    - the decoration and layout of the person's new bedroom/personal space.
    - plans to orientate to the new environment and any pre visits/overnight stays, etc.; visits to alternative services should be carried out with someone the resident knows, and the person should be in control of the nature and the length of the visit.
    - arrangements for continuity of care such as staff/relatives working alongside new staff to pass on skills and experiences.
    - Key documentation/information that is needed such as their social and clinical history, patterns of care and special needs, and their cultural and spiritual needs in order to help new care staff to provide the appropriate levels of personalised care.

- Timing of the move should be sufficiently flexible to ensure that people are not expected to move when they are seriously ill, or at the end of their life.

- The Assessment and Transfer protocol was informed by the paper “The Impact of Relocation on care home residents: a review of evidence for Leeds City Council” produced by Public Health in 2011 and reviewed in 2013, (Reference 11) which summarises as follows: “Mortality - The overall message from this body of work is of no significant difference in mortality rate between relocates and comparison groups, with a lower mortality rate reported in some cases. Morbidity - Most studies found (perhaps surprisingly) a higher level of general health or no clear change following relocation. This was true for both inter-institutional and intra-institutional movement of residents.”

- One common factor in research on whether there is any link between transfer of residents between residential homes and mortality is the recognition that the stress created by the move itself together with the way the move is managed are the two most important factors impacting on the outcome for residents and day centre users. Through appropriate assessment identified earlier in this document, stress factors should be minimised to allow a comfortable transition between services.

References

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5. Reed J., Cook G., Sullivan A., and Burridge C. (2003) '*Making a move: care home residents' experiences of relocation'.* Ageing and Society 23 pp225 – 241

6. Williams J and Netten A, *'Guidelines for the closure of care homes for older people: prevalence and content of local government protocols'* PSSRU Discussion Paper 1861/2

7. Glasby, J., Robinson, S., and Allen, K (2011) 'Achieving Closure- Good practice in supporting older people during residential care closures' University of Birmingham/adass.

8. Warchol, K. (2013) Transfer Trauma- A real issue for many individuals with Dementia

9. Struble, L and de Laski-Smith, D (1997) Dementia Care Series. Michigan Department Of Community Health.

10. American Alzheimer's Association

11. Duncan Cooper, (2011, reviewed 2013) *The impact of relocation on the health and well-being of care home residents: a review of evidence for Leeds City Council,* SpR Public Health, NHS Leeds.

Appendix 1- Service user Assessment process

- Establish team based on skills required.
- Liaise with staff at the unit.
- Produce information materials & supporting information.
- Involve advocates as required.
- Approach residents/ day centre users/ home/ carers/ families.
- Hold conversations with everyone identified as necessary to ensure a positive process.
- Decide/ discuss options for each individual resident and provide relevant information (e.g. information about other services, cost of the new service etc).
- Ensure resources (staffing, equipment, information, transport etc) are in place to support the transfer.
- Following transfer undertake a follow-up review to ensure that the individual is happy and settled in their new placement.

Reviewed April 2024

Appendix 2- The Resident care and support needs identification Pathway