# Best Practice Guidelines to Support the Person Moving to a Care Home

## Purpose of the guidelines

The purpose of these guidelines is to set out evidence-based recommendations to support care home staff in facilitating the best possible transition experience for the person moving to a care home, and to ensure the appropriate support for their families/representatives.

These guidelines were co-produced with over fifty care home leaders and the residents, families and staff in their care homes. The care home leaders participated in a Quality Improvement (QI) initiative on transitions as part of the My Home Life NI Leadership Support Programme at Ulster University. The work was guided by Professor Assumpta Ryan's early research into the experiences of families following the nursing home placement of an older relative (Ryan & McKenna, 2013; Ryan & McKenna, 2015; Ryan & Moore, 2021 ), and Dr Marie O'Neill's extensive research into transitions (O'Neill et al., 2020a; O'Neill et al., 2020b; O'Neill et al., 2020c). The guidelines have been structured around the following four key recommendations that originated from this research:

1. Decision-making and Management of the Move
2. Psychological Support
3. Social Support
4. Maintaining Independence

The Enhancing Clinical Care Framework (ECCF) pre admission pathway (DoH, 2023), and the Regulation and Quality Improvement Authority Care Standards for Nursing Homes (RQIA, 2022) were also considered in the development of the guidance. Contributions from previous work undertaken by 10,000 More Voices (PHA, 2020) added extra resident voices to the creation of the guidelines.

## Who are the guidelines for?

- Care Home Leaders, including Managers, Deputy Managers and Team Leaders
- All Health and Social care Staff working in the care home
- Care Home Providers
- Health and Social Care Trusts (HSCTS) commissioning care home services
- Residents living in the care home and their families/representatives, and potential residents and their families/representatives
- Whilst the guidelines pertain to older people, i.e. people over 65, it is important to note that they are transferrable to other programmes of care such as Learning Disability and Mental Health.

## 1. Decision-making and Management of the Move

It is important for older people to be involved in all aspects of their care and support and this includes the move to a care home. Healthcare professionals have an important part to play working alongside older people concerning decision-making and management of the move to a care home. A strong emphasis on autonomy and choice is advocated so that older people are supported to manage such an important transition, and this should be documented and reviewed as needed.

1.1 The prospective resident and family/representative should be supported in making an informed choice of care facility by the hospital social worker or an equivalent professional in collaboration with the multidisciplinary team. Prior to commencing the pre-admission, the prospective resident's involvement in the decision-making process around the move to the care home should be determined. Information in relation to the processes involved in the transition should be shared with the prospective resident and family/representative, including finance, service specific arrangements and level of support. Where a Care Home Liaison Nurse is appointed by a HSC Trust to co-ordinate the move to the care home, confirmation of the resident's first choice of care home should be sought from this professional.

1.2 Prior to the pre-admission, the prospective resident and family/representative should be given a verbal description of the service provision offered by the care home, with the opportunity to ask questions, engage in discussion, and have pre-conceived ideas addressed. This information should also be presented in a concise format that the resident can revisit.

1.3 Prior to admission and where possible, the resident and their family / representative should be facilitated to visit the care home and meet the staff and other residents before actually moving in. This will help them to get a sense of the layout and routines of the care setting, to view their room and the facilities that are available to them. If a visit not possible, a video of the care home should be provided that includes information on what is available and who to get in touch with to find out more information.

1.4 The resident and family/representative should be provided with a 'Welcome pack' that contains up-to-date information and details about the services provided with photo illustrations of the home, contact details, the staff's shift/working patterns, and the colours of uniforms of different staff members. The information should be available in a format and language suitable for the resident and their family/ representative.

1.5 Where possible, emergency admissions of residents to the care setting should be avoided. An emergency admission of a person to a care home from hospital or from their own home happens when the person is admitted to a care home urgently and

unexpectedly (i.e., the admission is not planned). The time period /deadlines for the planned admission of new residents to the care setting should be specified. It is recommended that the care home has a form of 'Red Flag' system clearly documented in terms of the potential trauma for a new resident coming into the care setting as an emergency admission or unplanned admission. A compatibility assessment should be provided by the hospital/community services/area the prospective resident is transitioning from, and contain accurate and up-to-date information about the individual. Where appropriate staff in the care home should receive training to help them develop an awareness and understanding about how traumatic the move can be for the older person and how it can impact the way they adjust (or fail to adjust) to life in their new care setting.

1.6 Prior to the move or shortly after, a key member of staff (a named nurse/care staff) should be assigned to the new resident and their family/representative. Where possible before admission, the assigned key worker should meet with the resident and their family/representative and capture the resident's social story, building a picture about their hopes, expectations and what is important to them. The key worker should collaborate with the relevant professionals in the hospital/community services/area the prospective resident is transitioning from, to ensure the information received about them t is accurate and up-to-date.

1.7 A pre-admission one-page profile of the prospective resident should be developed that includes information on: 'Things people say about me', 'Things that are important to me', 'How I like to be supported', including what supports the person with their spiritual well-being. The profile should also include: 'What are your main concerns in relation to the move?', 'What would you like to know about the move/the care home?' The assigned key worker should add this information to the prospective resident's personal file and it should be maintained as a 'live' document following admission. Where appropriate, staff should receive training in using Caring Conversations (Dewar et al., 2017) to capture prospective residents' and families' initial hopes and expectations of moving into the care home and how to document this information in the prospective resident's personal profile. Caring conversations supports staff to deliver compassionate and relationship-centred care using the '7 C's' to: celebrate what is working well, consider the perspectives of others, connect emotionally, be curious and suspend judgement, be courageous and take positive risks, collaborate to make things happen, and compromise to focus on what is real and possible.

1.8 The assigned key worker should be on duty on the day of the prospective resident's admission to provide support, establish trust, and take a lead in their care. They should remain the resident's key worker up until at least 4-6 weeks following the resident's move to the home. Staff in this role should have an understanding of the significant life

event that moving to a care home is for the older person and their family, and should understand the potential difficulties that can occur during this transition.

1.9 The key worker assigned to the resident should provide information and signpost the resident and their family /representative to information about funding, category of care, and other specific advice and information.

1.10 A care review should take place within six weeks following the resident's admission. It is important that the resident is present at the review, and subsequent reviews, and involved in shared decision-making about their care and support. The resident's family/representative and the care home manager should also be present.

## 2. Psychological Support

2.1 The key worker assigned to the resident should support the psychological and emotional needs of the resident experiencing bereavement and loss related to moving from their home into a care home. This should include identifying the resident's initial and ongoing hopes and expectations and having caring conversations that help both the resident and their family to manage the different emotions that arise during the transition. Where possible, a family liaison person should be identified to help enhance communication, collaboration and the sharing of information between the resident, family, and staff.

2.2 Loss of own home: where possible staff should help facilitate the resident with their family/representative to visit their own home and provide them with the opportunity to say goodbye to their home. The resident should be supported and facilitated in personalising their bedroom with familiar colours, bedclothes, and items of their choice from home that have sentimental value and/or interest, along with continued access to their preferred technology (iPhone, iPad, laptop etc).

2.3 Staff need to be aware that the resident may feel vulnerable and feel a loss of dignity because of certain protocols that staff are required to carry out as part of the initial assessment process. For example, the body map protocol which requires the new resident to have a body map done within 6 hours of admission. This involves the person being undressed by people they do not know and who they have just met on entering the care facility. During admission, the resident/ family member should be invited to identify a member of staff they feel comfortable with during the body map and provide signed consent. Where possible, staff should ensure that the resident's family member/person they feel most comfortable with, is present when the body map is being undertaken to minimise potential feelings of vulnerability and loss of dignity.

2.4 Often, relatives want to continue to have a role in caring for their loved one and therefore staff should support and encourage them in doing so. This approach helps

them to feel a valued part of the community in the care setting. It is important to agree what roles/activities will be undertaken by the care staff. Failure to do this can cause uncertainty about roles and boundaries and a lack of clarity around expectations in terms of 'who does what'. It is recommended that these roles are agreed at the outset and reviewed regularly as not all families can continue to provide the same level of care and support due to changes in their own personal circumstances.

2.5 Relatives of residents who are living with dementia require information related to dementia and who is available to give them that support, e.g. social workers/others external to the home. Staff should provide the resident's family/representative with specific information such as dementia specific leaflets that provide information on signs/symptoms, important information, updates on treatment changes, and evidence-based research. This is important in supporting relatives so that they can consider alternatives and make informed decisions on the different options available and should support and facilitate contact with the appropriate multi-disciplinary team members.

## 3. Social Support

3.1 Where possible, the new resident should be supported and facilitated by health care professionals involved in their care, to relocate to a care facility that is within their local geographical area if it is their wish to do so, as it is acknowledged that some older people choose to move to a care facility close to family members even if it is outside their local area.

3.2 Leaving friends behind: The assigned key worker should take the lead in encouraging and assisting the resident to maintain relationships with friends and family, and other relationships outside the care setting who can support them with the transition. This should include facilitating visits from those who support the resident's spiritual well-being. Staff should facilitate the resident in keeping their usual social routines with friends and family, encouraging visits, and having no restriction on visiting times where possible. For example, family movie nights, games, and family events, and keeping connected through the use of technology such as video chats and facetime.

3.3 Where possible, staff should support the family in helping the resident to remain linked with familiar places and hobbies, and support the resident to go out into the community. This may require additional resources i.e. increased staffing support with transport.

3.4 Staff should pursue opportunities to engage with the wider community and look for voluntary and community organisations to facilitate individualised and person-centred social care support for the resident. This should include linking in with

voluntary/charitable organisations for placements for residents to participate in community groups outside the home, and community groups coming into the home to facilitate meaningful activities. Staff meetings and supervisions can provide the opportunity for staff members to discuss how social support for residents can be enhanced.

## 4. Maintaining Independence

4.1 Staff should ensure that the resident's unique individuality is recognised, and that they work with the resident's values and preferences in terms of promoting independence while maintaining their physical and psychological safety. This should include promoting as much independence as possible with the use of technology while undertaking regular and ongoing risk assessments. Staff should receive training in the overall area of promoting and safely maintaining independence for residents including how to foster a culture of positive risk taking, and the importance of timely assessments to aid independence.

4.2 It is important for staff to be aware that, regardless of where the person is transitioning to- whether going back to their own home following a stay in the acute hospital, or going to a care home/care setting, the person is entitled to the same level of care and equipment to support their independence. A collaborative process needs to be put in place with the relevant HSC Trust to ensure that the resident moving to the care home receives continuity of care and support by the relevant healthcare professionals in the Multidisciplinary Team (MDT), e.g. Physiotherapist, Occupational Therapist, Tissue Viability Nurse.

4.3 Staff should foster a culture of maintaining independence and maximising rehabilitation taking due cognisance of direction and recommendations from relevant healthcare professionals to facilitate a more confident transition for the new resident. The assigned key worker should advocate on behalf of the resident to foster continuity with the relevant healthcare professionals in the MDT, and involve the resident and family in this process.

4.4 Staff need to be aware of how essential it is that an individual's human rights are protected and actively endorsed within the care home environment, and staff should receive training where appropriate. The resident and their family/representative need be able to access any advice and information they may require when making informed choices including accessing health care, community, and advocacy services. This could be delivered through various communication mediums: regular residents and family meetings; website; noticeboards; pamphlets, videos and Facebook uploads.

## 5. Acknowledgements

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The following participants who developed the Guidelines undertook the MHL Leadership NI Support Programme in 2024 and 2025:

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