

A series of research projects about health and social care for older people

**Final report 2013**

# **Assessment at Home Pathway: the experiences of service users, carers and staff in South Glasgow during the early stages of implementation – July 2012 – January 2013**

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**P•R•O•P**

**PRACTITIONER RESEARCH: OLDER PEOPLE**



centre for research on families and relationships



Institute for Research and Innovation in Social Services

# **An Overview of the Practitioner-Research: Older People Project**

## **Project overview**

The PROP practitioner-research programme is a partnership between the Centre for Research on Families and Relationships (CRFR) at the University of Edinburgh and the Institute for Research and Innovation in Social Services (IRISS). It was funded through the Economic and Social Research Council. This programme also received support from the Scottish Government's Joint Improvement Team.

CRFR and IRISS partnered with a group of Scottish Local Authorities, NHS, third and independent sector organisations to produce this practitioner-research programme. The partners include NHS Lothian, West Lothian Council, Glasgow City Council, Alzheimer Scotland, and Scottish Care and VOCAL Midlothian and Midlothian Council.

This project is underpinned by two key premises. The first recognises that to improve care for older people there is a need for an improved evidence base that relates directly to the needs of those providing services and those developing policy. The second premise is the need to better share this evidence base through greater use of this resource by key audiences and users. One way to achieve both objectives is through the co-production of knowledge between academic researchers and those involved in delivering care.

The PROP project brings together a team of practitioners in health and social care provision, academics and specialists in evidence-use and knowledge media from IRISS and CRFR. Collectively we have synthesized existing evidence, generated new evidence and improved the use of this evidence with the partner organisations. Our aim is to promote a culture of evidence-informed inquiry with the hope that this supports improvements in the lives of older people across Scotland.

## **Project Aims**

Through the delivery of a practitioner-research programme, we aim to achieve the following:

- Improve the volume and quality of research produced by those delivering health and social care for older people
- Increase awareness of, and improve access to, research created by those involved in providing care for older people
- Support greater engagement and collaboration between researchers and practitioners involved in researching and delivering care for older people across health and social care contexts
- Extend theoretical and practical understandings of the knowledge translation, brokerage and exchange processes that are effective between academics, users, policymakers and practitioners when sharing good practice in the production and utilisation of findings relating to the health and social care of older people

## **About Practitioner Research**

Practitioners undertake a considerable amount of research, in fact Mitchell and colleagues estimate that 'practitioner research in social work probably occupies a major part of the total volume of research activity in this field' (Mitchell et al, 2010: 8).

There is evidence to suggest that practitioner research can be a valuable approach for strengthening the use of research not just for the individual practitioner undertaking research but potentially for the organisation and perhaps even the sector in which they are based. These benefits vary depending on the support available for the practitioner and how the research endeavour is structured; which can for instance involve support being provided by other practitioners, academics or research colleagues based in-house or in external organisations. Some of the benefits of practitioner research for the practitioner and their organisation can include:

- Delivers research of direct relevance to practice concerns
- Improves research capacity of individual practitioners and organisations

- Strengthens the active role of the practitioner in the research process
- Brings the worlds of policy, practice and research closer together
- Helps an organisation develop the capacity for critical inquiry and a “learning orientation”
- Supports the desire for and the use of research done by “outsiders”
- Reduces the distance knowledge has to travel from research to practice
- Provides a starting point for further research-practice collaboration

(Armstrong and Alsop, 2010; Roper, 2002; Anderson and Jones, 2000: 430)

However, we are not necessarily maximising the impact of research undertaken by practitioners in social services and health for three main reasons:

- 1) Practitioner researchers often lack professional support and training related to the use and application of research methods and theory.
- 2) Practitioners struggle to access existing evidence related to their work, thus potentially affecting the quality of what they are able to produce.
- 3) Practitioners engaged in conducting research into their own team, service or organisation do not usually have the time or capacity to disseminate their research findings or to support its use in other services or organisations.

## **The PROP Practitioner-Research Programme**

This Practitioner-Research Programme (PRP) was delivered between May 2012 and August 2014. Over this period, the nine practitioners involved in the PROP project designed and carried out an empirical research project directly related to their practice and the theme of care for older people.

The partner organisations (Alzheimer Scotland, Glasgow City Council, Midlothian Council, NHS Lothian, West Lothian Council, and VOCAL) made a commitment to support selected members of staff to participate in the PRP. Practitioners were allocated ½ day/week for research, six days for research training and two days for knowledge exchange seminars.

Each practitioner-researcher was allocated a mentor from the University of Edinburgh, NHS Lothian or IRISS. This mentor supported the research design and analysis in the project and provided guidance on how best to use research findings to develop policy and practice.

A series of six training sessions was delivered between July 2012 and February 2013. These full-day events focused on six areas of research practice: (1) resources for research, (2) project management and research planning, (3) research design, (4) generating evidence, (5) analysing evidence, and (6) knowledge exchange.

Knowledge exchange events were held in October 2012 and May 2013 to facilitate learning from these research projects within and across the stakeholder organisations. These events supported practitioners to share and disseminate research findings and provide evidence to partners and stakeholders about best practice.

## **Project Outputs**

The project outputs focus on two areas: (1) improving the care of older people and (2) improving the use and usefulness of research for those involved in providing care. These include:

- 8 completed practitioner-research projects, including final reports and summary postcards
- 1 summary booklet of the PROP programme of practitioner-research
- 2 knowledge exchange events
- 2 peer-reviewed journal articles about improving the use and usefulness of research for those involved in delivering services
- An evaluation briefing paper about the practitioner research project

For more details, please see our website: <http://blogs.iriss.org.uk/prop/>

## **How to Reference this Report**

When making use of this material, use the following reference for this report:

Litteljohn, K. (2013) 'Implementation of the Assessment at Home Pathway'. Scotland: CRFR/IRISS.

## **References**

Anderson, G. and Jones, F (2000) Knowledge Generation in Educational Administration From the Inside Out: The Promise and Perils of Site-Based, Administrator Research in Educational Administration Quarterly (Vol. 36, No. 3 (August 2000) 428-464

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## Introduction

Scotland's population is ageing and it is widely acknowledged that current systems of meeting care needs will become unsustainable. By 2031 for instance, the number of people aged over 65 and 85 will increase by 62% and 144% respectively. In Scotland, around £4.5 billion was spent on health and social care for people aged over 65 in 2006/2007. This will rise to £7.5 billion by 2031. A large proportion of this was spent on hospitals and care homes, with emergency admissions to hospital alone accounting for £1.4 billion. If services continue to be provided in the same way it is estimated that this figure will increase by £1.1 billion by 2016, and by £3.5 billion (74%) by 2031 (BGS: Scotland's Health Numbers: 2011).

While increasing longevity of older people can be viewed as a positive trend in our society, the changing demographic of an increasing older population creates demand and challenges for health and social care services against a landscape of scarce and in real terms, decreasing resources. The Scottish Government's report, *Reshaping Care for Older People: A Programme for Change 2011 – 2021*, explores how health and care services for Scotland's older people can continue to be delivered and improved over the next ten years. A focus on preventative care and planning and providing services in more integrated ways (between GPs, hospitals and community-based health, social care, housing, the third and independent sectors) is the approach being pursued.

Assessment at Home (AAH) is a new hospital discharge pathway for people over 65 years of age with complex needs. It was developed by the South Glasgow Joint Health and Social Work Assessment At Home Working Group.

Glasgow City Council's Reshaping Care Strategy Group described Assessment at Home as a "project to establish a robust pathway for earlier discharge home for those deemed fit for discharge. It will involve a multi-disciplinary method of identifying individuals in wards that could be discharged home to complete their social care assessment. A flexible range of care supports will then be offered to ensure the person's well-being at home while longer term decisions are being taken" (Summary of Change Fund Projects, June 2012). The Change Fund has also funded additional support services to supplement existing resources for care packages in the community. These include a rapid response service (a 15 minute responder service linked to the telecare alert system), a managed medication service (to assist service users with medication regimes), an overnight visiting service, the development of Carer Support Teams providing support to carers and third sector befriender services.

The key areas of the Assessment At Home (AAH) Pathway are identified as:

- significantly shortening the length of time the service user has to wait in hospital to be assessed by a social worker or care manager
- reducing the time that service users spend in a hospital bed before discharge, thus reducing beds days lost
- supporting jointly agreed (social work and health) work to shift the balance of care away from care home placements, towards care at home.

The key rationale underpinning AAH is that no one should remain in hospital only for social care reasons, and thus discharge should not be delayed by the time it takes to complete a community care assessment (CCA). The current target for CCA completion and discharge is 6 weeks, and this reduces to 4 weeks in April 2013 and 2 weeks in April 2015.

The Pathway was implemented in the South Sector on 25 June 2012 and rolled out to the North West and North East Sectors of the city in August 2012.

## Research question

This research explores the AAH pathway as experienced by a cohort of practitioners, carers and service users. Specifically, it:

- i) explores staff, carer and service user experiences
- ii) identifies a number of factors which support or inhibit an effective AAH process

The research topic was chosen after several alternatives around interagency work in health and social care were examined. The proposal was developed in consultation with mentors from the Institute for Research and Innovation in Social Services (IRISS), in association with Practitioner Research Older People (PROP) and with help from the Social Work Services' Research and Development Team.

## Methods

This report describes a small-scale practitioner research project undertaken between July and January 2013 by a social worker based in the South Hospitals Social Work Hospital Team.

The research involved gathering data from:

- i) semi-structured interviews with ten practitioners and managers, five carers and four service users
- ii) case analysis: examining the process for people who were discharged home and for whom the pathway proved unsuitable

Ten staff (four social work and six health professionals) serving the Glasgow South Hospitals area and based both in hospital and community services were interviewed. They represented different disciplines and grades and had experience and expertise in discharge processes. The staff respondents were approached because they were involved at some level in the implementation of the new AAH process. All staff approached agreed to be interviewed.

The sample of cases analysed came from the researcher's caseload and were allocated during the period from July to December 2012. Of the four service users who were discharged using the AAH process one was too ill to be interviewed and the other three agreed to be interviewed. Carers for each of the four service users, a total of five, agreed to be interviewed.

Interviews with practitioners took place from mid-October 2012 to the end of November 2012. They were carried out in privacy and were recorded with the agreement of the participants. Interviews were based around an interview schedule (which can be found in the Appendices II and III) lasted on average 40 minutes and have been anonymised in reporting. Interviews with service users and carers took place in the service user's locus of care - three took place in their own homes, two took place in care homes. Of these, one service user and her carer consented to the interview being recorded. Three service users were too debilitated to have their responses recorded and in those cases their responses and those of their carers were noted.

The choice of this qualitative approach was predicated on i) being able to elicit considered responses about a new process and ii) providing an interpretive balance to the case examples. Data collected from interviews was selected and transcribed for analysis. The volume of data precluded full transcriptions, but all the data informed the research. Analysing the data included charting the assessment at home journey for service users and carers and exploring the experiences of those involved in the process. Key themes emerged from the interviews relating to the factors which enabled or inhibited assessment at home; the experience of processes and practices; and service user quality of life and outcomes. The data was examined according to these themes.

Limits of time and resources did not allow all stakeholders to be involved or all AAH cases to be sampled. During the research process incremental changes were made to AAH, meaning some of the findings during this period would already be different if the exercise were to be repeated.

## Ethical issues

The study was given ethical approval by Glasgow City Council's Social Work Research and Development Section.

All interviewed participants agreed to become involved in this research and have been anonymised in reporting. Care was taken to remove potentially identifying material.

A key ethical issue was the professional role of the researcher and how this would affect respondent attitudes. To limit this possibility care was taken in the choice of methods used (use of anonymity/



confidentiality; semi-structured interviews). The practitioner interviewer was careful in her conduct as a researcher (e.g. demonstrating empathy and openness to respondents, and acknowledging their own professional expertise). This enabled the researcher to build trust with respondents and to capture perceptions that might not have been as easily shared with a researcher who lacked the practitioner role. All service users interviewed had capacity to consent to the interviews. Consent forms used for interviews are shown in Appendix VII.

Multiple styles had to be adopted to create empathy, as the professional cohort required a different approach from the service user and carer group. Even given appropriate methods and personal approaches, the researcher's position as a professional and practitioner may have caused some interviewees to moderate their views.

A largely descriptive approach was used to analyse the rich data collected. This approach gives priority to the views obtained. Respondents' observations and experiences were mapped against supporting and inhibiting factors and key stages in the AAH process. Perspectives gained were treated iteratively in order to develop a set of themes that could characterize views in a way that provides insights on the operation of AAH from both a practitioner and a service user perspective.

## Findings

The report now describes the research context of AAH before turning to the substantive areas of practitioner and service users and carer experiences and perceptions, closing with factors that enable AAH and research conclusions.

### Context

The research was conducted early in the design and introduction stage of AAH. At the early stage of its implementation, AAH referrals to Social Work Services were limited and of those referred to Social Work Services few service users were discharged home under the AAH model. Consequently every practitioner interviewed in this study had limited direct experience of the AAH pathway.

### Gaining buy-in to AAH

Interviews with practitioners identified issues of buy-in to the AAH pathway and contrasting levels of knowledge, understanding and involvement in the process.

Of three practitioners who considered they were well informed about the AAH process prior to its implementation, one practitioner felt able to promote the approach:

*I was introduced to AAH at the very beginning. I've been promoting it to the ward staff, consultants, at the hospital MDTs, and with social work. (P6)*

Some practitioners were not convinced that a case had been made for the efficacy of a shift from the existing assessment and discharge processes. Others would have welcomed more consultation and joint social work and health information events.

Added to a heavy workload not all felt fully prepared:

*Suddenly I feel like it's (AAH) upon me. Like so many things, suddenly it's upon me. (P8)*

As outlined in Appendix I, the referral protocol, whereby suitability for every AAH referral had to be confirmed by the hospital consultant was considered ambitious and impractical by social work staff that had engaged in the process.

*The biggest issue is that the default position is Assessment at Home; the first thing you have to do is contact the Consultant. You phone the Consultant or Consultant's Secretary but you never get a response. So do we stop work? It's a stumbling block. (P3)*



Another commented on the speed of implementation:

*I think we rushed it a bit to start with really. You need to have everyone at the same starting point. If social work is a bit ahead or a bit behind where everyone else is it doesn't go very well. (P9)*

From a management perspective the introduction of a new initiative is generally seen as complex, involving leadership, co-ordination and other management functions. Across the agencies several interviewees expressed the sense that the full range of existing expertise was not fully involved in preparing the pathway:

*I feel there has been little consultation with practitioners. I feel a lot of the decisions have been reached at senior management level... (P1)*

Particular issues were raised in relation to staff involvement in AAH. Comments were made about a lack of knowledge on the part of staff of AAH:

*Everyone has a different perception of what Assessment At Home is, how the process works and who fits the criteria for Assessment at Home. (P2)*

The lack of clarity in a written document about the level and extent of resources available to support the patient at home under AAH and not knowing what resources would be available after the 21 days post discharge stage hindered confidence in the pathway:

*The response to my suggestion asking staff to consider Assessment at Home is negative - but I don't think they understand or know the benefits. Consultants don't perceive Assessment at Home as being beneficial. (P3)*

Probing also uncovered deeper issues about professionals dealing with individuals referred to the Pathway. There was a view expressed by one respondent that some medical and nursing staff had limited experience of service users coping at home day-to-day in the community:

*It's not just about services, it's about other dimensions, your expectations and your training. I used to do domiciliary visits and I am used to seeing frail older people sitting in their bedrooms looking vulnerable and leaving them. That's a thing that some Juniors and the younger Consultants never see, and therefore they can't transfer this vulnerable little lady sitting by the side of her (hospital) bed into someone who can live at home... some nurses even less because they don't even see them at the out patient clinic. (P9)*

This may be a particular issue for staff who do not see service users outside the ward setting,

*... At least if you see them at the clinic or... the Day Hospital and they have a bit of makeup on and really nice fresh clothes you suddenly see the person you didn't see in the ward'. (P9)*

## **Not for Everyone?**

Several interviewees were concerned about the high needs of service users being considered for AAH and whether or not AAH was the appropriate pathway. One practitioner's comments emphasised the importance of ensuring that the discharge pathway should fit the person rather than the person fitting the pathway.

*The (AAH) outcome for some has not been successful and it's perhaps because they were wrongly identified to begin with and there were over optimistic expectations... We need to ensure the focus continues to be on what is right for the individual, is safe for the individual and what brings best quality of life to that individual. (P4)*

This was echoed in the views of a service user. One man, on his seventh admission in seven months was particularly clear about coming to terms with his inability to manage at home, he said:

*I felt respected when planning was taking place in hospital. I was involved all the time. I would have liked to go home. Everybody likes to go home but in my case it was not possible... and it's hard to accept that... very hard. You think you're invincible. Even with lots of help and I need lots of help now. I was concerned when I went home (referring to*

*an assessment visit home with a hospital OT). It was all different from what it used to be. I wasn't the boss anymore when I went out on the home visit. I am a stubborn old git. I was not capable. I had been in and out of hospital quite a few times before. I didn't manage to stay home very long the last time I left hospital. This (nursing care home) is a good place. Full of old women. The staff are first class. 100%. I doubt I'd want to be anywhere else. In some cases it's not possible to live at home. I'm one of those cases. (SU5)*

### **What's in a name?**

AAH's title, it was felt by some, could send out a misleading signal because it implies that services users are not being assessed in hospital:

*Assessment At Home is not a phrase that you can mention to clients or to other professionals and ... they know what you are talking about. You spend a lot of time trying to explain what you are talking about and it doesn't get you anywhere. (P3)*

*We're not assessing the person in the home, we are assessing someone in a hospital, before they go home. Maybe it needs to be changed to assessment for home where we would look at someone for going home as opposed to them being at home. (P1)*

As badged, there was a sense that AAH underplays the intensive period of assessment, including risk assessment, that precedes the pre-discharge case discussion. One member of the hospital team made the point that a significant part of the AAH assessment, in particular the risk assessment is actually being done in hospital and what's being addressed at home are reviews about how well the home care supports are meeting the needs of service user.

### **Other discharge processes?**

Where the home support requirement is relatively straightforward and not complex, the discharging nurse, on the basis of the multi-disciplinary team's (MDT) assessment has authority to order up to four home care visits daily or restart pre-admission home care arrangements without the involvement of the hospital social work team. These cases are not referred to social work services in the hospital.

Several respondents felt that AAH may be confusing to some because similar procedures such as the one quoted above, are already operating and the additional benefits of AAH are not clear. One interviewee stated:

*I have thought about it. I have had referrals for Assessment At Home - but normal discharge has met their needs. I've had referrals where Assessment At Home may have delayed discharge. (P2)*

Another interviewee made reference to complex care and support needs of services users who could not be discharged:

*The patients we are now left with to try and do AAH with are very, very few and far between because we have actually met AAH by getting these patients out already. (P8)*

Others stressed that the rationale of AAH required buy-in by those close to the service user:

*There is a high level of need from a relatives point of view: if you have an elderly mother/father/aunt who is going home for the nth time and you know it hasn't worked the times before you would need to know that there is something different being done this time, something additional being done. (P10)*

### **Inter-agency working**

A number of practitioners raised the need for more inter and intra agency information dissemination and knowledge sharing around the process and the implementation of the AAH pathway.

*We need joint briefing opportunities with others working with assessment at home... accurate information and more information sharing. (P5)*

*I don't think the communication has gone hand in hand with the development (of AAH). I think that's been a problem for its implementation. (P4)*

*There needs to be better information in the ward setting, for the ward doctors and between health and social work – guidelines and guidance, what extra [resources] the patient gets and what they don't get. The purpose of the Assessment At Home should be clearer. You definitely have to get everyone on board to get it to work. (P6)*

One interviewee commented on the challenge of partnership working:

*In geriatric medicine, there is always the dimension of the patient's social care and that's the difficulty... because you have to do that in partnership. It doesn't always feel like a partnership. (P9)*

The potential differences in perceptions between medical and social care staff about how well the service user can function in their home environment, raises a possible gap in approaches to AAH. This challenge appears to arise sometimes because people from different professional backgrounds have different levels of knowledge of resources and services which can be delivered in the community and expectations for those they support. This leads to very different messages sent to service users and their carers about meeting future care needs:

*I feel that a lot of communication is being done back with the family before they even get into DME (the Department of Medicine for the Elderly) and we need to look at what families are being told when they're in medical (wards). They often come here with preconceived ideas of the possibility of not being discharged home and going into a care home before they actually get to the unit – so by that time it can be very difficult to back track. (P8)*

While the above comment refers to communication between health professionals and family from A&E onwards, one social work professional who has been involved in the process commented that in some cases GPs could also influence expectations. Some advised families that a return home for their relative was no longer feasible .

Interagency co-ordination is formalised in the pre-discharge case discussions. The interviews confirmed that some practitioners were apprehensive about the time to be spent in meetings while others saw the pre-discharge case discussion as effective for collating assessments, refining opinions and agreeing service users' needs across different areas and confirming discharge planning decisions. Community support services especially welcomed the opportunity to meet other professionals, to discuss the scope of their roles and resources and to gain a clearer view of the planned care package.

*When I actually went through the process, I was really impressed with it. I was impressed by the work and commitment by everybody, Telecare, SSRS (South Sector Rehabilitation Service – a community based rehabilitation service), CORDIA (an agency which provides home care). The hospital MDT was great. Everything was put in place for the service user to go home. Everyone worked hard. I was impressed by the speed of setting up the package as well. (P2)*

## **The benefits of AAH**

There was recognition of the benefits of close inter-agency working, particularly, the inclusive nature of the pre-discharge case discussion. There was also a recognition that the pre-discharge discussions are time and resource intensive and some staff doubted if they could afford the time involved away from patient care. Staff identified a range of benefits of AAH. For example, with regard to time to plan, increased inter-agency co-ordination and improved communication with service users and their carers, a community health care professional stated:

*It was very helpful being included in the process prior to the patient coming home rather than getting a phone call to say a patient is being discharged. I found the process of including us from the beginning extremely helpful. You can get to know the patient and the family. You get to know what other packages are involved in the patient's care. You can organize the order of equipment if that is required. You coordinate with social work, the ward staff, the OT and the physio[therapist] so that everything is streamlined. (P7)*

It is perhaps no surprise that, in view of the complex nature of service user medical conditions, staff found that increased and early communication and connectivity was beneficial.

*The process (the pre-discharge case discussion) is good and I think it would be ideal if it happened for lots of other patients as well, on the basis of the improved communication and connectivity and particularly communication with the families. I think that is where we often fall down in discharge planning is the communication. The transition from hospital to home is not always as smooth as it should be or as well connected, as it should be. (P10)*

One respondent suggested that focusing on anticipatory care assessments, while the service user is at home, would prevent admissions.

*People with high packages of care in the community should have a full assessment completed ... for certain clients in the community, [to] adopt a preventative approach, fully assessing people in their own environments... would work in shifting the balance of care. (This would be) good care management. (P1)*

## **Service users' profile**

This research focused on the first 11 people who were referred to the researcher for discharge under AAH. It was early on in the process and it emerged that seven of the referrals were not suitable for discharge home. All the service users had complex health and functional capability profiles, and some were cognitively impaired. All were elderly and frail, two were aged 70 – 79; eight were aged 80 - 89 and one was 90. Prior to admission seven were living at home, two were in sheltered housing, one was in very sheltered housing, and one was in a residential care. Of the seven service users who were screened out of the AAH process, five were assessed as requiring either nursing or residential care, one returned to residential care and was subsequently transferred to nursing home care and one died in hospital.

Of the four service users that were discharged home, one was readmitted to hospital after two weeks, discharged to a nursing home, readmitted within six weeks and died in hospital; one was at home for seven weeks, had a stroke and was readmitted. Two service users continue to be supported at home with home care services. One lives alone and the other lives with a spouse. Both benefit from active family support and assistance.

Their journey from admission to hospital through the assessment period and beyond is based on a review of the case histories and is documented in Appendix V for the four service users who progressed through all stages of the AAH process; and Appendix VI for the seven service users who exited the AAH pathway for a range of reasons. Key stages from the initial social work referral to outcome are counted in calendar days.

## **Service user perspectives**

Data was gathered from interviews with three service users who went home on AAH with additional interviews with carers, including one whose recently deceased relative had been on AAH. To illuminate user AAH experience further, a response is included from one service user who entered the assessment process but who did not go home.

Overlapping themes of improved quality of life, the importance of direct communication and the value of including service users and carers in decisions at each stage of the process were consistent across responses.

Service users were positive about the impact of support on their quality of life.

*Yes, I think it (the package of care) is working really well. I am living where I want to live (at home). I'm not living as I want. Once I can get out and about that will be me. I'm getting there. I get to mix with the other residents (in Very Sheltered Housing) for meals at night (with the assistance of Cordia Carers). I get to chat to other people. I don't have to be in my flat alone in the evenings. (SU9)*

*I've had every sort of help and encouragement (with) carers coming in 4 times a day. An Occupational Therapist came before and after my discharge. (SU4)*

*I feel safe. I have things to do. I'm trying to make it that bit better for myself. I'm listening into the (faith group teleconferencing) meetings again and I'm seeing people. I'm staying as well as I can, right now as we're talking I'm fine, the pain is less. I'm living where I want to live. (SU4)*

Aspects of the service user experience of AAH reflect issues also raised by the practitioners earlier in this report, though the service users and their carers provide their own perspective of involvement with the AAH process. The name or badge used for AAH may introduce some confusion in the organization and assessment points in the pathway.

*So there was that assessment at home, rehab girls for 5 weeks... they did the overall assessment – a very careful assessment as what the needs may be and it was at the end of that, the sixth week that my mother had two falls and was admitted to hospital ...but the main (AAH) assessment was done after the fall – when Dr X was the consultant and the social worker came on the scene and that ran its course... until we had the main meeting ...and that decided she could go home. I would say the (AAH) assessment was mainly conducted in the hospital. (C1: SU4)*

Some service users and carers valued the pre-discharge case discussion though there were issues in its organisation and the role of service users and their carers, as illustrated by the following views: -

*I felt there were too many people there. I was worrying that I might not get home. I trusted (names of family attending meeting) to speak. If we'd had less people I would be alright. (SU9)*

*I look back and I didn't know what I was facing... But I've learned quite a lot of things about the way things were operating. It didn't do me any harm... I was surprised by the number of people gathered there. (SU4)*

*The meeting was a bit stressful. Think of other ways around the meeting (C2 SU9).*

*I thought it was fine for (SU9's son) and I, and it wasn't daunting. We were aware it might have been daunting for SU9. We all did the best we could in the circumstances. It's probably not a one size fits all process. (C1 SU9)*

One service user who was unable to return home reflected on how important it was that he was included in pre-discharge planning and in particular, the pre-discharge case discussion.

*I felt respected when planning was taking place in hospital. I was involved all the time. I would have liked to go home. In some cases it's not possible to live at home... I'm one of those cases. (SU5)*

Some carers valued the process even if the outcomes were not what they had originally anticipated or hoped for. Two families valued the pre-discharge case discussion in particular as an opportunity to explore options and if possible afford their relative a final chance to go home. The views of one family were reflected in the minute of a pre-discharge case discussion:

*'the family stated that they thought the process was fantastic and wanted to thank everyone present at the meeting for the opportunity given to discuss in detail all the concerns that they had with regards to discharge and ongoing care of... (SU9)*

Another family carer appreciated that even with a full and complex package of care her relative was unable to cope after two weeks at home in view of acute symptoms that resulted in the GP readmitting her mother into hospital.

*My mum's care needs were met when she was discharged. It was... her health (that) deteriorated. She was that long in hospital... 13 weeks... You can't stay in (hospital) forever, but with all the things that were put in place for her, as I say, trying her at home... she had to get that option... (While at home) there was CORDIA (home care service),*



*the district nurse, telecare - the alarm system people, the social worker, doctors from the Health Centre – they (GPs) were called out three times in the two weeks she was home... and the ambulance men came when she pressed the buzzer by accident and there was another day when we managed to cancel (the ambulance)... and she was getting the four times a day visits from CORDIA plus the overnight the staff from CORDIA were excellent and they were so polite – they devoted as much time as she needed for what she wanted – they were friendly... you know... you couldn't ask for better. (C1: SU6)*

A relative in the same family echoed this feeling of reassurance that their mother had had the opportunity to test her ability to manage at home and, seeing that she couldn't, prepared the family to accept that she really needed to be looked after in a nursing home:

*At least I feel happy that mum had that experience of being at home and to find out it was not feasible. It was still worth that to know for sure. We're really not thinking now 'what if we had taken mum home, it might have been better and so on'. At least now we think she has to be in here (in a Nursing Home). (C2: SU6)*

One informal carer said of a service user:

*She's very happy in her home. The discharge package made a difference. Her mental attitude has improved. She has more control in her home and... a say in things. I'm positive it was the medication and the extreme pain that caused the problems before. She is coping better and she likes the carers – they are really good and adaptable. (C2: SU4)*

Carers from all four families reported they appreciated the level of practitioner engagement, their sensitivity to the caring role and the quality of care provided to the service user. Service users who progressed through the AAH pathway were positive about their care. They valued the level of support that enabled them to remain at home and one who needed a nursing home was able to discuss her views and felt better prepared to accept that change.

## **Limits to the research**

The analysis shows that during the early stages of AAH its implementation there were positive developments, but also challenges for all stakeholders.

The research insights provided by the analysis are limited by the following:

- Only a small number of cases were examined, from one part of the city's social work area, and insights provided are only a snapshot in time. They may provide a useful platform for subsequent evaluations of the AAH pathway involving larger samples of service users.
- The guidelines and processes of AAH as indicated in the report were refined and developed over and since the period, thus the research cannot be replicated.
- Service user and carer interviews were undertaken by the social work practitioner allocated to the case – This may have influenced service user and carer responses as the interviewer was not a neutral or independent party.

## **Conclusion**

Whilst the views among stakeholders reflected their different professional, carer and service user standpoints in providing and receiving care, there was considerable agreement over a wide range of issues that point to factors that can further support the successful development of AAH and by their absence inhibit the process.

A number of enablers that make AAH easier to achieve, identified in this research, include:

- **Information and communication**
  - o a title (badge) that everyone understands. The term 'Assessment At Home' can be misleading because it suggests that AAH replaces assessment in hospital. A new title

- o could reduce confusion by acknowledging that the assessment precedes discharge from hospital and continues through reviews in the community
  - o clear guidance and knowledge of the resources and services available for assessing and supporting the service user safely at home for professionals, service users and carers
  - o clear, unambiguous inter-agency communication and follow up between key agencies involved in a services user's individual care plan, the service user and carer - pre and post-discharge (no mixed messages).
  - o involvement of the service user, carer and community support service staff in the pre-discharge case discussion where the range, frequency and intensity of post-discharge home supports and resources are negotiated and agreed.
- **Process and interagency co-operation**
    - o risk assessment of AAH referrals by social work services and the multi-disciplinary team.
    - o engagement of all stakeholders in the pre-discharge case discussion and follow up
    - o ensuring the full care package is in place prior to discharge and understood by everyone: e.g. home care support, health, rehabilitation & social care services, telecare, 15 minute responder for emergencies, carer support services and befriending.
    - o enhancing inter-agency communication and co-working, for example joint training particularly around the aims and implementation of AAH may strengthen interagency understanding of roles and responsibilities and reduce any differences in professional approaches to AAH
  - **Service User and carer factors**
    - o relative(s) or carer(s) who can offer emotional and practical support to service users
    - o flexible community services that can respond to the changing needs of service users and carers.
    - o Service user capacity to engage and make decisions about their future care plan (or an Adult with Incapacity proxy granted powers to make decisions about future care planning)

Some practitioner respondents would have welcomed consultation and joint social work and health staff briefings. There was concern that there was not sufficient clarity about criteria for referring service users for AAH and that existing discharge and community care assessment processes were better suited for some people. Although there was concern about the time commitment, the staff were generally positive about the benefits of the multi-agency pre-discharge discussion, particularly the way in which it connects with community support staff. Carers in particular, valued being involved in pre-discharge discussions and reviews. Both service users and carers valued the services that supported them.

## Postscript

Since this piece of research finished, Glasgow City Council Social Work Services and its partners have been auditing and reviewing the Assessment at Home processes. Key developments include i) the introduction of Intermediate Residential Care placements to facilitate the post discharge three week social care assessment and ii) social work practitioner information and resource meetings to streamline processes.

## Acknowledgements

Thank you to everyone who assisted me in this research project.

I am especially grateful to service users and carers I met during the course of this research project who showed grit and determination as they coped with living with change, transitions and uncertainty of complex health conditions and frailty. Throughout the report I have referred to the individuals I worked with as service users - but they, and those close to them, their relatives and carers are very real people to me. Of the 11 people referred for Assessment at Home, five sadly passed away before publication of the research.



A special note of thanks is due to colleagues who agreed to be interviewed, my team and line managers who supported me and to Margaret in the Admin Team who was so helpful throughout the project.

I also wish to thank my IRISS mentors, Claire Lightowler and Alison Petch, the support staff at IRISS, The Practitioner Research: Older People Project (PROP) facilitated by Catherine-Rose Stocks Rankin, and staff at Edinburgh University's Centre for Research on Families and Relationships, all of whom guided and supported me throughout the research process.

My thanks also to social work services colleagues Teague McFadden in the Planning, Policy & Performance Team and Tina Callan in the Research and Development Team for their help and support.

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## Appendix 1

### AAH Process

The process during the research period (July – December 2012) had 4 stages.

- |                    |  |
|--------------------|--|
| Stage 1 (1 day)    | <ul style="list-style-type: none"><li>i) referral from ward staff to social work and</li><li>ii) suitability for AAH confirmed by the hospital Consultant.</li></ul>   |
| Stage 2 (5+2 days) | <ul style="list-style-type: none"><li>i) initial SWS assessment and discussion with the MDT,</li><li>ii) Consultant agreement for AAH to continue,</li><li>iii) Specialist Multi-disciplinary Assessment Tool completed by hospital MDT and passed to SWS to inform assessment.</li></ul>  |
| Stage 3 (5+2 days) | <ul style="list-style-type: none"><li>i) pre-discharge case discussion involving; MDT, carers, service user, community health and social care services,</li><li>ii) date of discharge and post-discharge care plan agreed – to anticipate additional support that might be needed to avert readmission to hospital for a non-medical need.</li></ul> |
| Stage 4 (21 days)  | <ul style="list-style-type: none"><li>i) discharge with supports in place,</li><li>ii) assessment at home continued (care management, monitoring and evaluation of positive outcomes for service user)</li><li>iii) review and recommendations for continuing care needs – medium and long term.</li></ul>   |

Note : In January 2013, stages 1 and 2 were merged.

## Appendix 2

### **Semi-structured interview outline for interviewer: manager interviews**

1. What has been your experience of the Assessment at Home Pathway?
2. Have you faced any issues around the Assessment at Home Pathway?
3. Have staff in your team raised concerns or issues around the Assessment at Home Pathway?
4. If so, do you have any suggestions around ways of overcoming issues faced by you and/ or your staff?
5. Do you consider there is scope for you, in your role, to contribute to the development of the Assessment at Home Pathway?
6. How successfully has the information around the Assessment at Home Pathway been communicated?
7. Are there lessons we can learn from the experience of the Assessment at Home Care Pathway?
8. Do you have any other comments or views about the Assessment at Home Pathway?

Thank you!

## Appendix 3

### Semi-structured interview outline for interviewer: practitioner interviews

Tasks before starting interview: Set up mic for recording interview.

Well Hello \_\_\_\_\_, many thank you for agreeing to meet me. It's good to see you

I hope this will take no more than 45 minutes or so. However I know you are busy. Is there a specific time you need to wind this up?

First of all - Just to go over my research aims briefly, I am exploring the experience of the Assessment at Home Discharge protocol with a mix of staff, carers and service users. I am keen to learn from your experience of the process so far. Is there anything you would like to ask me in relation to the information I gave you in the consent form?

1. What is your:
  - i) Job-title
  - ii) Grade
  - iii) Are you a practitioner / manager / other

2. Are you involved in discharge planning for service users?

Over 65                      Yes / No  
Under 65                    Yes / No  
Neither

If Yes - How many service users over 65 referred for discharge planning have you worked with in the last 4 weeks?

3. Can you tell me whether there are other models of discharge planning in place in the hospital other than Assessment at Home Pathway?

4. Does your involvement in discharge planning include:

Assessment of need:	Y/ N	Not an aspect of my role
Assessment of risk:	Y/ N	Not an aspect of my role
Care planning:	Y/ N	Not an aspect of my role
Developing a risk management plan:	Y/ N	Not an aspect of my role
Developing a Support plan for carers	Y/ N	Not an aspect of my role
Strategic planning	Y/ N	Not an aspect of my role
Review of care plan - Client	Y/ N	Not an aspect of my role
Review of support plan - Carers	Y/ N	Not an aspect of my role

Do you do a risk assessment:                      Y/N      Not an aspect of my role

If yes:

- a) As part of assessment of need
- b) As a stand alone risk assessment
- c) Both

5. The Assessment at Home Pathway:

- i) What has been your experience of Assessment at Home?

- ii) What issues have you faced?
- iii) How did you overcome these?
6. Have you received information about the assessment at home pathway?: Y/N
- When did you receive this information?
- Did you receive this information by:
- |    |                       |     |          |
|----|-----------------------|-----|----------|
| a) | Email?                | Y/N | Comments |
| b) | Hard copy             | Y/N | Comments |
| c) | Verbally              | Y/N | Comments |
| d) | At a briefing session | Y/N | Comments |
| e) | Other                 | Y/N | Comments |
- i) Have you read it? Y/N
- ii) Have you a good understanding of the pathway presented in the document?  
Y/N
- iii) Do you have any comments about the design of the document?
7. Do you feel you have all relevant information to undertake an assessment in reference to the assessment at home process?
- Are there issues about the pathway that are unclear? Comments:
8. How do you present information to service users?
- i) written, ii) www, iii) verbal Comments:
- 9: Where or from whom do you source information / advice if you have queries about AAH?
10. Are you aware of the 4 staged procedural elements of the assessment at Home pathway?
- [Show interviewee the relevant page of the power point presentation]
- Do you have experience of working with services users directly or indirectly at
- Stage 1    Stage 2    Stage 3    Stage 4
- Do you have comments / issues / challenges around cases you have held which have halted or moved on to the following stages:
- Stage one / Stage two / Stage three / Stage four
11. What is your experience of working with MDTS in moving forward assessments in consideration to the AAH Pathway?
- When you receive a referral is it clear to you that:

i) the referral is being made at the earliest opportunity and in anticipation of the patient being fit for discharge? Y/N

ii) there has been some discussion with service users and carers (as appropriate) to make them aware that a referral has been made? Y/N

Have you been successful in meeting the target of contacting the service user's Consultant within 1 working day from referral? Y/N

Attending MDT meetings with hospital ward staff – at pre-discharge case discussions and at primary care team level? Y/N

Have you participated in MDT at hospital ward level to discuss issues specifically around AAH referral? Y/N

What has your experience been of attending MDTs at ward level?

12. Have you attended a Pre-discharge Case Discussion? Y/N

What has your experience of the Pre-discharge Case Discussion?

Timing / Venue / Chairing / Outcome / Decisions / Action points

Were you clear who was responsible for SWS care planning? Y/N

Were you clear who was identified as the health care representative for the care plan after discharge? Y/N

Did the Pre-discharge meeting, in your view, fully explore the needs of:

The service user and carers

From your experience to date – can you identify any benefits of the Pre-discharge case discussion process?

From your experience to date – can you identify any weaknesses of the Pre-discharge case discussion process?

13. In your view has the AAH Pathway had a positive impact / a number of positive issues / which has benefitted service user outcomes?

14. In your view has the AAH Pathway had a negative impact / a number of negative issues / which has not benefitted service user outcomes?

15. Do you have comments about your experience of assessing people in reference to the AAH pathway which you have not raised in this interview?

Thank you for your time and help with this project

## Appendix 4

### Semi-structured interview outline for interviewer: service user / carer interviews

- A. Thank you for agreeing to let me ask you some questions about your experience of being discharged from your most recent hospital admission.
  - B. Explain the research project and ask for written consent to proceed.
  - C. Explain that there is no problem if the interview needs to be cut short for any reason / or service users prefers to withdraw consent for proceeding.
- 

1. Was your (your relative's) admission to hospital planned?
2. Had you received services from health or social services prior to your admission? If so, can you describe them to me?
3. How long were you in hospital before you were told you were medically fit for discharge?
4. Were you consulted about the referral to social work services to assess your needs for discharge planning?
5. Were you consulted and informed about the discharge planning process?
6. Did you receive information about the discharge process called Assessment at Home?
7. Were you consulted about attending the Pre discharge Case discussion?
8. Were you able to say what was important to you about the discharge planning arrangements, and did you feel able to ask questions ?
9. Do you feel you were listened to?
10. Do you have any comments about the overall experience of attending the pre-discharge planning meeting?
11. Did you feel the plan agreed at the Pre-Discharge case discussion would make you feel safe on your return home?
12. What is your package of care?
13. Is this sufficient? Are there other kinds of assistance or support you need?
14. Are the staff involved in your care treating you with respect and listening to you ?
15. Are you living where you want?
16. Are you living as you want?
17. Are you staying as well as you can?



18. Are you seeing people?
19. Are you having things to do?
20. Are you feeling safe?
21. Have your needs as carer being considered and addressed?
22. Have you received appropriate support in your role as carer?
23. Are all the staff involved in your care treating you with respect and listening to you?
24. Any other comments?

Thank you.

Appendix 5

Outcomes for 4 service users who progressed through all stages of the AAH process: i) 3 continued to be supported at home following AAH reviews of their care and ii) 1 service user was readmitted to hospital for medical reasons following a period of support at home.

SU 4: 90-94 years Home	DME 29 inpatient days prior to AAH referral. 1 admission in previous 3 months	Ref to SW screening & allocation	Consultant agrees to AAH ⇒ PDCD	PDCD ⇒ Discharge	AAH at Home/Reviews	Supported at home ⇒
Days	0	16	29	35	56	
SU 6: 85-89 years Home	A&E ⇒MHU 91 inpatient days prior to AAH referral no admissions in previous 12 months	Ref to SW screening & allocation	Consultant agrees to AAH ⇒ PDCD	PDCD ⇒ Discharge	AAH at Home/Re- views	Nursing Home Care A&E ⇒ medical ward (deceased)
Days	0	13	19	26	41	138
SU 9: 75-79 years Very Sheltered Housing	A&E ⇒ Medical ⇒DME 61 inpatient days prior to AAH referral	Ref to SW screening & allocation	Consultant agrees to AAH ⇒ PDCD	PDCD ⇒ Discharge Xmas & New Year	AAH at Home /Reviews	Supported at home ⇒ A&E ⇒ DME Stroke Ward
Days	0	1	16	35	67	90
SU10: 80 - 84 years Home	A&E ⇒ Stroke Ward ⇒ DME 54 inpatient days prior to AAH referral	Ref to SW & allocation. Consultant agrees to AAH	AAH ⇒ PDCD	PDCD ⇒ Discharge	AAH at Home/Reviews	Supported at home ⇒
Days	0	1	16	17	56	

## Appendix 6

Outcomes for 7 service users who exited the Assessment At Home (AAH) process: i) 1 service user required NHS continuing care, ii) 3 service users required Residential Home Care, iii) 2 service users required Nursing Home Care iv) 1 service user's health deteriorated rapidly and she was placed on the Liverpool Care Pathway.

SU 1: 70- 74 years Home	A&E ⇒DME ⇒ psychiatric hospital 140 inpatient days prior to AAH referral no admissions in previous 12 months	0	1	0	1	25	NHS Continuing Care
Days							
SU 2: 80-84 years Home	A&E ⇒DME 12 inpatient days prior to AAH referral No admissions in previous 12 months	0	22	0	72	72	Nursing Care Home
Days							
SU 3: 80-84 years Home	A&E ⇒DME 24 inpatient days prior to AAH referral No admissions in previous 12 months	0	1	0	45	45	Nursing Care Home
Days							
SU 5: 88-89 years Sheltered Housing	A&E ⇒DME inpatient days prior to AAH referral 7 admissions in previous 7 months	0	13	51	76	143	Nursing Care Home (deceased)
Days							

Appendix 6 - continued

SU 7: 80-84 years Residential Care Home	A&E ⇒DME 92 inpatient days prior to AAH referral No admissions in previous year	0	AAH referral	15	Discharged to former residential care home without PDCD. Care Management /AWI reviews recommend- ation : Nursing Care placement in ref to 13ZA	83	Nursing Home Care	192	Readmitted ⇒ A&E ⇒ Medical Ward ⇒ discharged back to NH	210	Nursing Home Care (deceased)	
SU 8: 85 -89 years Sheltered Housing	A&E ⇒Acute Ward ⇒DME 4 inpatient days prior to AAH referral 54 previous admissions in previous 12 months	0	Consultant agrees to AAH	3	AAH allocation to PDCD	7	PDCD outcome: Care needs agreed to be at residential category of care	10			Residential Care Home	
SU 11: 85 -89 years Home	A&E ⇒DME 7 inpatient days prior to AAH referral No admissions in previous year	0	Referral to SWS / Consultant agrees to AAH Changes in health condition	14	SU's health deteriorated rapidly and SU placed on Liverpool Care Pathway						31	(deceased)

**Key to abbreviations**

A&E: Accident and Emergency  
 DME: Dep't of Medicine for the Elderly  
 PDCD Pre-Discharge Case Discussion  
 SU: Service User  
 MDT: Multi-disciplinary team  
 NHS: National Health Service  
 POA: Power of Attorney

**Age profile of the 11 service users:** Two service users were aged 70 – 79; eight were aged 80 – 89; one was aged 90 - 94.

## Appendix 7

### **CONSENT FORM : Practitioner Research : Older People October – December 2012**

#### **Research Question:**

**What is the experience of service users, carers and professionals of the implementation of the Assessment At Home (AAH) Pathway, a newly developed hospital discharge process in the South Sector of Glasgow City Council?**

This research is part of the Practitioner Research: Older People project – a project involving 10 health and social care practitioners from a range of statutory, voluntary and private agencies and organisations. The Project has been developed and is managed by staff from the Centre for Research on Families and Relationships at Edinburgh University and the Institute for Research and Innovation in Social Services in collaboration with partner organisations and agencies.

I am a Glasgow City Council hospital based Social Worker working in the South Hospitals Social Work Services Team. The focus of my research is to explore a new hospital discharge process devised by the Joint Health and Social work Assessment at Home Working Group and implemented in the South Sector in June 2012.

I will be using case studies from my workload of people over 65 referred to Social Work Services in reference to the AAH. I will be undertaking a small number of interviews with service users, carers and a mix of staff in the multidisciplinary team.

I am very grateful to you for agreeing to assist me in this part of my research.

Please do not hesitate to ask for clarification if you have any questions/ concerns before completing this consent form.

#### **Please tick to confirm:**

- I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.
- I give permission for the researcher to record the views I express, and use these views in their report provided that my identity is kept anonymous.
- I give permission for the researcher to record my role (service user/carer/family member) being linked to the views I express.
- I do not give permission for the researcher to record my role (service user/carer/family member) being linked to the views I express.
- I agree to take part in an interview for the research study above.

Name of Participant: \_\_\_\_\_ Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Name of researcher: \_\_\_\_\_ Date: \_\_\_\_\_ Signature: \_\_\_\_\_

When complete 1 copy for participant: 1 Copy for researcher.

**Appendix 7 - continued**

**CONSENT FORM : Practitioner Research : Older People October – December 2012**

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- I give permission for the researcher to record the views I express, and use these views in their report provided that my identity is kept anonymous.
- I give permission for the researcher to record my professional role.
- I do not give permission for the researcher to record my professional role.
- I agree to take part in an interview for the research study above.

Name of Participant: \_\_\_\_\_ Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Name of researcher: \_\_\_\_\_ Date: \_\_\_\_\_ Signature: \_\_\_\_\_

When complete 1 copy for participant: 1 Copy for researcher.