

Older people moving to residential care in Aotearoa New Zealand: Considerations for social work at practice and policy levels

Delia McKenna¹, Barbara Staniforth²

¹ Waitemata District Health Board, Aotearoa New Zealand

² University of Auckland, Aotearoa New Zealand

ABSTRACT

INTRODUCTION: This exploratory study, undertaken in 2013, sought to examine how older people, living in Auckland New Zealand who did not have family living locally, experienced the move from living at home, through a hospital admission to living in residential care.

METHOD: Nine qualitative, semi-structured interviews were conducted with participants while in hospital and following discharge to a residential care facility. Data were analysed thematically.

RESULTS: For most, this move was a major, traumatic event in their lives. Participants identified both hindering and supportive factors through this process.

CONCLUSIONS: The process of transition from hospital is helped by older people being involved in decision making, and having adequate time and prior information. An assisted living facility that enables autonomy, has flexibility, and services in place to meet on-going physical and psychosocial needs supports the settling-in process. Continuity of social work interventions, advocacy and reviews of policy may also be useful.

KEYWORDS: assisted living facilities, hospitalisation, social work, transitioning

As the world's population is ageing, people over 60 are becoming a proportionately larger group within the total population. According to the United Nations Population Fund (UNFPA) and Help Age International (2012), global life expectancy has increased, and now new-borns can expect to live to 78 years in developed countries and 68 years in developing countries; by 2045 to 2050 this will be 83 years in developed countries and 74 in developing countries.

In response to this demographic shift, the Aotearoa New Zealand government has developed the Positive Ageing Strategy (Ministry of Social Development (MSD), 2001) and the New Zealand Health of Older People Strategy (Ministry of Health (MoH), 2001). These documents see ageing as a lifelong process and keep policy direction

and annual reporting focused on providing funding and service initiatives to assist older people to age in place—remaining in their own homes and communities.

To assist older people to live as independently as possible in their own homes, their physical and psychosocial needs are met by a range of services, predominantly funded by District Health Boards (DHBs) in accordance with the New Zealand Health Strategy (MoH, 2001). People entering residential care facilities have their medical needs met through DHB services, but DHBs do not consistently provide services such as social work to meet the rehabilitation or emotional needs of older people in the transition (Thornton, 2012). This is a major gap in service provision—no other agency consistently provides these services without

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CORRESPONDENCE TO:
Delia McKenna
delia.mckenna@
waitemataadhb.govt.nz

cost. This raises concerns about the impact of this gap on the emotional well-being of older people moving to residential care and any on-going impact on their quality of life.

This article reports on a study which examined the experiences of nine older people, as they moved from their homes into hospital, and then on to residential care. It aims to raise awareness of the impact of this transition and provide some insights into how social workers can facilitate this process. Implications for social policy and advocacy are also discussed in the context of social justice and human rights for older people.

Literature review

In the literature there is agreement that the societal and individual context in which the move to residential care occurs is an important consideration. The social construct of ageism (Age Concern New Zealand, 2008; Curren, 2007) impacts on older people's self-perceptions transitioning to residential care. Internationally, ageism is seen to impact service provision through the move to residential care and in the care facility itself (Attig, 2004; Curren, 2007; Doka, 2002; Kane, Priester, & Neumann, 2007). Ageist attitudes evidenced in one Australian study indicated that the provision of nursing care in older care settings was perceived as having less value by other health professionals and nurses (Henderson, Xiao, Siegloff, Kelton, & Paterson, 2008).

International evidence demonstrates that policy, funding streams and service provision to older people are less comprehensive than for younger people presenting with the same issues (Kane et al., 2007). It has been suggested that residential care facilities themselves could be viewed as a construct of an ageist society; that they are places where older people are separated from the rest of society, and are treated identically (Minichiello, Somerville, McConaghy, McParlane, & Scott, 2005). Curren (2007) notes that older people also hold ageist attitudes so, at a personal level

they are also negatively impacted by ageism. This self-stigmatisation (Peterson, 2007) is associated with depression, lessening self-confidence, poorer function, decreasing social interaction and lower self-esteem (Link & Phelan, 2001).

A study by Atkinson, Tilse, and Schlect (2000) demonstrated that older people moving to residential care are experiencing a major life-changing event. Continual losses, which happen with increasing rapidity in old age, often underpin the move into care. There is also a high incidence of depression among residents in care where people are confronted with the loss of their health, and their previously known life: community activities and connections, their home, and their independence (Atkinson et al., 2000). These losses have sometimes come alongside the loss of a spouse or partner (Curren, 2007).

Doka (2002) introduced the concept of *disenfranchised grief*, to describe the situation where people are not afforded the right to grieve. Attig (2004) has further asserted that when people discount, dismiss, devalue or discourage another's experience of grief, they exhibit a failure to empathise. For Attig this is a political failure involving both an abuse of power and serious neglect. It is an ethical failure to not respect the bereaved, both in their suffering and in their efforts to overcome it and live meaningfully in the aftermath of loss (Attig, 2004). Research highlights some things that may aid older people experiencing the grief of transition: Cooney (2011), Marshall and MacKenzie (2008) and Thein, D'Souza, & Sheehan (2011), for example, noted that, when research participants could rationalise the need for a move to residential care, or understand the necessity, that their ability to accept the idea was enhanced.

The prospect of going in to residential care has usually been viewed as an undesirable and unwelcome occurrence in older people's lives (Atkinson et al., 2000; Jorgenson, 2006). Jorgensen explored the factors influencing

admission to care facilities of 31 older people and found that most did not feel they had actively participated in the decision to move and were not happy with their relocation. Furthermore, many older people moved to residential care because they did not have local family support (Jorgenson, 2006). Koenig, Hee Lee, Fields, and Spano (2011) have noted that, for many older adults, decision-making about entering a care facility usually occurs over several months rather than days. This is at odds with current medical systems that require older people to make the decision, and choose their facility, within a few days.

Some studies have indicated that participants' active inclusion in decision-making increased their level of engagement and satisfaction with the move (Cooney, 2011; Jorgensen, 2006; Marshall & MacKenzie 2008; Thein et al., 2011). They found that security, safety, hopes of being cared for and being purposeful, all supported older people in preparing for moving. Regehr and Sussman (2004) identified that the personal attributes of "mastery, control, flexibility, and optimism" (p. 293) as a cluster of personality traits had positive effects on people's ability to work through traumatic occurrences.

Meaningful connections with others have been shown to assist people to feel a sense of belonging, and of being cared for. Finally, international and Aotearoa New Zealand research has also shown that family support is vital for older people moving to residential care (Atkinson et al., 2000; Marshall & MacKenzie, 2008; Thein et al., 2011).

Methodology

This study's aims were to gain an in-depth understanding of what older people experienced during the move to residential care, the impact this had on each individual and how they coped. Social workers on an older persons' health ward were asked to identify people who were likely to be discharged into a residential

care facility. Potential participants were given information about the study, and if agreeable, were then introduced to the researcher for further discussion.

Ethical approval was obtained from the University of Auckland Human Participants Ethics Committee and through the relevant DHB ethics process. Several ethical considerations were considered: the participants were vulnerable in that they were unwell physically—they had experienced some form of trauma due to accident or illness and they were also experiencing emotional trauma, facing a major life-changing event in undertaking an uninvited and unwelcome move to residential care. It was important to ensure that participants were able to make an informed choice to participate and that they had access to the emotional support needed before, during and after the interview process. Since funding was not available for interpreting services, participation was confined to English-speaking participants. Kaumatua and Kai Awhina were available to support Māori participants. Ward social workers provided emotional support and social work services to assist participants before and after each interview. All participants were actively engaged with the social work service in hospital and most accessed the social work support available to them following their interview in the residential care facility. Here the social worker worked with the participant and, with their consent, referred any issues arising from the move to the appropriate services.

Of the nine participants, five were male and four female; they ranged in age from 78 years to 98 years, with most in their late 80s. Eight participants had no supportive family living locally, one was married to a partner having cognitive issues and thus unable to support the participant in their move. Another was unmarried and had no living family. All other participants had been living alone. All were considered to be competent to make decisions for themselves.

All participants were assessed as requiring 24-hour residential care due to declining physical health. Not having supportive family living locally may have contributed to participants' need for residential care because a return home with extra support from family members was not an option. Five participants moved to rest home care, three to private hospitals and one to an apartment where rest-home level of care was provided. All participants identified as New Zealand European/Pākehā; one identified their family as Māori and Pākehā.

Participants were interviewed using a semi-structured interview format first in hospital and then again approximately one month after they had shifted to residential care (two participants were interviewed only after they had moved).

Data gathered from these interviews were analysed thematically using Braun and Clarke's six-stage model for qualitative analysis (2003). From the data, three general categories were developed focusing on perceptions in hospital, in the residential care facility and of the overall transition process. Specific secondary themes were developed from reading the text iteratively and these were developed into supportive/facilitative and distressing/hindering factors. Through continuous revision and refining of the categories and themes, and through looking for contradictory viewpoints and new understandings, information was gathered and formatted.

Findings

The findings were categorised into factors that were distressing or hindered the transition, and then those that helped facilitate or support the transition. These are presented for pre-discharge hospital interviews (A), and then for post-discharge residential interviews (B). Results are presented in Table 1 and then described in detail. Quotations from participants are presented in italics.

A. Hospital interviews

Hindering factors

Reluctance. Participants' initial experience was usually a strong feeling of reluctance: "I don't want to go," (Participant A, male, 88 years). The reluctance was both an initial reaction to a situation that felt unacceptable, and for some, an on-going distress. Participants' views of residential care were generally negative. Some participants used terms such as "zombies" and "the walking dead" (Participant E, male, 92 years) to describe the older people they had seen in care homes and struggled with the idea that they may be perceived, and perceive themselves, in the same light.

Trauma and Loss. As inpatients, participants were all recovering from some form of physical trauma. There was personal trauma too, associated with the shock of an undesirable major life change where participants considered what they were losing, as one participant stated: "It's the biggest thing I've had to deal with in my life," (Participant C, female, 90 years).

Participants also expressed regret that residential care was their only option, and shock at the unexpectedness of unfolding events. One participant indicated: "I'm annoyed with myself ... that I'm broken ... I can't do things for me anymore," (Participant A, male, 88 years). For many participants, multiple losses were represented by their loss of home. These included partner, work and memories of work, independence, driving licence, pets, and familiar places. "It feels like I'm saying goodbye to my life" (Participant A, male, 88 years).

Anxiety. The trauma people experienced was also mixed with anxiety associated with facing uncertainty in residential care. One participant stated: "My tummy's in a knot" (Participant D, male, 89 years). Participants' views of residential care were generally negative, partly influenced by thoughts of loss of independence, partly by remembered incidents of abuse in "care" and partly by

Table 1: Factors Impacting on Move to Residential Care

	Hindering	Facilitative
A Hospital	Reluctance Trauma and loss Anxiety	Move made sense Autonomy Personal strengths Family and friends Professional social work service
B Rest Home	Trauma and grief Strangeness of the place Inflexible facility Abuse and neglect	Memory Autonomy Feeling cared for Belonging Flexible environments Attitude Professional support in transition

their own culturally attuned attitudes about what being old and in care meant.

Participants felt distressed by the short timeframe from when they were given the information that they were not considered safe to live alone, to when they were discharged to residential care. Where participants had neither visited the residential care facility, nor had agency in the decision-making process, anxiety was increased. The majority of participants wanted more knowledge of residential care and the options available to them before leaving hospital.

Facilitative Factors

Move Made Sense. Where the participant felt that the move made logical sense, they were more able to engage in the process of decision-making. Most participants reported being told *“in a kind way”* (Participant C, female, 90 years) that they could no longer live safely alone. When participants chose to go home against medical advice and tried living on their own, and then saw for themselves they needed more support, they actively chose to move to residential care and consequently their acceptance and willingness to settle increased.

Autonomy. Where participants were given autonomy to make decisions for themselves,

they felt respected and that consideration had been given to the enormity of their situation. One participant, who had had the opportunity to view residential care facilities and make their own choice, said *“You’ve got to check carefully, to go without looking would be silly”* (Participant F, male, 92 years). Another participant, who did not have the opportunity to view facilities before making a decision, stated, *“I didn’t get to see the place—no one could take me—it’s like a nightmare”* (Participant B, male, 79 years). The participant who chose to move to their own apartment retained a full sense of autonomy, *“I took one look [at a facility] and thought ‘no, not for me’ ”* (Participant F, male, 92 years).

Personal Strengths. Participants considered that their personal attributes of resilience from many years of living, of positivity and of flexibility, would assist them in making the move. One observed, *“I’m ninety and I look forward to how I’m going to carry on for the next ten years”* (Participant E, male, 92 years). Some participants identified that their faith gave them a strong sense of support: *“God has his hand on me always”* (Participant C, female, 90 years). Faith was part of these participants’ identity, and gave them a strong sense of belonging and of being valued. Their faith also gave them a sense of hope and purpose.

Family and Friends. Family connection was important to participants, as it gave

them a strong sense of belonging; that they were of value to someone and vice versa. Seven participants had family who, while not living locally and who were therefore not able to offer consistent ongoing support were able to assist with initial decision-making. Participants spoke of the importance of their family knowing what was happening and of agreeing with outcomes, *"I'm lucky I've got family, it makes a big difference to know that we can talk and that they agree with what I should do"* (Participant C, female, 90 years). When family were respectful of participants' circumstances and their right to autonomy, then the family was seen to provide vital practical and emotional support. Where participants did not have family to talk with, and sometimes even when they did, they also valued the opinions of other important people in their lives, notably their general practitioner.

Professional Social Work Service. Participants found the provision of a social work service useful for discussing their situation with someone independent of family and friends. They also noted it was helpful to have advocacy when it seemed they were not being listened to, and to have help in complex problem solving around the practical aspects of moving when they had no family support available. One participant noticed, *"I'm not sure who is sorting everything out ... [social worker] is helping me"* (Participant D, male, 89 years). Family members also engaged with the ward social worker to talk about their concerns regarding the moving-to-care process.

B. Post-Discharge Residential Care Interviews

Hindering factors

Trauma and Grief. At the second interview participants spoke of their losses, particularly of their homes and this being sold. They spoke of their sadness and of trying to *"get used to the place"*; trying to *"settle in,"* noticing

"it's not home ... but." Perceived trauma and anxiety were heightened when participants did not remember the reason for the move, when they did not agree with it, and when they felt unsure of themselves and their residential care facility. As one participant put it: *"I have nightmares ... sometimes I think they are real... it's very hard to define what's real"* (Participant D, male, 89 years). Eight of the nine participants reported having difficulty confronting what they perceived to be the realities of having grown old. All participants commented on the busyness of the care-giving staff and so did not feel able to stop the staff to talk with them. The majority of participants noted that the researcher and social worker were the first people they had talked to about how they were feeling in relation to the move to residential care.

Strangeness of the Place. Most participants stated that they were still adapting to the *"strangeness of the place,"* trying to fit in with the routine. *"We have to go down to the dining room for dinner and wait and wait..."* (Participant B, male, 79 years); trying to understand what was expected of them. Participants also spoke of the difficulty of having to live with other people and accept different behaviours: *"That guy over there, he's so loud. He says the same thing day after day... He calls me mate ... I don't know him ... I don't like that"* (Participant B, male, 79 years).

Inflexible Facility. Participants spoke of difficulty with the facility's inflexibility, which could also contribute to experiencing a lack of autonomy. Participants who found their care homes inflexible found their living circumstances difficult. Some participants spoke of not being able to go out and do the things they used to do and cited their own disabilities and the busyness of staff as impediments. As one participant put it: *"if I can't get there—I just have to accept it"* (Participant C, female, 90 years). Some residential care homes had more obvious routines over mealtimes in the dining room, showering at certain times, and group-activity times. Smaller care facilities

appeared to be more flexible in attending to the individual needs of participants, for example of being able to accommodate participants' pets.

*Abuse and Neglect*¹. All participants spoke of at least one incident where they had felt ignored, undermined or neglected. One participant described how, "After my shower I just sat there shivering on the toilet waiting to be dried" (Participant B, male, 79 years). Another, speaking of mealtimes, stated that: "sometimes I can't reach it and hold on to it and eat it. Sometimes they help me and sometimes they don't" (Participant D, male, 89 years). Participants described being told to "just wait", or of staff "playing childish games." One was not given assistance to change their hearing-aid battery and was not able to hear staff. Participants described situations of passive neglect, as there was no opportunity for the participants to talk with their care-givers because they were perceived as "too busy" and no assistance with problem solving.

Three participants spoke of feeling abused. The first spoke of not being able to remember why they had come to "this place" and so felt they were being held against their will. The second spoke of having been forced by family to move into residential care without their partner of 65 years this loss was greater than the participant could bear "I've got no money and no clothes. I've lost time between night and day ... I'm a bit confused this morning and I've been having nightmares ... I can't sort out which is right and I worry ... I hope [we] can be together again" (Participant D, male, 89 years). Another participant reported regular physical and emotional abuse by a carer: "She's so rough drying me ... she talks to me like I'm a dog ... 'sit there and stay still' ... she showers me under pressure, ... and when I get upset she laughs at me ..." (Participant G, female, 88 years). This participant talked to their facility manager but no remedial action

¹ A social worker was available to each participant and, with their consent, actively listened and assisted the participant through an agreed-upon social work intervention.

appeared to be taken. She then engaged the assistance of a friend to help move to a different facility.

Facilitative factors

Memory. Participants considered that remembering the process that had led to them coming to residential care, and holding their memories of their previous lives, supported them in their life within residential care. "I remember the doctor telling me in a kind way I couldn't live by myself anymore" (Participant C, female, 90 years) and "I get a lot of pleasure looking back and remembering" (Participant I, female, 97 years). The memory of their love for their family and how important it might be for their family to know that they had settled in to their care home added motivation to settle, "It's important to my family that I settle" (Participant C, female, 90 years; Participant D, male, 89 years).

Autonomy. The ability to act independently was empowering for participants. Smaller care homes appeared to offer greater flexibility to allow autonomy, "I can more or less do what I want ... I have my animals, my pictures on the wall ... I take my dog for a walk everyday ... it's just like home" (Participant E, male, 92 years). The ability to bring loved pets who could stay with them in their room, was noticed to markedly assist one participant to feel settled. Being able to go for a walk and to go to the shops also assisted some participants' with autonomy and purpose, which appeared to increase their feelings of being settled. The ability to exercise some independent thinking was seen as crucial to maintaining a sense of self, "I can walk to the telephone and toilet without my walker now. I think I'm not allowed to do that but you need your little bit of freedom" (Participant H, female, 90 years).

Feeling Cared For. Feeling cared for by family, the care home, and by the wider community contributed to a sense of belonging. Within their residential care homes, good food was

also perceived as a key indicator of feeling well cared for and most of the participants felt satisfied with the food. Feeling cared for also involved mutually caring for those who cared for them. Participants demonstrated this by being grateful and not giving their care-givers anything more to do. For participants who were critically ill, being cared for was most important outweighing all other considerations: *"I just need to be looked after now ... they [care-givers] are so kind"* (Participant I, female, 97 years).

Belonging. The sense of belonging to self (retaining self-identity including cultural identity) and to family, *"Knowing I have family [who love me]... that they'll come if I need them"* (Participant E, male, 92 years) was a vital support to participants and assisted their feelings of security. Where participants felt a sense of belonging to their care home, *"Everybody knows my name"* (Participant E, male, 92 years) and to the community, the gap between life at home and life in the care home seemed to be bridged, and provided a sense of continuity for the participants. One, who had moved to a residential care home in their own community stated, *"It's my old stomping ground ... I know every inch of it"* (Participant A, male, 88 years).

Flexible Environments. In residential care, flexible environments were those that had a more relaxed routine, for example, flexibility around shower times or where they ate. Flexible environments were also those where their loved pets could be with them, that allowed participants to have sleep-overs at home, and where they were able to *"have a drink"* or *"a smoke."* These environments were where participants could exercise agency in their lives as far as possible.

Attitude. The participants' positive self-identified attitudes to life assisted them to engage with the settling-in process. Participants used terms that portrayed a positive attitude to life: *"a smile on your face"; "I'm grateful"; "I adapt quickly"* and *"I like people."*

Professional Support in Transition. The participants found the ability to talk about their situation and express their grief to be useful. The strength-based interview questions also encouraged them to acknowledge their strengths in the face of the move. Participants expressed gratitude for the chance to engage with the researcher and the social worker who supported the research process.

"Talking about it has helped me put two and two together" (Participant E, male, 92 years).

"Talking about it has been the best thing" (Participant C, female, 90 years).

"This is what I really do miss ... being able to really talk ... let my hair down and talk about everything" (Participant G, female, 88 years).

Participants provided rich data about their experiences of moving to care. The following section explores some of the implications of their experiences for social workers at practice and policy levels.

Discussion

The findings of this study confirm the general consensus in the international literature that a move to residential care can be traumatic and life-changing for older people. The significance of the move to residential care is often not acknowledged, or assisted, by formal services. Where people make this move with no family or formal support, they do so without support for their emotional and social needs. As suggested previously, lack of service provision for older people undertaking this move represents a political failure to show empathy for the suffering of older people. The lack of assistance for them in their efforts to overcome the trauma and to live meaningfully in the aftermath of their loss constitutes abuse of power and serious neglect (Attig, 2004); this may reflect prevalent ageist attitudes. The social construct of ageism also makes older people less likely to ask for services since they often hold the same ageist views as the rest of society and

are limited by them (Attig, 2004, Curren, 2007). Certainly the participants in this study themselves reflected ageist beliefs with one participant referring to older people living in residential care as “zombies” and “the walking dead” and perhaps fearing that they may be perceived in the same light. These statements are examples of internalized oppression—the participant(s) having internalised the dominant discourse of ageism.

Based on these findings and the literature, some insights are offered as to how the process of moving into residential care from hospital might be improved at various points in the transition.

In Hospital

Social workers could contribute to a review of policy and practice in older adult services to ensure that older people’s rights to informed decision-making are assured. These findings, and the literature, both point to the need to ensure older people have adequate time to make informed decisions about their future care needs. The process of decision making ought to include: information provision regarding diagnosis and reversibility (Atkinson et al., 2000; Thein et al., 2011); the opportunity for independent emotional support and processing (appropriate to the person’s needs); the opportunity to view possible facilities; the opportunity to consider all available care options without undue influence; the opportunity to go home with increased support while deciding; the opportunity to trial a residential care facility and the opportunity to go home to say “goodbye” to one’s home. Ensuring and upholding the older person’s right to autonomy and agency in decision-making shows respect for them, respect for their circumstances (Attig, 2004; Brownie & Horstmanshof, 2012), and correlates positively with increased feelings of settledness with their decision (Thein et al., 2011).

International literature (Atkinson et al., 2000; Brownie & Horstmanshof, 2012; Koenig, Hee Lee, Fields, & MacMillan, 2011; Koenig et al.,

2013; Thein et al., 2012) and these findings show that social work services can assist older adults and their families to attend to the social, emotional and practical issues implicit in moving to residential care. This study showed that, for the participants, the provision of a social work service through the transition assisted the participants’ sense of security, gave them increased confidence in the move, and the opportunity to talk about issues that were impacting on their sense of well-being in the facility. It also allowed the opportunity for social work intervention in complex situations.

Social work intervention in this study included such things as assisting a participant’s partner who was not managing at home without the participant (as the participant had been the main care-giver); advocating for a participant to ensure their voice was heard regarding safety issues; and grief counselling, which included listening to their story and their grief; acknowledging this grief and assisting the participant to remember and use those strengths, thoughts and activities that assisted them to manage their grief. Koenig et al. (2011) acknowledge the importance of social workers in assisting older people and their families through the decision-making process of moving to residential care and in addressing the needs of older people transitioning, including assisting with problem solving, and coping strategies.

In Residential Care

Age Concern New Zealand (2013) has made recommendations to the Aotearoa New Zealand government to improve service provision in residential care. These include: creating the conditions for dignified and respectful care; ensuring that there is a residential care audit process that accurately assesses the well-being of residents and ensures concerns are addressed promptly; undertaking a review of the staffing ratios in residential care; developing a nationally recognised qualification for care workers; and combating ageism in the health sector.

The findings of this study support Age Concern's recommendations and also inform other possible suggestions for facilitating transitions to supported care.

The findings support the idea of creating flexible environments where older people experience their individual choices being accommodated, rather than feeling moved into a routine that better suits the needs of the providers (Brownie & Horstmanshof, 2012; Thein et al., 2011). Within this study, smaller rest homes appeared more able to create a homely, flexible environment: participants more quickly developed a sense of belonging. When the care home was in the participant's usual community, feelings of being settled increased. Being able to bring pets also increased people's ability to settle in their care home. There also appeared to be an unmet need for residential care homes and funders to cater for life partners to live together or have a shared care arrangement. These are all important variables where social workers can advocate for their clients.

Social workers could be involved in the continuing education of residential care staff about the cultural and psycho-social needs of people living there. It is important for staff and volunteers at all levels of care provision to have opportunities to recognise cultural differences in residents, including their different sexual orientations, beliefs and needs and to consider how best to meet their requirements. Increased educational opportunities could assist caregivers and facilities to become increasingly flexible in acknowledging and attending to these needs (Barrett, 2008; Brownie & Horstmanshof, 2012).

Participants in this study spoke of their sadness at having to leave their own GPs, hairdressers and their usual faith groups. Were it possible to retain these connections, this would likely enhance a sense of continuity and ongoing community belonging. When the participants had community outings, or entertainment and

groups coming in, they expressed feeling part of the community. Recent initiatives, such as Eden Alternative Communities (Barba, Tesh & Courts, 2002), have demonstrated a greater sensitivity to these connections and to creating a sense of continuity.

The international literature (Brownie & Horstmanshof 2012; Cooney, 2011; Thein et al., 2011) and the findings here show the importance to older people of retaining autonomy in their lives and of feeling valued and purposeful. With increased mobility and ability comes increased confidence, assisting autonomy. The provision of ongoing physical rehabilitation within residential care facilities would likely help in maintaining this autonomy.

Social Work Service

The findings demonstrated a need for a social work service that would work with people through the transition to residential care. This service could attend to the psychosocial needs of residents and their families and also be there for conflict resolution. Internationally, Atkinson et al. (2000) have expressed concern regarding the lack of support older people have with "emotion-based" (p. 10) coping. Marshall and MacKenzie (2008) also state that, "relocation [to residential care] can pose a threat to physical and psychological health if an older person perceives [a lack of] adequate support, resources, or personal control" (p. 124). Koenig et al. (2011) see provision of social work services in residential care facilities as essential to uphold residents' rights to independence and privacy, to mediate and assist with conflict resolution, and to collaborate with staff in resident-care planning.

All participants in this study engaged with the social work service offered to them through their transition. Nine engaged prior to leaving the hospital and eight with the social worker again at the care facility. Participants found participating in the

process of the research, and being able to talk to a professional person to be of benefit. They described being able to talk about how they were experiencing the move, what was important to them through the move, and being able to identify their own strengths in facing this challenging experience to be both supportive and reassuring.

Abuse and Neglect

Within this study of nine older people, all reported having experienced some form of behaviour they found unacceptable and three participants described situations where they felt abused in the process of transitioning to residential care or *in* the facility. This rate within such a small sample is alarming, and likely to be the tip of a much larger iceberg.

Sections 195 and 195A of The Crimes Amendment Act No 3 2011 identify a vulnerable adult as a person who, due to age, health, cognition, illness or any other reason is unable to remove themselves from an unsafe situation. The Act also makes it a criminal offence to harm a vulnerable adult or to leave a vulnerable adult in a situation where they are in danger of serious harm (Crimes Amendment Act No 3, 2011). Since the law came into effect, some DHBs have enacted policies outlining the responsibilities and duty of care health professionals have to vulnerable adults who use their services. Older adults living in residential care have often not been considered in this cohort of vulnerable adults because it is considered that their needs are being appropriately met by the facilities themselves.

People living in residential care are among Aotearoa New Zealand's most vulnerable: they are often invisible to the rest of society, and they may lack the ability or the confidence to speak up or draw attention to their situation if they need to. Where they have no family living locally, they are entirely reliant on the staff of the facilities in which they live. This research has highlighted that in Aotearoa New Zealand many people

move to residential care because they do not have family support available to them in the community (Jorgenson, 2006). The Ministry of Health has a process for investigating allegations of abuse or neglect in residential care facilities and an auditing process. The Health and Disability Commission also has a process for working with complaints about health care delivery including the care delivered in residential care facilities. Age Concern New Zealand has contracts to investigate allegations of abuse in residential care facilities. While these services are available to assist people living in residential care, it is often difficult for people living in residential care to connect directly with them.

DHBs are responsible for the care they provide to older people living in the community, as inpatients, and in residential care facilities. Funding for people living in residential care facilities comes, in part, through the DHBs. Recommendations regarding a social work service being provided in residential care facilities *as standard*, a rehabilitation service being offered in residential care *as standard*, or a decrease in the patient to staff ratio in residential care *as standard*, have all been made to the Ministry of Health. There are significant financial implications involved in providing these initiatives however, and there appears to have been little movement around these recommendations.

Raising awareness regarding vulnerable adults and the responsibility of the health service and individual workers to notice vulnerability and ensure safety is a first step to bringing about change in policy and process as to how older people are treated in the move to residential care. Challenging ageist attitudes that lump older people together and ignore their psychosocial needs is a challenge all health social workers are intrinsically called to meet in their roles on a daily basis. Social workers and social work leaders are ideally positioned to be at the forefront of advocating for appropriate service provision for older adults moving to residential care and living in those facilities.

Conclusion

This article has presented results from a small-scale study that explored nine older people's experience of moving from home to supported residential care following a hospital admission. None of these people had supportive family living locally. Several themes emerged from interviews and provide some understanding of the physical, emotional, social, spiritual and political context in which the "move to care" happens.

Accounts of participants' lived experience and their wisdom provide the information and impetus for us (policy makers, health care professionals, managers and care-givers) to develop patient-informed policies and practices that better acknowledge, respect, and mitigate the trauma of this move. While the findings of this study cannot be generalised to all people making this move, the results validate much of the international literature and offer some important considerations for social workers in Aotearoa New Zealand. A larger-scale study would be of use to further explore the impact of moves to residential care and would add to this developing body of knowledge.

The research brings to light the real journey of nine older people who made this transition and their thoughts about what helped, and what hurt, them through this process. It seems that a social work service through the transition to residential care had the immediate impact of empowering the person moving. A social work service through the transition and in residential care facilities may well positively assist both the resident and the facility with the provision of grief counselling on site, assisting family/whānau manage the changing behaviour and needs of their partner or parent and provide strength-based interventions in complex situations. A social work profession that is able to challenge stigma and discrimination, impact social policy and funding of programme initiatives is also important to ensure social justice at wider levels.

*He aha te mea nui o te ao? He tangata ...
he tangata ... he tangata!*

*What is the most important thing
in the world?*

*It is people ... it is people ... it is people!
(Whakatauki)*

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