What makes older people choose residential care, and are there alternatives?

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Abstract

This article summarises some results of an interview survey of older people recently admitted to care homes, which aimed to estimate how many might have been able to take advantage of Extra Care provision as an alternative. Information was collected via interview and semi-structured questionnaire relating to 36 older people, their circumstances prior to admission, and the factors which were decisive in directing them towards residential care

In over three quarters of cases, the decision to enter a care home followed a critical event such as a fall and/or hospital admission. In the absence of community-based 24 hour care, residential care was seen by relatives and professional teams as the option of least risk, and clients acquiesced in the decision in order not to become a burden. It was estimated that two thirds of the older people included in the survey could actively have benefited from Extra Care provision, either currently or at the time of an earlier move.

Introduction

In January 2003, the Institute of Public Care (IPC) was asked to report on some issues relevant to the development of Extra Care in a Unitary Authority (UA). Managers wanted help in quantifying likely numbers of people for whom Extra Care might be an appropriate solution in the future. One element of this work would be a survey of people recently admitted to a care home, their families and care managers, in order to establish the events and care pathways that had led to that particular outcome. This would help towards an understanding of how many people currently entering a care home could have taken advantage of Extra Care provision had it been available. The work was funded by the Department of Health: Housing Learning and Improvement Network (Housing LIN) within the Health and Social Care Change Agent Team.

Extra Care is increasingly being seen as having a key role to play in offering choice to more frail older people who value independence and autonomy Extra Care provision emulates as far as possible the conditions of remaining at home, including having one's own front door and security of tenure, access to social networks, and opportunities for leisure and recreation and lifelong learning, with the advantage of flexible care and support to make that independence a reality (Housing Learning and Improvement Network: 2003).[1] Crucially, informal carers can continue to care, and spouses can remain together.

The sample.

The survey sample consisted of 36 cases, all of whom had recently entered a care home. Data was collected through examining case notes and interviewing residents where possible, as well as through interviewing relatives and care managers. Table 1 below shows the sources of information for the 36 cases.

[1] See Housing LIN Factsheet 1: What is Extra Care Housing, 2003.

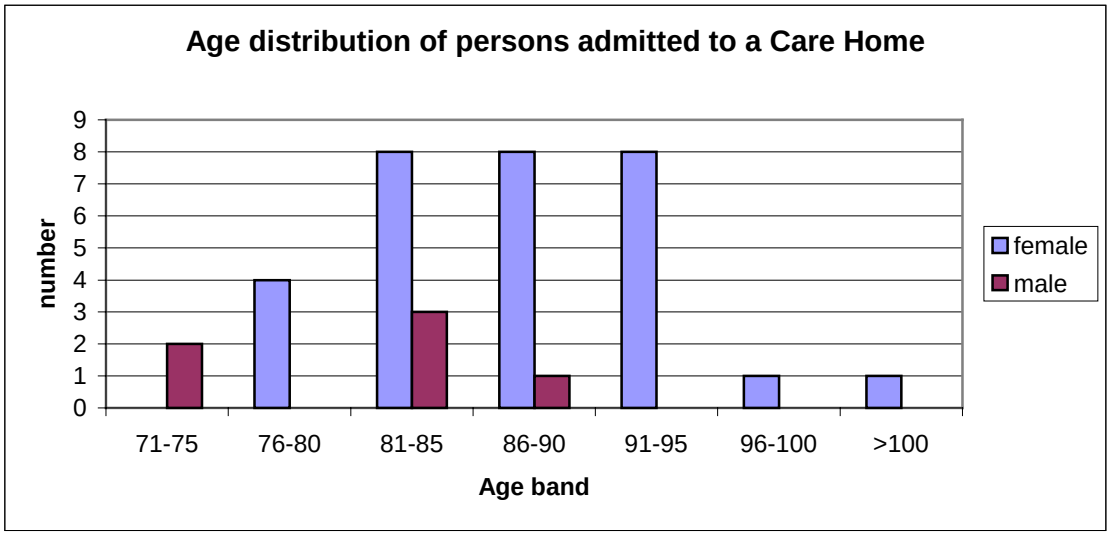
Table 1: Sources of information

Source	Number
Case notes or care manager only	14
Case notes /care manager plus interview with client	5
Case notes /care manager plus interview with relative	7
Case notes /care manager plus interview with client and relative	8
Client only	2
Total	**36**

The sample was smaller than expected due to difficulties found by social work teams in accurately identifying which individuals met the criteria for inclusion. This suggests that more systematic recording is needed of outcomes of social work interventions, and the reasons for decision making.

The distribution of age and gender in the sample is shown in Figure 1 below. The average age at admission was 86 years 5 months: average age of men was 79 years, and of women 88 years. The youngest person in the sample was aged 71, and the oldest, 103. Of the 36 people in the sample, only 6 were men.

Figure 1



Out of 6 married people, one couple shared accommodation in the care home, and three had a spouse still living at home. The husband of one client had been in EMI provision for seven years. All the rest were widowed.

Previous moves before admission to a care home

Of the 36 older people studied, only 5 were still living in the family home at the time of admission to a care home. Thirty-one had already moved to a smaller or more accessible building, or nearer to family. However, we found that in a number of cases the move was a compromise, with increased support (for example in a son or daughter's home) or smaller

size (for example a mobile home) resulting in decreased accessibility. Table 2 below shows where people were living immediately prior to admission.

Table 2: Previous accommodation

	Living with spouse*	Living with son or daughter	Living alone	All
Ordinary Sheltered Housing	2	0	13	15
Client's Family Home	3	0	2	5
Mobile Home	1	1	0	2
Flat or bungalow, no warden	0	0	6	6
Son's or daughter's home		8		8
All	6	9	21	36

Formal and Informal Care prior to Admission

Volumes of care were divided into high, medium, and low. High volume formal care was defined as meals on wheels and two home care visits a day: high volume informal care as greater than 20 hours a week or living with the carer. At the time of admission to residential care, one client in the survey was receiving no help at all, either from the family or from statutory services, whilst three were receiving a high volume both of informal and formal care. Six were receiving a high volume of care from the family and none from home care, whereas none were receiving a high volume of formal care without input from the family. Overall, two-thirds of cases were receiving a medium or high volume of informal care whilst only one quarter were receiving a medium or high volume of formal care.

These findings suggest that, whilst input from statutory services can help frail older people to remain at home with family help, and whilst families can sometimes achieve this objective without help from the statutory services, the provision of statutory services alone is not enough. Dalley (2003) notes that *an intensive care package (which) provides no more than care for the needs created by frailty but little to meet the need for companionship and other interaction*. Although the numbers were too small to be other than indicative, we found that all three of those receiving high volumes of statutory care (100%) were lonely, whilst 5 of the 18 receiving high volumes of informal care (28%) were lonely. This in turn confirms the findings of numerous studies, that informal carers should be valued for their contribution and given support, either through appropriate services to the cared-for person, or to themselves, to maintain it (Pickard 2003).

Reasons for entering a Care Home

For 28 of the 36 cases (78%), admission to a care home was precipitated by a critical event, usually a hospital admission. The nature of these events is shown in Table 3 below.

Table 3: Critical events precipitating admission to a care home.

Sudden illness, no hospital admission	1
Admitted for respite and did not want to go home	2

Fall but no hospital admission	5
Fall resulting in hospital admission	6
Hospital admission for another reason	7
Carer fallen ill or died	7
Total	28

Who suggested admission to a care home as a solution?

Of the 15 clients interviewed, only one reported that the suggestion to enter a care home originated with him or herself, whereas, for these same 15 clients, the care manager or case notes attributed the decision to the client and carer in every case.

It seems likely that in many cases the suggestion is made to the client or relative by another professional, who then raises it with the care manager, who in turn attributes it to the family or client. The discrepancy in reporting is very marked. It seems likely that the client no longer felt able to resist the genuine concerns of carers and professionals, and did not wish to become a burden to their family, so acquiesced in a decision which was by no means an active choice. However, it is possible that a wide range of unstated. Some quite sensitive, factors underpinned the decision. They included:

- The requirement to find a placement quickly for people in hospital and no longer in need of medical care
- The increasing responsibility placed on carers as frailty of the cared-for person increases, coupled with the absence of 24 hour care in the community
- The limitations of intensive home care, and its failure to address the psychological and social needs of clients
- The propensity of medical professionals and housing wardens to see residential care as a natural 'next step' in service provision
- The absence of alternatives.

Would the choice of placement be different if these questions were made explicit, and addressed? Clearly the absence of alternatives at the time of the study was a key factor, and impacted on the quality of the discharge arrangements. Support for carers as a way of delaying institutionalisation is more likely to be successful if the hidden relevant factors are acknowledged and addressed. However, a study by the Audit Commission (2003) found that only 36 per cent of carers said that they had received any extra help at the time of the hospital discharge of the cared for person, whilst only 43% of carers who needed help out of hours actually received it.

Extra Care as an alternative to residential care

Researchers examined the information collected for each case, and made a judgement as to which residents would have been able to take advantage of Extra Care provision had it been available, based on the following checklist:-

- The advantages of residential care
- The disadvantages of residential care
- The advantages of Extra Care
- The disadvantages of Extra Care
- Would this client have been able to take full or moderate advantage of the facilities of Extra Care?

Evidence was sought that the client would have been able to use and benefit from the opportunities for independence, and the additional space, offered by Extra Care – not just to cope with the different surroundings. Table 4 shows the results of this exercise

Table 4: Residents who might have taken advantage of Extra Care as an alternative to residential care.

	Number	**%**
Could have entered Extra Care at time of admission to residential care	11	30.5
Could have entered Extra Care at time of earlier move	13	36
Preferred residential care	2	5.5
Would not have benefited from Extra Care	6	17
Insufficient data to judge	4	11
Total	**36**	**100**

Discussion and conclusions.

The results of the questionnaire survey pointed to a set of linked objectives relevant to care pathways and the place of Extra Care within them.

- The idea that older people are a passive audience who fail to make decisions about their future accommodation needs is not supported by this or other studies. Dalley (2002) notes that *A considerable number of people move in retirement – with peak times for moving just after retirement and then again at around the age of 80*. In this study 31 cases, or 86% of the sample, had already moved from the family home. However, not every move was successful or provided a permanent solution. If Extra Care is to be successful it needs to become an option of choice for people when a move is being contemplated. Some people will have worked very hard to purchase their own properties and will be reluctant to surrender that perceived independence, whilst others will see Extra Care is just an option in the local authority / RSL sector. If these groups are not targeted for Extra Care the likelihood is that they will stay in their own homes past the point where Extra Care would be an option.

- There was marked discrepancy in reporting between clients and professionals on the question of who first suggested admission to a care home as a housing solution. This may be attributable to a whole range of sensitive issues around maintaining the balance between risk and intervention, and the moment when professionals and relatives find the risks too much, whilst clients capitulate in order not to burden others with that responsibility. Better information for professionals (particularly GP's, consultants, hospital discharge coordinators and care managers), carers and clients, coupled with a wider choice of provision, would help to address these problems, which need to be made explicit.

- Generally, the assumption is that low volumes of care are largely informal, and high volumes of care are formal. In this study it was found that large volumes of care were being delivered by relatives, and no clients were being maintained in the community solely through high volumes of formal care. Although the sample was small, the impression gained from the interviews was that, whilst the statutory services can increase home care or occupational therapy interventions, without the social and

psychological support that comes from family or social networks people may not feel motivated to continue at home.

- Whilst the need for Social and Health Care being swiftly available after discharge is increasingly recognised there needs to be flexibility in determining when people are emotionally ready to 'go it alone'. Evidence from this study is that if people do decide they want to go home then these services need to give people confidence that they are making the right decision. Rigid application of a six week limit for Intermediate Care, for example, may be counter productive if the time is not enough to give people the confidence they need.

- Extra Care can provide both independence and interdependence for its tenants by creating balanced communities within schemes, enabling less frail people to engage with the very frail in organising leisure activities and lifelong learning, and in contributing to decisions about service delivery. However, in order to create such communities, the role of Extra Care as a preventative service has to be acknowledged, and a proportion of residents will need to have few or no care or support needs. This in turn implies the provision of sufficient units to accommodate older people at all levels of frailty, and their spouses. It will require service commissioners to take a broad view in ensuring that a plentiful and wide range of accommodation options are available in their area. Failure to do so is only likely to increase demand for residential care.

- Finally, this study, albeit limited in sample size, does indicate that it is possible for Local Authorities to establish criteria and estimate from the numbers of people who are currently going into care homes, those for whom Extra Care might be an alternative. However, if Extra Care then simply becomes a replication of residential care, with a slightly more community focus and less on site services, then the other gains required to make it successful are unlikely to occur. Such provision is also less likely to be attractive to people who wish to plan and purchase their own accommodation needs in old age. Consequently, as the population of older old people increases, a limited or narrow interpretation of Extra Care may do little to diminish demand for care home places in the long term.

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