Guidelines for the closure of care homes for older people: prevalence and content of local government protocols

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Summary

Introduction

1. The rise in the number of care home closures in recent years has raised concerns about the way in which residents and their relatives and carers are being affected by such relocation and the way in which it is managed. Currently there is no statutory guidance in England aimed specifically at the way in which care homes close.

2. This paper presents a review of local government guidelines and protocols for the closure of care homes for older people. The objectives of the study were to identify the prevalence of written guidelines and the nature of existing principles and recommendations for good practice. Thirty-three documents were analysed to identify their purpose and scope, the ways in which roles and responsibilities were defined and allocated, and suggestions and recommendations for good practice.

Regulatory and policy context

3. Existing guidance, regulation and legislation relevant to the closure of care homes includes:

    - The responsibility of local authorities to assess vulnerable people;
    - Advice that it is sensible for local authorities to draw up plans and protocols in the event that a nursing home closes or a resident is evicted;
    - The requirement that care home providers apply to the National Care Standards Commission to close and should do so not less than three months before the proposed closure date. Notification to service users should be not more than seven days after application to the Commission;
    - The requirement that residents should be given a written contract that includes a period of notice, and the opportunity of trial visits to new homes.

Findings

4. In total information was collected from just over a third (55) of the 150 councils in England. Of those departments with over 100 care homes 67 per cent (48) responded.

5. Nearly two thirds of the responding authorities reported having a closure protocol.

6. Document length and scope varied. The majority covered either voluntary closures or voluntary and emergency closures. Five were checklists. Few considered measures to prevent closure. Most focused on actions to be taken after notification of closure.

7. Legal issues raised included: communication by inspectors to operational staff about the financial viability of a home; required permissions, for example, for transferring residents' records; the payment or sending of additional care staff into a closing home. Advice on some of these legal issues differed.

8. Recommended principles for good practice included: taking residents' social and personal needs into account (existing friendships with residents, preferred geographical location, ability of family and friends to visit); maximising residents' ability to make an informed choice. Several comments suggested that enabling choice was likely to be difficult to achieve in practice.

9. A quarter of the protocols referred to the length of notice proprietors should or ideally would provide. Typically these recommended notice of around a month or as much as possible.

10. Views and recommendations varied in relation to a number of issues:
    a. Definitions of urgent and planned closures
    b. Overall responsibility for the management of a care home closure
    c. Responsibility for particular tasks
    d. Organisational arrangements for the provision of care management
    e. Which residents should be offered guidance, help and information
    f. The way in which residents should be notified of a closure and the level of council involvement
    g. Whether moves should be arranged to coincide with the moving of other residents or spread over more than a week
    h. The desirability of temporary/second moves

11. Considerable importance was placed on involving care staff in the closure process, respecting their friendships with residents, and their likely concern for residents' future welfare.

12. Plans for resident reviews rarely specified whether all residents or local authority funded residents only would be reviewed.

13. A minority of protocols referred to a formal debriefing of social services staff, or an evaluation of the closure process.

Discussion

14. The range of roles, responsibilities and procedures discussed in the reviewed protocols suggests that there is a need for such plans to ensure that practical and efficient systems are in place.

15. The variation in approaches to providing assessments and support to self-funding residents who have arranged their own care home place may leave these residents vulnerable and raises issues of equity and access to social care services.

16. The variation in roles, responsibilities and procedures across local authorities raises issues of geographical equity and access to social care services.

17. Factors that affect the way in which a closure process can be managed are likely to affect the feasibility of introducing standard requirements: the cause of closure, the timescale, the local availability of care home places, and local authority staffing resources.

18. Managing the process of a care home closure requires that a balance be struck between what is desirable and what is achievable. It would be useful to establish which actions or measures are more or less essential to the support of residents, relatives and carers, and care staff and providers during care home closures.

Policy and research implications

19. There appears to be scope for the rationalization of roles and responsibilities within councils during care home closures, for national guidance on legal matters and on the role of the National Care Standards Commission.

20. Equity and welfare considerations for residents and effectiveness and efficiency considerations for authorities suggest that there is a role for guidance and information at three levels: nationally, at council or care trust level and for care managers directly involved in the process of closure.

21. Policy and practice might be supported by further research evidence. Ongoing qualitative work is investigating the experience and views of residents, relatives, social services staff, and care staff about what is important during a care home closure. Ideally evidence is needed to establish whether positive outcomes for residents and their relatives and carers are associated with particular processes, arrangements and practices during a care home closure.

1. Introduction

The impact of care home closures for older people in England has been the subject of considerable media coverage and campaigning by independent provider associations, charitable organisations, campaigning groups and residents of closing homes (Carvel, 2002a; Carvel, 2002b; Bright, 2000; Residents Action Group for the Elderly (R.A.G.E.) National; Sapstead and Womack, 2002). The central concern is that residents' health will not only suffer as a result of such involuntary relocation, but that they may die. Empirical research, in the United Kingdom, United States and Canada, examining mortality rates after care home closures is currently ambiguous and likely to remain so given the methodological and ethical difficulties involved (Smith and Crome, 2000). There is also a lack of evidence about whether resident adjustment, health and emotional well-being is protected or promoted by particular approaches to closing a care home. Few studies have linked resident health following a home closure to specific practices, arrangements and activities during home closure, although some have related a lack of any increase in levels of mortality after hospital relocation to preparation and planning (McAuslane and Sperlinger, 1994; Thorson and Davis, 2000). It is likely that any effects of care home closure are influenced by the way in which a home is closed. It is important therefore to understand current arrangements and practices during home closures. This paper reports research into the prevalence and content of council guidelines for care home closures. The research was part of a larger study that also aimed to explore the process of care home closure from the viewpoint of residents and relatives and social services care managers and managerial staff.

There have been calls for 'closure protocols' to safeguard residents' welfare. Such appeals have unfavourably compared current arrangements for closing local authority care homes with arrangements for closing schools (which require the permission of the Secretary of State), for council housing transfers (which require a vote among tenants). They have also emphasised the need for consultation and possible intervention to delay or prevent closures (Bright, 2000; Bright, 2001; Brindle, 2001).

Since 1948, under section 21 of the National Assistance Act councils with social services responsibilities (hereafter referred to as "councils" or "local authorities") have had a duty to provide accommodation, including care home places, to persons aged 18 or over who are in need of care and attention by reason of age, infirmity or other circumstances. Since 1993 councils have had a legal responsibility to assess the help and support needed by vulnerable people and a duty to provide appropriate accommodation for those with needs that meet the council's eligibility criteria (NHS and Community Care Act 1990). The Act also allowed

councils to purchase care services from independent providers (NHS and Community Care Act 1990).

Nearly 70 per cent of older people living in care homes in England are publicly funded and the majority of publicly funded places are in care homes in the independent sector (Netten et al., 2001; Laing and Buisson, 2001). Consequently the vast majority of care home residents live in independent homes over which authorities have little or no direct control over the decision whether or when to close the home.

There are two main types of closure of independent homes: enforced and voluntary. When inspectors apply to cancel registration, under the Care Standards Act of 2000, the closure is classified as enforced. Enforced closures may be 'emergency' or 'non-urgent'. An application for an emergency cancellation must be based on grounds that pose an immediate and serious risk to the life, health or well-being of residents or patients. When a provider decides to close a home and notifies the National Care Standards Commission of their intention to cancel their registration the closure is classified as voluntary. Closures due to actions by receivers or creditors are included in this category.

The characteristics of the care home sector, the types of homes that are closing 'voluntarily', and the reasons for closure raise issues about how guidelines for home closures should or could be introduced, implemented or imposed. The nature and scale of activities during a closure are likely to be restricted by practicalities such as timescale, particularly when a provider faces business failure. Providers have reported closing voluntarily due to a combination of factors related to financial viability, including the level of local authority fees, the cost implications of the proposed National Minimum Standards, difficulties recruiting staff, meeting staff costs, and reduced demand (Williams et al., 2001). In such circumstances, it is difficult to see how specific guidelines to protect residents, such as a required standard length of notice of closure, can be adhered to in practice. Traditionally the independent residential sector has been characterised by small business providers, typically husband and wife teams running homes in converted, rather than purpose build, premises. Despite the increasing number of major nursing home providers, providers who own only one or two homes supply more than fifty per cent of nursing places (Laing and Buisson, 2001). An analysis of care home closures between 1996 and 2001 found that it is these typical homes, smaller, single businesses in converted buildings that were closing (Darton, 2002).

The rise in the number of voluntary closures, combined with the number of openings, has brought about a reduction in the number of places in care homes providing nursing and residential care for older people (Netten et al., 2002). This reduction in places, in turn is

likely to add a further constraint on how closures are managed, by further reducing the number of homes with vacancies and limiting the choice available to residents and their relatives and former carers.

The aims of this investigation were to identify:

- the extent to which councils have written guidelines or protocols relating to their involvement in the closure of independent care homes for older people;
- how roles and responsibilities are assigned;
- principles and objectives for good practice;
- recommended approaches and procedures.

Questions we aimed to answer in part or whole included:

- Is there agreement about what is a good way to close a care home?
- What circumstances and issues affect the guidance about the closure process?
- To what extent are recommendations, or advice, based on past experience or evidence?

The paper outlines the regulatory and policy context of home closures, including the statutory responsibilities of local authorities. Objectives and procedures for good practice suggested in the literature are also reviewed before the findings are presented, and their implications discussed.

2. Regulatory and policy context

2.1 Law and guidance

There is no national law or statutory guidance in England aimed specifically at the closure of independent residential and nursing homes. Government guidance on local authorities' powers to make arrangements for residential accommodation states that 'it will be sensible for local authorities to draw up plans and protocols with health authorities in the event that a nursing home closes or a resident is evicted (and in the event that a residential care home closes)' (Department of Health, 1993). The guidance also recommends that such contingency plans should support self-funding residents as well as those receiving public financial support: they should 'as far as is possible, aim to ensure that all residents are helped to identify opportunities and choices in finding alternative accommodation within a similar timescale (irrespective of the source of financial support)'. In general guidance is not law. This guidance, however, has the force of law insofar as it was issued under section 7 of the Local Authority Social Services Act 1970, which states that councils are obliged to follow guidance from the Secretary of State.

The most recent good practice material that discusses the relocation of residents in detail is a Health Service Circular that offers guidance on how to relocate frail older patients following hospital or long stay ward closure (NHS Executive, 1998). The recommendations cover consultation, a project plan, the needs of the individual and their relatives or carers, the process of transfer and role of the receiving setting, and arrangements for follow-up and monitoring.

A number of the national standards and regulations, introduced under the Care Standards Act, are relevant during the closure of a care home:

- Providers are required to give residents a statement of terms and conditions, or a written contract, that includes a period of notice (Standard 2, Department of Health, 2001a);
- Prospective residents should be offered the opportunity to visit new homes and to move in on a trial basis (Standard 5, Department of Health, 2001a);
- Providers should apply to the Commission to cancel their registration and should do so not less than three months before the proposed effective date or at 'such shorter period (if any) before that date as may be agreed' (Regulation 15 (2), Department of Health, 2001b);
- 'not more than seven days thereafter' providers should give notice to terminate accommodation to residents, their next of kin, and any local authorities that have made provision of accommodation, nursing or personal care (Regulation 15 (3) Department of Health, 2001b).

When a home is closed due to financial difficulties or bankruptcy it is unclear how practicable or enforceable this provision for three months notice is.

The legal obligation on care home owners/managers to meet this requirement is further complicated by the lesser amount of notice required for terminating accommodation: 'reasonable' notice must be given to the service user, their next of kin and the local authority, if they arranged the accommodation. The requirement also allows for the possibility that providers might find it difficult to give reasonable notice:

> 'If it is impracticable for the registered person to comply with the requirement in paragraph (1) -
> (a) he shall do so as soon as it is practicable to do so; and
> (b) he shall provide to the Commission a statement as to the circumstances which made it impracticable for him to comply with the requirement.' (Regulation 40, Care Home Regulations, 2001)

This discrepancy in requirements may allow care home owners to notify councils of their intention to close a home by giving notice that they are terminating accommodation for each individual resident.

The agreement between the statutory and independent sector, *Building Capacity and Partnership in Care*, also calls for greater openness and collaboration to reduce instability in the social care market. It urges providers to 'undertake prompt and timely communication with commissioners' and states that councils should work with independent providers to manage closures: 'If services have to be withdrawn, commissioners and providers should seek to achieve this in a planned way.' (Department of Health, 2001c p17, p16).

2.2 Legislation in the United States and Australia

In the United States and Australia residents' rights are also protected by legislation, including the right to security of tenure. In the United States a resident of a nursing home, and their family, or guardian, has the legal right to at least 30 days notice of an involuntary transfer or discharge (Nursing Home Reform Act 1987: s. 483.12). Some state laws expand upon this. In Washington State, for example, the licensee of a nursing home must notify the local administration office of the Department of Social and Health Services, all residents and their representatives in writing of voluntary closure sixty days beforehand (Washington Administrative Code). In Australia older people in residential homes have a right to at least 14 days notice of having to leave (Aged Care Act, 1997: Part 4.2 s. 23 [5-6]). The Accreditation Standards that services have to comply with also state that residents should be made aware of their rights and responsibilities, including their right to security of tenure (Aged Care Standards and Accreditation Agency Ltd). In addition a provider cannot make a resident leave

> 'or imply that the care recipient must leave, before suitable alternative accommodation is available that meets the care recipient's assessed long-term needs and is affordable by the care recipient.' (Aged Care Act, 1997: Part 4.2 s. 23 [6])

In both the United States and Australia the form of notification is specified. Notification must be in writing, include the reasons for the decision, the date on which the resident is required to leave, and their rights to appeal/complain. In America notification also has to include where the resident is to move to and the provider is responsible for making arrangements to transfer residents safely.

2.3 Councils' responsibilities

Before services can be publicly provided or arranged a person's needs must be assessed. Since 1998 councils have not been able to refuse to carry out an assessment on the grounds of a person's financial resources (Department of Health, 1998). This entitlement to an assessment was emphasised in recent policy and practice guidance to councils on how to promote fair access to care services (Department of Health, 2002a). The guidance also states that reviews, including re-assessments of individual's needs, should be made within three months of help first being provided or when there is a major change to the service. Thus councils have specific responsibilities to provide community care needs assessments to people who may be in need and/or seeking long term care and during a home closure councils have a responsibility to re-assess the needs of publicly funded residents and to secure alternative accommodation for them.

However, local authorities are permitted to arrange services on a temporary basis without an assessment 'if, in the opinion, of the authority, the condition of that person is such that he requires those services as a matter of urgency …(and) as soon as practicable thereafter, an assessment of his needs shall be made' (NHS and Community Care Act, 1990: 47. paragraphs 5 and 6). This provision for the urgent arrangement of services without an assessment may be interpreted as meaning that during urgent home closures the needs of residents need not be assessed before 'suitable' alternative accommodation is found. Consequently, the extent to which councils are obliged to re-assess the needs of publicly funded residents during a home closure is unclear.

Once a council has agreed to fund a residential placement they are required to ensure that they arrange for care in a person's preferred accommodation, if they have expressed a preference and if their choice meets certain conditions, for example that it is available and suitable to their needs (National Assistance Act 1948 (Choice of Accommodation) Directions, 1992). The extent to which this responsibility to ensure people are able to exercise a genuine choice over where they live applies during a home closure is unclear.

During a home closure a re-assessment of a self-funding resident, who has arranged their own care, might identify important changes in their circumstances or needs. They might have become eligible for funding for example, or need a different type of care. Yet it is unclear whether councils are obliged to do any more than offer self-funded residents information or advice, or possibly to make arrangements if the resident or family are unable to do so themselves. When seeking residential care people are entitled to a needs assessment, irrespective of their financial support, but this does not appear to apply during a home

closure; people may be seeking alternative provision but their eligibility for services has already been established.

2.4 Legal challenges and local authority reviews

The European Convention of Human Rights was incorporated in the Human Rights Act 1998, and implemented in England in October 2000. Two Articles of the Convention have been used in court cases appealing the decision to close NHS hospitals and authority run homes: Article 8, which gives the right to respect for private and family life, home and confidentiality; Article 2 which gives the right to life (Human Rights Act, 1998). For example, a judicial review of a health authority's decision to close a nursing home found the authority in breach of Article 8 and the decision unlawful, because patients had been told in writing that it would be a home for life (Court of Appeal judgement R v North & East Devon Health Authority ex parte Coughlan, 1999). Permanent residents entitlement to consultation from local authorities before they decide to close a home has also been confirmed in judicial review (R v Devon County Council ex parte Baker and Durham County Council ex parte Curtis and Others, 1995). Councils have a duty to inform and consult existing residents, to provide the reasons for the decision to close a local authority run home and to allow reasonable time for responses, which in turn, should be considered by the authority. Recent challenges to council's decisions to close care homes, however, have been dropped. For example, three legal challenges to Lancashire County Council's decision to close 32 of its 48 care homes were withdrawn when the council agreed to include a medical assessment of the risk of transfer in assessments of the residents' needs, to move residents with staff to new or refurbished homes, and to consider postponing transfers until any risk could be minimised or managed (Lancashire County Council and Chorley Borough Council, 2003).

The Human Rights Act applies to 'public authorities' only. The definition of public authority includes private bodies that are carrying out public functions. This raises the issue of whether independent sector organisations, that provide services purchased by public authorities, are performing a public function and are consequently required to uphold the European Convention on Human Rights. In a case against the closure of a care home by the voluntary sector housing association Leonard Cheshire, the court of appeal upheld the dismissal of the application for a judicial review of the decision to close, on the grounds that Leonard Cheshire did not constitute a public body and so did not fall within the remit of the Human Rights Act (R v Leonard Cheshire Foundation, 2002). The British Institute of Human Rights has called for the government to promote legislative change to remove the disparity in protection 'afforded to those residents placed by a local authority in a care home which it runs itself as against that afforded to those the local authority places in privately run homes' (The British Institute of Human Rights, 2002, p5).

Councils have also used local government overview and scrutiny committees, introduced under the Local Government Act 2000, as a means with which to investigate the closure of care homes. For example, scrutiny committees have investigated the way in which residents' are moved between care homes, including moves brought about by home closure and the closure of an independent nursing home (Gloucestershire County Council, 2003; Prasad, 2003). Issues identified in relation to moving residents included the lack of a requirement or policy for "follow up" assessments, the lack of an independent advocacy service, and the lack of understanding among the local community about the role and responsibilities of social services departments (Gloucestershire County Council, 2003).

3. Good practice literature

While there are a number of regulations and standards relevant to the closure of care homes for older people (although not all relate specifically to the way in which homes are closed) there are few publications that offer guidance or report research findings about the way in which care homes have been or should be closed. Studies about the relocation of residents or patients in settings other than independent care homes are more numerous; historically literature focusing on the process of moving older people or other service users has focused on relocation resulting from hospital renovation (Brugler et al., 1993), the closure of long stay hospital wards (Dickinson, 1996), and hospital closure (McCourt Perring, 1993; Knapp et al., 1992; Korman and Glennerster, 1985).

Many of the circumstances and issues do not apply to independent care home closures in the current UK and wider international context. However, some planning issues and recommendations are relevant: the importance of ensuring services are maintained throughout the closure period (Korman and Glennerster, 1985); recognition that the process of closure is likely to be more complex than anticipated (Korman and Glennerster, 1985); the importance of attending to residents' reactions to change and loss, as well as the practicalities of finding alternative accommodation (McCourt Perring, 1993); that patients and staff should take part in activities that offer control, predictability and decision-making (Brugler et al., 1993).

Available practice guidance includes a professional practice handbook for social care staff working with all user groups in residential, day, domiciliary and community care settings, which includes a chapter on closing homes (Leonard Cheshire and Social Care Association, undated). This emphasises: careful planning; provision for the support and involvement of staff and residents and their relatives and carers; a charter of rights for service users to promote informed choice and involvement; the retention, ideally, of a full complement of

existing staff; a time-scale of two to six months. It warns against allowing closures to 'slide into unstructured winding down' (Leonard Cheshire and Social Care Association, undated: 10). When managing a local authority home closure Lane similarly recommends that 'All individuals, staff and residents should be encouraged to avoid panic inspired precipitate moves during the countdown to closure. Ideally a target of not less than three months and not more than six months should be set at an early stage' (Lane, 1987).

Recommended timescales for relocation differ. While Lane suggests between three and six months for local authority home closures, others have recommended a longer timescale, between six months and a year in the context of moving nursing home residents to a new facility (Lane, 1987; Leonard Cheshire and Social Care Association, undated; Amenta et al., 1984). Given the lack of evidence on which to base decisions about timescale Age Concern has recommended that the decision be made 'as far as possible by the older people concerned' and that advocates are available to residents to ensure their views are prioritised (Age Concern, 2002: 12).

The importance of not excluding residents who have cognitive deficits when preparing residents for relocation has been highlighted by Dickinson's finding that, except for those with severe impairments, residents with dementia can recall factual information, and express appropriate emotional responses, making individual counselling and support appropriate (Dickinson, 1996).

A recent summary of good practice in care home closures identified a limited evidence base (Woolham, 2001). The available guidance focused on the need to minimise resident disruption and distress, familiarise residents with their new care setting, and provide continuity, and recommended more specifically the need to:

- identify and attend to residents who are predisposed to stress and show signs of stress after the closure announcement;
- prepare residents via discussions and visits to their new home;
- allow a time-scale of three months;
- minimise the degree of environmental change;
- ensure detailed resident information is transferred;
- support the care staff;
- move staff and residents together where possible, and if not, have a key worker from the new home visit;
- ensure residents are accompanied by someone familiar on the day of the move.

Factors that help residents to adjust in their new accommodation following a care home closure is another area that has been under-researched. It is likely that good practice in terms of the provision of support to newly arrived residents by care staff is applicable to residents arriving from a home closure. One would expect Reed and Payton's (1997) recommendations to be relevant and hopefully to be of benefit to relocated residents as part of routine practice. For example, the ways in which staff can help and support relationships between residents should be included in care plans and established residents could be invited to act as informal hosts or mentors to new residents. However, relatives and residents may regard arrival from a home closure as something that requires different types or level of support.

An American study which attributes a successful transfer of nursing home residents to a larger facility to careful preparation, emphasises early notification, choice and continuity: 'Six months to a year is not too long for many residents to be able to retain the information' (Amenta et al., 1984: 360). Staff retention, communication and timescale have also been identified as central issues in a study which compares four models of temporary relocation due to refurbishment (Wyld et al., 2002). The least problematic alternatives were found to be to let residents stay put during a refurbishment, or to move every resident to a newly built home. The objectives of increasing residents' familiarity with a new facility, minimising the stress experienced by residents, and staff preparation were also pursued in a Canadian study, which recommended that planning and outcomes benefit from conducting an implementation evaluation (Grant, 1997). The benefits of such an evaluation are said to include:

- accountability information;
- specific and measurable goals, objectives and activities;
- practical information that could be drawn on by others.

If implemented routinely, evaluation information about resident outcomes might also be compared across home closures, by resident characteristics, and closure procedures and processes.

Box 1 summarises the issues, activities and objectives highlighted in the guidance literature. The relocation of service users is not a new focus of research enquiry. However, comparatively little empirical research has focused on the closures of independent care homes for older people. A better understanding of the processes involved, residents' and relatives' views and feelings, the resources required, the comparative advantages of different organisational approaches, influences on process and outcome, and the consequences and costs is needed to support any future debate, guidance, regulation or training aimed

specifically at the closure of care homes for older people. The closure of care homes for older people is not going to disappear in the immediate future. The purpose of this research was to establish the prevalence of local authority written guidelines and the nature of recommendations for practice. [1]

Box.1: Actions, issues & objectives during home closures identified in the literature

Actions and issues	***Objectives***
Consultation May need definition Can the closure decision itself be informed by consultation?	Comply with residents' rights Promote resident and relative involvement
Notification of decision Can the timescale be too long as well as too short?	Prepare residents
Retention of existing staff	Maintain ongoing care Provide continuity of care
Preparation of residents Ongoing discussions Counselling Visits to new home Charter of Rights How might residents' with dementia be supported?	Minimise resident stress and distress Promote understanding and minimise distress Promote predictability and support choice Protect choice and decision making
Support and involvement of staff	Promote sense of control and decision making and minimise stress
Assessment of residents' needs	Ensure new accommodation is suitable
Finding of alternative accommodation Involve residents Consider protecting friendship groups	Promote sense of control and decision-making Respect personal and social needs
Organisation of actual move and move itself Residents to be accompanied Timing Transfer of information	Continuity and respect of individuals Avoid problematic days/times of day Provide continuity of care
Settling in period Can staff visit or move with residents?	Provide continuity of care
Monitoring and follow-up	Ensure suitability of placement

[1] This investigation was part of a wider study focusing on the process and consequences of care home closures. The experiences and views of local authority staff, residents, relatives and carers, providers and care staff are currently being identified through case study work around particular home closures.

4. Methods

All local authorities in England were contacted in March 2002 and asked whether they had a protocol for the closure of independent care homes for older people, and if so, to provide a copy. Since authorities with a considerable number of homes are more likely to have experienced closures, and as a consequence might be more likely than other authorities to have guidelines, a follow-up letter was sent to authorities with 100 or more independent residential or dual registered care homes, as at March 2001(Department of Health, 2001c). Twenty seven of these were also telephoned.

The home closure guidelines and protocols were analysed using a combination of quantitative and qualitative approaches to content analysis. Protocols were reviewed to identify the format, length and scope before the number in each category was quantified. Similarly, the content of the documents was reviewed to identify the nature of recommendations before quantifying the prevalence of particular subject matter and suggestions. Issues and recommendations were then compared in more detail to identify common views of best practice and any variation or agreement.

Our request for guidelines from councils was made before the implementation of the Care Standards Act and the replacement of local authority and health authority registration and inspection units by the National Care Standards Commission (NCSC or the Commission) in April 2002. In reporting the findings the terminology used reflects that used in the council guidelines and so includes reference to registration and inspection units rather than the Commission, and nursing homes and residential homes, rather than care homes.

5. Findings

In total information was collected from just over a third (55) of the 150 councils in England. Of those councils with over 100 independent care homes 68 per cent (48) responded. The highest response rate among the larger councils was from Shire County Authorities (80 per cent).

Of the local authorities who responded with over 100 independent residential or dual registered care homes, in March 2001, 62 per cent (30) reported having a protocol, and 37 per cent (18) said that they did not. A further seven authorities that had fewer homes also provided examples of their protocols.

Table 1 shows the response from local authorities with more than 100 care homes by type of authority. Almost two thirds of the shire county authorities reported having a protocol. None of the councils in Inner London volunteered a protocol. Almost half of the protocols received were from the Northern and Yorkshire region and from the North West. None of the councils that reported not having a protocol were in the Northern and Yorkshire region. Of the larger authorities who reported no protocol a third were in the South East.

Table 1: Response from local authorities with more than 100 homes by type

	Number of Councils	*No. of responding Councils*	*No. that reported having a protocol*	*No. that sent an example protocol*
Shire County	31	25	17	16
Shire Unitary Authority	18	10	5	3
Metropolitan District	15	10	7	6
London	6	3	1	1
Total	70	48	30	26

Several local authority staff stated that they did not have a protocol, or had not finalised their protocol because of the imminent replacement of the registration and inspection units by the National Care Standards Commission. One added that they had destroyed their existing guidelines. Four said that they were expecting the Commission to provide advice about closures or to develop a national protocol. One protocol, published in 1994, noted that guidance or a national protocol was likely to be issued in due course.

A couple of comments made by local authority staff suggest that views of the usefulness of closure guidelines differ, perhaps reflecting the regional variation in the number of care homes; one department, with a draft protocol, described the need for a protocol as urgent, while another reported not having had an occasion when they had to use their protocol.

There may be more protocols in use than reported. Different council departments responded, and telephone enquiries as to the existence of protocols also typically involved being put through to more than one department. Obtaining a definite no as to the existence of a protocol was consequently difficult; knowing which department should be contacted was far from straightforward and deciding when all relevant departments had been contacted more

so. Sources of protocols or information included: Adult Services, Contracts, Commissioning, the Directors Office, Communication, and the Policy department within councils, and the National Care Standards Commission. Moreover many of the protocols received were formal policy level agreements, outlining responsibilities and resource allocation. Initial analysis of our cases study work suggests that guidelines may be developed by front-line social services staff, based on their experience and for use by their teams. Such guidelines may not be known about at higher levels of the organisation.

5.1 The documents received

Thirty three protocols or guidelines were received and analysed. Twenty seven of the larger authorities and a further seven councils with fewer than 100 homes provided protocols. The nature of the documents varied. Just under a third of the protocols were temporary in so far as six were drafts and a further four were being updated. One inspector sent notes based on guidelines that could not be located. A date of 'publication' was shown on just over half of the documents and ranged from 1994 to 2002. Of these about half had been produced in the last three years (2000-2002) and two thirds in the last four years (1999-2002)[2]. Three dated back to 1994. Document length varied considerably, ranging from one to 71 pages. Only three were over 20 pages. A third were between two and six pages.

Just under a third (10) of the protocols stated that they were developed or agreed jointly by health and social services. The author(s) of the documents, however, were not always specified, and neither were intended audiences. This possibly reflects the internal and/or working nature of some of the documents. To a degree, intended audiences could be inferred from the departments or agencies whose roles and responsibilities were outlined. Some protocols appeared to be intended for multiple audiences (such as local and county councillors, advocacy services, GP practices, the Benefits agency, Ambulance Service, Fire Service, Health and Safety Executive and Environmental Health), while others appeared to be written for one main audience, such as the care management team, or care home providers. In two instances very similar protocols were provided from adjacent local authorities that had previously been the same local authority.

5.2 Aims, scope and principles of good practice

Less than a third of the documents outlined aims and objectives. Of those that did, the majority identified their aim as protecting and supporting residents, carers and relatives, their rights and interests, and safe transfer to appropriate care.

[2] As most of the protocols were written before the introduction of the National Care Standards Commission, where reference is made to Registration and Inspection Units this reflects the wording in the documents.

The majority (27) of the protocols covered voluntary closures (13), or voluntary and emergency closures (14), and it is these that are the focus of this analysis. Two protocols related to the closure of council run homes, and four covered emergency closures only, of which one was reportedly used for planned/voluntary closures. A few documents were said to also apply to temporary emergency closures, such as those due to structural damage to the premises, catastrophic failure of a utility service, fire, or flood. A couple of protocols also covered the eviction of a single resident. A few applied to the closure of residential care homes for adults only, and one emergency protocol related to children in residential care as well as adults.

The scope of the documents also varied in the extent to which they set out to cover 'all aspects which may occur or require addressing', to outline key issues, or to list actions to be taken. Five protocols were checklists and a further 14 included a checklist or checklists. Over half of the checklists within protocols consisted of a list of step-by-step actions to be taken from notification to post closure. As well as checklists of actions, appendices included the paperwork needed for a cancellation of registration order, a resident master sheet, a resident identification sheet, a resident property sheet, a permission to remove property form, information on Preserved Rights, and standard letters to relatives, general practitioners, and pharmacists. One protocol included a copy of the Health Service Circular (NHS Executive 1998). Another included a leaflet for residents, relatives and friends, and another a nine-point list of residents' rights.

The majority of documents focused on actions to be taken after the closure decision but four protocols referred to measures to prevent a closure, or measures to keep a home open to allow a longer closure period. Of these, two noted that 'The most effective way of dealing with home closures is to prevent them happening and, in many instances, closures can be avoided if there is co-operation and negotiation between interested parties'. Recommended measures for extending the closure period, or for preventing an emergency closure included: faster payment of any outstanding invoices; advance payments; the registration of the receiver. Views differed about the legality of some of the options, for example, sending additional care staff into a home (this is discussed in greater detail below). Several authorities reported trying to be in a position to identify when a home is having financial difficulties in advance, so that they might be able to prevent an emergency closure, or assist a planned closure. The monthly monitoring of occupancy levels, and regular communication with proprietors was recommended and high staff turnover and disinvestments highlighted as warning signs.

Just under half of the protocols summarised or advocated principles to be adhered to during a closure, some of which reflected wider goals. For example, the protection of service users'

welfare, rights and interests. During the closure of a care home such principles centre on minimising disruption, stress and distress, while promoting independence, choice, privacy, dignity and respect. One protocol referred to protecting residents' human rights. Six protocols recommended that advocacy services should be made available to residents and relatives to ensure that they can make an informed choice about alternative accommodation. The need for care managers to ensure that alternative accommodation was appropriate and met residents' needs was emphasised frequently.

The social and personal needs of residents, and relatives or carers highlighted as considerations that should be taken into account included existing friendships between residents, the preferred location of a new home, and the ability of relatives and friends to visit. Only one protocol highlighted the importance of taking the needs of minority ethnic communities into account when moving residents to a new care home. Six protocols referred to the desirability of finding accommodation that friends within the closing home could move to together if they wished. One of these cited the Health Service Circular recommendation, made in the context of transferring NHS patients to other long stay settings, that friends should be moved together (NHS Executive 1998). One protocol highlighted issues that should be considered by social services staff trying to identify friendships between residents:

> 'Sometimes relationships are observed to be positive by outsiders, but one of the partners could be experiencing some form of abuse. It should not be assumed that relationships between confused people or people with a learning disability are less important to them than between others.'

The need to maximise residents' ability to make an informed choice was highlighted in six protocols. In some cases this choice was referred to as a right. Comments in two protocols implied that offering choice might be impossible or difficult to achieve during a home closure: 'choice …[is] likely in fact to be minimal'; 'the right of the resident to choose … should be upheld as far as possible'. One protocol suggested offering residents two or more choices where possible.

5.3 Definitions of types of closure

The protocols distinguished between emergency and voluntary closures, and between planned and unplanned voluntary closures. Definitions varied, although they were often classified in terms of timescale and/or reason for closure. One protocol referred to urgent or sudden closures (presumably 'unplanned') as those with less than six weeks' notice, and defined planned closures as those with a minimum of six to eight weeks' notice. In contrast, one of the emergency closure protocols defined urgent closures as those that occur within a few

hours, and added that experience had shown that one week's notice was sufficient for residents and relatives to be involved in choosing new homes. Another protocol defined unplanned voluntary closures in terms of examples, citing financial failure, staffing issues, and change of category of registration. Yet some of these reasons for closure could meet the criteria given for an emergency closure: 'any event in a residential or nursing home which necessitates the urgent removal of residents from the home in questions', for example fire, flood, failure of power supply, structural problems with the building, staffing crisis. As another protocol noted, financial problems may lead to a home closing within a few hours, 'because the proprietor could no longer purchase food, or was relying on nursing agencies who gave short notice that because they were not being paid they would not supply staff for the next shift.'

5.4 Legal issues

Just under half of the protocols highlighted particular legal issues, over and above the general legal framework described earlier. Four protocols noted that local authorities are not empowered to move residents against their will, and that a general practitioner may need to apply for a court order in order to do so. Another restriction related to communication between the registration and inspection unit and local authority operational staff: the registration and inspection unit could not inform operational staff of concerns about a home's financial viability as 'to do so would render them liable to legal action in connection with restraint of trade.' However, as mentioned earlier, two protocols recommended that local authorities monitor vacancy information, so as to be better placed to gain the co-operation of a proprietor if a closure cannot be avoided.

Another legal issue related to the transfer of residents' documents to their new care home. Permission should be sought from the registered person at a closing home to remove documents, and the receiving home should agree to return records at a later date for retention by the proprietor of the closed home. One protocol included a permission form to be completed for each resident. Another suggested that files from the closing home should be photocopied.

In an appendix on legal issues one protocol advised care managers to restrict any advice that they give to residents, and relatives and carers, about finding alternative homes to the immediate care needs of the residents. The same protocol also stated that 'meddling in any way' with the running of the home was 'ultra vires and should not be undertaken'. Social services staff were also advised to avoid being the last out of the premises.

A minority of protocols referred to the possibility of existing care staff being paid by the local authority, or to council or health authority care staff being put into a home to allow a longer closure period. Local authorities had received different advice on this matter. One protocol indicated that according to legal advice statutory agencies could not pay staff in homes that were closing because 'this would require an individual being registered as a fit person to run the home and … there is no such thing as temporary registration … the person so registered could… only be removed from that role if the statutory agency had grounds for de-registration.' In addition if the statutory agency were to pay staff it would become responsible 'if something went wrong in the home'. Yet, both the temporary payment of staff, and the possibility of providing additional staff were identified as an option in two protocols.

5.5 The allocation of roles and responsibilities

The principal actors with responsibilities during a care home closure are the residents and their relatives or former carers, the owner of the home and the home staff, the local authority, NHS/health authority, and the registration and inspection unit/NCSC. The allocation of roles and responsibilities varied between councils. It varied in terms of the level of organisation and co-ordination described, and in terms of who was responsible for particular tasks. Three of the council protocols referred to the central government recommendation that councils draw up plans in the event of a care home closure (Department of Health, 1993).

The degree to which the protocols outlined levels of management structure varied, as the audience and coverage varied. Formal and comprehensive agreements tended to outline arrangements for a co-ordinating task group, which would include representatives from the council and the NCSC. In other documents overall responsibility 'for ensuring that all the parties involved work together' was placed within one agency, such as the registration and inspection unit, or more commonly a district manager, or above, in the local authority. In one case the registration and inspection unit was allocated overall responsibility only when a closure was enforced, although in another case they were said to always take overall responsibility. In another protocol responsibility varied according to the type of home; social services team managers were responsible for residential home closures and the registration and inspection unit was responsible for nursing home closures.

Responsibility for particular tasks varied across the protocols. Obtaining a current list of residents, along with details of funding arrangements, and the names of GPs and next of kin was said to be the responsibility of the social services department in six protocols, the registration and inspection unit in five protocols, and the proprietor or manager of the home in another five protocols. The majority of protocols that outlined roles and responsibilities

for finding alternative placements identified social services staff. In one protocol, however, the registration and inspection unit was responsible for advising residents, carers, relatives and purchasing authorities about vacancies and their appropriateness. Another four protocols identified the proprietor of the home as responsible for 'making satisfactory alternative arrangements'. In one of these this applied to non-enforcement closures only. In two cases, however, the proprietor or person in charge of the home was said, 'in the first instance' to be responsible for making adequate arrangements 'for the future well being of residents – even when closure is sought by local authority or health authority registration and inspection unit'. Another protocol recommended that proprietors be encouraged to collaborate closely:

> 'Although the relevant guidance may imply that the proprietor is responsible for making arrangements to relocate all residents, it is better that the proprietor works with the relevant people/organisations … since the Local Authority has power to advise and assist all groups.'

Proprietor involvement in the matching of vacancies to residents was another issue covered in varying degrees of detail in only a few protocols. That proprietors should be involved in discussions was recommended. Yet one protocol advised that any such involvement by proprietors be based clearly on the understanding that they do 'not enter any arrangements with other proprietors about transferring residents, including self-funders, and benefits only and preserved rights residents.' Three protocols emphasised that the proprietor, or any organisation acting on their behalf, has continued responsibility for the safety and care of residents, and the National Care Standards Commission was responsible for advising the registered person or person in charge of this.

5.6 Care management arrangements

Organisational arrangements for care management during home closures differed across the documents. Approaches to allocating staff to carry out assessments of residents' needs and identify new placements included: re-allocating residents to the care manager who carried out their initial assessment before admission; identifying a temporary team of care managers to work on the closure; allocating residents to a specialist team responsible for annual reviews. One document described flexible arrangements for assessment where assessments could be carried out by a team identified by the Co-ordinating Group, or the residents' own social worker, district nurse or GP, depending on the timescale of the home closure. This variation reflects findings of a national study of care management, which found that the same practitioner was usually responsible for assessment, care planning, monitoring and review for older people in 44 per cent of authorities, and that such continuity in involvement occurred sometimes in 48 per cent of authorities (Weiner et al., 2002).

Just under a third of the protocols discussed the possibility of residents having been placed in homes in their area by other local authorities. The extent to which this issue was discussed ranged from a page to a sentence. For example, a page long appendix recommended that formal reassessment and placement arrangements should be completed by the placing authority, or, if necessary, by a social worker in the lead authority (where the home is located) on their behalf. In the latter case care mangers would have to make sure that they adhered to the other authorities' documentation, eligibility criteria and payment levels. Notifying other councils about a planned closure was said to be the responsibility of the proprietor in one document. Another suggested that when relatives lived in another authority, their local authority should be contacted to provide liaison.

5.7 Recommended notice periods and timescales

A quarter of the protocols discussed the length of notice of voluntary closure that providers should give of their intention to close, either to councils or to registration and inspection units/NCSC. While the likely timescales and notice periods identified ranged considerably, the typical recommendation was that notice should be around a month or as long as possible. Some of the notice periods were said to be requirements, while others were described as desirable. Contract stipulations for written notice of closure to councils for local authority funded clients, or to the registration and inspection unit included: four weeks' notice for local authority funded clients; four weeks' notice to the registration and inspection unit; 90 days notice to the council of withdrawal from contractual obligations. The 90 days notice was described as technical. Three guidelines recommended that as much notice or warning should be given as possible. That timescales should be agreed between the local authority and the owner was also noted by three protocols. Two protocols adopted a pragmatic approach to timescales: one recommended that a month was 'probably realistic' to carry out reassessments, identify new placements and move residents. Another suggested that a timescale of between two and six weeks should be agreed, depending on the number of residents in the care home.

5.8 The provision of help and information to self-funders

Recommendations concerning the provision of guidance, help and information to self-funding residents varied. One protocol referred to, and another quoted from the central government recommendation that local authorities should help all residents:

> 'Contingency plans and arrangements should as far as possible aim to ensure that all residents are helped to identify opportunities in finding alternative accommodation within a similar time scale (irrespective of the source of financial support).' (Department of Health, 1993)

Two further protocols also said that every assistance should be offered to all residents. Five protocols, however, recommended that care managers should only offer information and help to self-funding residents without relatives, or to those incapable of finding new accommodation for themselves. In such circumstances, one protocol noted that self-funding residents should be allocated a care manager. In other cases the criteria for offering help to a self-funding resident was more general: when they require help. Another protocol, however, noted that information and advice on choosing a new home should only be offered to a self-funding resident if they request it.

5.9 The provision of assessments of residents' needs

Approaches to the assessment of residents' needs by care managers and/or nurse assessors before relocation varied considerably across the guidelines in terms of whether all, or only publicly funded residents should be assessed, and whether publicly funded residents would be assessed in all closure situations. Six protocols noted that councils have a statutory duty to reassess residents that they fund. That assessments should be offered to all residents, irrespective of funding, was noted in eight protocols, one of which added that self-funding residents could refuse the offer. Another protocol emphasised that assessments of self-funding residents should include a review of finances, since residents' savings might have reduced to the extent that they have become eligible for support. In protocols that covered both voluntary and enforced closures the issue of whether assessments of residents' needs should be carried out in both situations was often unclear. In some of the protocols the situations were not addressed separately. Recommendations in two protocols, however, suggested that during an emergency closure residents' needs would not always be assessed; assessments of need would be carried out 'where it is clear that a resident's needs have changed since placement', or 'where appropriate'. One protocol referred to the need for care plans to be updated and recommended that updating include the 'resident's response to and understanding of the current changes'.

5.10 Approaches to resident preparation and consultation

Recommendations about how to prepare residents during a care home closure related to a range of activities: the provision of information so that residents would know what was happening; resident consultation and involvement in decisions; the provision of emotional support; visits to new homes to allow residents to make an informed choice and become familiar with new surroundings.

Recommendations about who should be involved in deciding how residents, and/or relatives and carers should be notified about a closure differed by authority, and type of closure. One protocol recommended that social services staff should discuss the form of notification with

the proprietor, and that the proprietor, a care manager and a representative from the registration and inspection unit, should give notification jointly. In contrast, another protocol, apparently intended for the registration and inspection unit, appeared to suggest that social workers may have to inform residents of the closure when they are carrying out assessments: 'If homes have not informed clients and relatives, though this is rarely the case, they will in any event, be notified by social work staff in due course.' Three protocols stated that notification and consultation with residents and relatives was the responsibility of the proprietor, registered person or responsible party. In the context of an emergency closure another protocol said that the inspecting unit, the social services duty unit, or the Community Care Division should contact relatives.

Some of the protocols recommended a collective meeting of relatives, residents, or both, and the merit of this form of notification appeared to be taken as self-evident. One obvious advantage of a collective meeting would be that everyone was notified simultaneously. Other protocols, however, suggested that the form of resident notification should be decided flexibly and on an individual basis. These discussions of resident notification either assumed or ascribed a degree of involvement by social services staff: 'There is little benefit in delaying matters to hold what could be a traumatic meeting'; 'Social Services do need to be clear … that any discussions meet agreed standards and are seen to be made in what is believed to be the best interests of the person concerned'.

A further recommendation related to the nature of notification: residents and staff should be given information in written form as well as being told verbally. An earlier version of this protocol, published by the same registration and inspection unit, included evidence for this recommendation, although the source was not cited: 'Research shows that in times of extreme stress people will only retain about 20 per cent of what they are told verbally.'

Four protocols recommended that residents should be given the opportunity to visit potential homes, although responsibility for such arrangements varied. One protocol stated that the Care Management Review team should make arrangements, and another that the registered person should make arrangements, which the Assessment and Care Management Team should facilitate. The potential value of visits, both in terms of supporting informed choice, and reducing the uncertainty and unpredictability of the situation, which in turn may make relocation less stressful, was rarely discussed.

5.11 Sources of information about other care homes

During a home closure social services staff and/or relatives and carers need to be able to identify homes with a vacant place and to decide whether any of these homes are suitable in

terms of meeting the resident's needs. Little was written in the guidelines about the nature and quality of any information to be made available to residents, and relatives or carers to help them find or choose a new care home. Written information provided to residents and relatives by councils or registration and inspection units included lists of care homes, an accredited provider list, home brochures, and inspection reports. One protocol reminded care managers that they are obliged to restrict the verbal information that they give to residents and relatives when looking for a new home, to residents' immediate care needs. Advice about how social services staff should go about identifying vacancies was more frequent.

Seven protocols referred to how social services staff should go about identifying vacant places. A couple of protocols referred to a council vacancy list. The remaining protocols advised social services staff to establish the availability of care places themselves, for example 'by phoning round', and possibly liaising with the Contract Unit. One protocol highlighted the potential need to identify hospice beds for terminally ill residents. In response to the possibility of an insufficient local supply of nursing places, one protocol suggested that registration rules be relaxed, in order to 'allow a nursing home to take residents in excess of the number it is registered for.' However, this was said to be an undesirable option since 'it would undoubtedly result in an inappropriate environment (camp beds, overcrowding, a feeling of chaos) and undue stress'. Staff were advised instead to look for vacancies in adjacent districts.

Another protocol suggested that a list of the information provided by social services staff to residents and their relatives or carers, and their responses, be recorded for the purpose of accountability:

> 'Experience … suggests that some providers, with vacancies, may feel aggrieved if they do not receive residents from the home that is closing. Therefore it is important not only to provide residents with lists of homes with vacancies but also to document which homes have been visited by residents and the reasons why a particular home has been chosen.'

5.12 The role of care staff

There was more consensus in the guidelines about the role of care staff during a home closure. Where care staff were mentioned the majority of the recommendations were in agreement; seven protocols recommended that care staff should be consulted, asked to help, and encouraged to be involved in the closure process. Considerable importance was placed on securing the help of staff: 'Strenuous efforts should be made to involve the staff throughout'. Five protocols highlighted the potential role of care staff in transfer

arrangements. One of these recommended asking existing care staff to produce 'pen pictures' of residents' routines, and their likes and dislikes, for staff at their new homes.

One protocol recommended that friendships between staff and residents should be respected and another noted that staff might want to be present during transfers to say goodbye to residents, and so should be kept up-to-date about moving arrangements. Three protocols recognised that care staff might be concerned about residents after a closure. Suggested responses included: asking staff to go with residents to their new homes, which would also provide continuity (and staff could be paid to do); informing staff of how residents have settled in. An emergency closure protocol suggested the provision of emotional support and counselling for care staff.

Typically protocols that referred to the importance of involving care staff also stated who was responsible for notifying them about the closure, the reasons and the timescale. Allocation of responsibility for notifying care staff differed across the protocols. In three cases the proprietor, or manager of the home, was said to be responsible. Council staff were said to be were responsible for keeping care staff informed of arrangements and progress. One protocol noted that the council might need to take the lead to avoid confusion in the home. In contrast, four protocols indicated that social services staff were responsible for ensuring that care staff had been told of the situation. In another protocol the registration and inspection unit was said to be responsible for telling care staff, if the proprietor was unwilling or unable to do so.

5.13 Approaches to temporary moves

Few guidelines discussed the issue of whether temporary or second moves should be discouraged or facilitated. Those that did offered different advice. One protocol suggested that temporary moves might be arranged when there was a lack of places available in a resident's preferred home. In such circumstances accepting a temporary place would allow a resident to move again to the home of their choice as soon as a place was available. Another protocol, however, advised against second moves, recommending instead that moves be permanent. One protocol identified temporary moves as an option during emergency closures, when time might be insufficient to find more permanent placements.

5.14 Safe transfer recommendations

Two protocols offered different advice about how resident moves should ideally be organised. One advised against moving large groups of residents on the same day, and included the Health Service Circular as an appendix (NHS Executive, 1998). In the context of transferring older NHS patients the circular states that 'experience suggests that no more than three or four patients should be transferred in any one week.' In contrast, another

protocol recommended that social workers should move all residents on the same day. Avoidance of evening and weekend moves was also recommended.

Just over a quarter of the protocols discussed the kinds of practical arrangements and activities involved when moving residents. Several protocols suggested the use of wrist-bands to ensure identification of residents. A pre-packed box of emergency equipment was mentioned in five protocols. Proposed contents included secure plastic bags for medication, large envelopes for records, parking cones, and copies of property sheets. Several protocols suggested that mobile phones should be made available to inspectors, care managers and key care home staff. The need to be able to identify and equip a reception centre in the event of a closure caused by a disaster, such as a fire or flood was identified in only one protocol.

Advice offered about the way in which residents' possessions should be moved focused on ensuring that suitable bags were used, particularly when suitcases were unavailable. Bags suggested as suitable included plastic property bags or boxes from the emergency provision stores. Ensuring that residents' belongings could be identified, through labelling, was also highlighted as important. Two protocols stated that black bin liners should not be used. Yet, another two protocols referred to ensuring adequate supplies of black plastic bags. The possibility that property belonging to a resident might be left at a closed home was also identified as something that might need to be addressed. One protocol noted that although this was legally the responsibility of the resident, their legal representative or next of kin, assistance might be required from the new home. Some of the example property sheets record the destination of property. Two protocols noted that care managers might have to liaise with a pharmacist and/or inspection unit to ensure that no medication was left on the premises. Another protocol suggested that social services staff ask for advice about the relocation of individual residents from GP's.

Other practical considerations identified in the protocols included: the arrangement of appropriate transport; whether wheelchairs would be needed and the number of escorts required; the transfer of residents' care records; the need to ensure that medication supplies would be sufficient for one or two weeks after the closure; the potential transfer of residents to new general practitioners; the notification of relevant pharmacists. The allocation of responsibility for such tasks varied across the protocols. Responsibility for checking and or packing medication, for example, could be allocated to social services staff, the owner, or the member of care staff normally responsible for administering medication.

Advice about ensuring that residents do not feel like they have been 'dumped' included: encouraging relatives to arrange or be present during moves; ensuring that social services

staff used their own cars and only used taxis when there was no alternative. Checking the readiness of the new homes was also highlighted in one protocol as the responsibility of the closure task group.

5.15 Approaches to placement review and closure evaluation

A number of approaches to resident and/or closure follow-up by social services staff were described in the protocols. These included checking how residents were settling in during the first few days, a formal review of the placement, debriefing of social services staff and/or some form of evaluation. Five protocols recommended that social services department staff continue to monitor resident welfare immediately after a closure. Advice included: ongoing liaison between social services staff and staff at the new home; social worker visits to see residents on the day after relocation, or during the first week; ongoing social worker liaison with relatives. One protocol suggested that a record be kept of any complaints, or comments made by residents, or relatives, about the closure at this time.

The majority of the protocols that referred to care manager placement reviews were in agreement. Seven protocols stated that residents and their placements would be reviewed within four to six weeks of relocation due to a care home closure. One protocol suggested that residents be reviewed sooner, within 2 weeks. Plans for reviews rarely specified whether all, or some, residents would be reviewed. One protocol, however, noted that reviews should take place 'for residents for whom we are responsible'.

Five protocols specified some sort of formal team debriefing, longer-term review of residents, or evaluation of the closure and the procedures used. Debriefings would aim to identify what went well, what went wrong, the lessons learnt and any changes that might improve future planning and implementation. The aim of a review meeting or evaluation would be to consider the impact of the closure on residents, and to examine procedures, either on an annual basis or some months after the closure.

5.16 Local authority resources and closure costs

Resource and cost issues were rarely discussed in the protocols. Issues that were identified related to staffing: the number of care managers that would be needed; how sufficient care managers could be designated to a closure; the allocation of existing and ongoing work. Four of the documents offered advice about the number of care management staff that would be needed during a care home closure. One recommended that: 'depending on the time available, it is probably better that as few care managers as possible are involved'. Three protocols suggested the number of residents one care manager could be expected to take responsibility for. One protocol suggested one social worker to three to five placements, with

one social worker to five 'other placements' (presumably self-funding placements), and another two protocols recommended a minimum of one care manager to four residents.

Designating care management staff and allocating ongoing work was another resource issue addressed in several protocols. Two stated that home closure activities should take priority over routine work. Of these, one added that team managers should take responsibility for existing work. Four protocols noted that finding sufficient staff or staff shortages could be a problem. A suggestion in response to this was that the wider department might have to support the district involved. Another protocol noted that extra staff or volunteers might be needed. Another noted that in exceptional circumstances additional internal resources might be available on a temporary basis. 'Capacity problems obtaining' nursing assessors and mental health assessors were also anticipated in another protocol.

Few resource issues, other than staffing, were highlighted in the protocols. Those that were related to costs that might be recovered or met by the home owner, such as transportation costs, or recovered from other councils, such as the cost of helping residents placed by other councils.

6. Discussion

Much of the available literature on the process of care home closures describes broad objectives and types of activity related to minimising the distress experienced by residents (Lane, 1987; Leonard Cheshire and Social Care Association, undated; Woolham, 2001). There is little research evidence linking specific approaches or measures during home closures to residents' successful adjustment, or to their health and quality of life. Where particular approaches or issues are discussed recommendations tend to be 'ideal' and many relate to aspects of a care home closure that are likely to be outside the control of councils (for example, length of notice, retention of existing care staff and staffing levels within a closing home). Control of these aspects of care home closures is also likely to be affected, or determined in part, by the circumstances and causes of closure, further limiting the extent to which the process might be managed or made to comply with standard procedures. Yet local authorities have a responsibility to protect and support service users and vulnerable people. Their role during a home closure is at once very important and restricted.

This study aimed to identify the prevalence and nature of local authority guidance on the closure of care homes for older people. We selected authorities with more homes on the basis that those with relatively few homes would be less likely to invest resources in

developing protocols for relatively rare events. Just under two thirds of the larger authorities reported having a protocol for the closure of care homes for older people in 2002. This suggests that nationally a substantial proportion of authorities do not have protocols in place. Some of our respondents clearly felt that guidance was going to be forthcoming from the Commission although there is no indication of this to date. Although the existence of protocols does not guarantee their use in practice, their absence does suggest that within such authorities there is likely to be considerable variation in practice, particularly given the numbers of people involved and crisis that a home closure can often represent.

In the examples provided there was consensus about the main aim of local authority involvement in care home closures: the protection and support of residents and their relatives and carers. It is likely that any absence of a statement of this aim reflected the 'checklist' nature of some of the documents rather than an absence of the intention. Other areas of agreement in the protocols included: the goal of promoting resident involvement and choice; the importance of involving care home staff in the closure process.

However, what was most striking was the variation in scope, definitions, arrangements and advice provided. Many recommendations differed. Although in some cases this simply reflected alternative but comparable means of achieving similar objectives, in other instances, the variation was likely to have implications for residents. For example, the different actors variously identified in different protocols as responsible for finding alternative placements might be, more or less, willing and/or able to find new placements that are appropriate to residents' needs.

The apparent inconsistency in the responsibilities of the registration and inspection units is likely to reflect the lack of a national regulatory system at the time the protocols were drawn up. However, clarification of the role and responsibilities of the National Care Standards Commission, and it's successor organisation, would be useful.

Clarification of the responsibilities of local authorities would also be helpful, given the likely importance of council involvement to residents and families and the need to be accountable to the public. In particular, clarification of councils' assessment and reviewing responsibilities during care home closures would be useful since the variation in councils' plans raises policy issues of geographical equity and fair access to social care services. Recent policy guidance aimed at promoting fair access to adult social care services asks councils to base eligibility criteria on a national framework to ensure that factors such as location 'play no part in deciding an adult's eligibility to care services' (Department of Health, 2002a: 6). The guidance notes that an individual's 'financial circumstances should have no bearing on

whether a council carries out a community care assessment or not.' (Department of Health, 2002b:14). However it is unclear whether those already funding services themselves should be re-assessed at a time of crisis, such as a care home closure, to ensure identification of any changes in their circumstances that might make them eligible for services. It is also unclear whether the recommendation that 'There should be an initial review within three months of help first being provided or major changes made to current services' should apply to the relocation of self-funded residents due to home closure (Department of Health, 2002b:12).

The variation in approaches to providing support to self-funding residents may leave these residents, who have been estimated to make up nearly a third of independent care home residents, vulnerable in a number of ways (Laing and Buisson, 2001). The responsibility for finding alternative accommodation suitable to their needs, which may have changed since admission, may be left to the resident and their next of kin, who may themselves live at a distance or be unaware of the residents' needs. Given the likely pressures on resources, even when self-funding residents are offered help from care managers their needs may be of relatively low priority compared to those of publicly funded service users. Self-funding residents may also be relatively isolated once they have moved to a new home, possibly not receiving any follow up support, even from advocacy services, unless on their request.

Different approaches, arrangements and recommendations were also described in relation to: definitions of what time period constitutes an urgent or sudden closure; notice periods; views of the measures available to local authorities to try to extend a closure period; care management arrangements; the identification of vacant places in other care homes; whether it is better to move residents within a short time or more gradually; whether temporary moves should be facilitated or discouraged.

One protocol reminded care managers that they are obliged to restrict the information that they give to residents and relatives when looking for a new home to residents' immediate care needs. Yet care managers are themselves important sources of information about potential new homes since they have a professional and personal knowledge of the quality of the care provided, as well as of the facilities and services available in local care homes. Since care managers are restricted from offering advice relatives may have to rely on other sources of information. Little was said in the protocols about these beyond what they were: lists/books of providers, inspection reports and provider brochures. Lists of providers are likely to be produced on an annual basis and to contain brief entries on individual homes, their services and facilities. While they are available to the public, inspection reports are not written specifically for a public audience. Making available information that has been written

specifically for them may better support resident choice, and that of their relatives and friends.

The protocols highlighted a number of circumstances and issues that may constrain or limit the way in which an independent care home closure is managed. The cause of closure may determine the timescale for closure. When a home closes due to business failure the timing of the closure date and the degree of flexibility or scope for extension are likely to be affected. The timescale may in turn limit the amount of time local authorities have to prepare and organise, limit the forms of resident preparation possible, influence whether needs assessments can be carried out before alternative accommodation is found, and limit the extent to which a range of care homes can be viewed by residents and their relatives. The extent to which care staff in a closing home could be involved in the closure process was also recognised as dependent in part on the timescale of the closure, and whether the proprietor was willing and able to support care staff in doing so. Generally the level of co-operation established between local authorities and the proprietor may affect negotiations and the options available. The availability of vacant places in suitable alternative care homes may restrict or prohibit choice and bring about a reduction or an extension of the closure timescale. The availability of care management staff and health assessors may affect the provision of assessments and help offered to residents, relatives and carers.

The tensions between the objectives specified in the guidelines and their practicability, and between recommendations for 'ideal' practice and plans for 'worst case' scenarios may reflect local authorities' attempts to combine their practical experience, which would have varied, with existing guidance, which relates to other settings and circumstances, and explain some of the variation across the protocols. It also suggests that managing the process of a care home closure requires that a balance be struck between what is desirable and what is achievable.

Despite the variation it is clear that protocols can serve many useful purposes: support joint working between health and social services and independent providers; provide owners, and residents and relatives with information about what is likely to happen and about their rights and responsibilities; ensure that systems are in place, responsibilities are allocated, resources, tasks and activities are identified; support social services staff and ensure that they have access to information and documentation.

7. Policy and research implications

Equity and welfare considerations for residents and effectiveness and efficiency considerations for authorities suggest that there is a role for guidance and information at three levels: nationally, at council or care trust level and for care managers directly involved in the process.

Nationally there is need for guidance to clarify the legal responsibilities and restrictions on councils during independent care home closures. Are they permitted to staff closing homes on a temporary basis to delay closure and facilitate the support of residents and their relatives during the process? If not, is there an argument that perhaps legislation should be amended to allow this? What are councils' responsibilities to self-funding residents during a care home closure? What is the role of the NCSC or its successor during closures?

There is also a need for guidance about best practice for safeguarding residents' health, welfare and rights. Recommendations would need to be flexible enough for social services staff to react to individual circumstances and closure situations locally whilst equipping front-line staff with the information and knowledge they need to make decisions. The development of examples that relate to the issues staff might face and the considerations they should take into account might be useful.

Councils or care trusts need to have in place clear guidance about who is responsible for what in the event of a closure and how they translate national recommendations and/or requirements into practice.

Care managers need to have information about vacancies that is easily accessible and reliable, sources of advice and guidance to help them make decisions and to inform and support residents and relatives and providers, and checklists of procedures based on national recommendations and/or requirements.

Developers of future or revised guidelines for care home closures might want to consider:

- The sort of document(s) that would be most useful to each of the principal parties involved (in terms of form and scope, advice and/or requirements, specific procedures and/or approaches and principles);
- What actions or measures, if any, are essential to safeguarding residents' health and well-being during a care home closure?
- Is there a need for national recommendations or standards for care home closures?
- Should such national recommendations or standards be made obligatory?

- Would such recommendations or standards for care home closures be enforceable and, if not, how might good practice be promoted?

Some of the local authority protocols drew on past experience of home closures or general principles of good practice in care management. Unsurprisingly the majority of the local authority recommendations were not linked to evidence, based on academic or practitioner led research. There is little research evidence on which to base recommendations for good practice. Our ongoing qualitative case study work focuses on the process and consequences of care home closures from the perspective of residents, relatives and carers, care staff and local authorities. It aims to develop a better understanding of what happens in practice and of the views and experiences of those involved. Their views of what is important for residents' well-being, views of the advantages and disadvantages of different courses of action, and suggestions for good practice should be valuable to and included in any development of good practice recommendations or guidance.

Ideally policy and practice would be supported by further research that established whether positive outcomes for residents, and their relatives and carers, are associated with particular processes, arrangements and practices during a care home closure. Establishing such causal links is likely to be far from straightforward. However, more focused work might be able to address other unknowns: Are existing closure protocols used in practice, and if not, why not? Who uses them and in what ways? At what level of the organisation or during which aspect of the process is guidance most useful? What sort of consequences would guidance for care home closures have for council's resources? Is the Commission's notification requirement having an impact on the timescale of independent care home closures? Other issues where research might support a better understanding of the process and consequences of care home closures include: the incidence of second transfers after care home closure and the reason for and outcome of such transfers; how care staff might best be supported throughout a home closure.

8. Conclusions

The local authority protocols provided advice and recommendations that were often practical, sensible and considered, and attended to the co-ordination of roles and practicalities in a level of detail unavailable in much of the published literature. The range of roles and responsibilities, and organisations and departments discussed in some of the longer protocols suggests that some form of local authority plan, protocol or agreement is clearly justifiable, in terms of practicality and efficiency at the very least. While there is no one good way to close

a care home based on this evidence, there is scope for research evidence about some of the issues, procedures and measures that might be considered to support good practice.

The rise in home closures has been of particular concern in recent years. But even if the market stabilises closures will continue. The closure of care homes in order to safeguard residents' health and safety is part of the regulatory process. The market mechanism means that 'voluntary' closures will also continue. The closure of a home will always be a time of stress for residents and their relatives. It will also put strain on those responsible for their care both directly and indirectly. It is important that there are evidence-based consistent arrangements in place to support all those involved wherever they live and whatever their role.

References

Age Concern England (Undated) *Moving On: Good practice guidelines for involving residents in the closure or refurbishment of sheltered housing*, Policy Paper, Age Concern England, London.

Aged Care Standards and Accreditation Agency Ltd (2003) *Results and processes in relation to the expected outcomes of the Accreditation Standards*, Parramatta, NSW, The Aged Care Standards and Accreditation Agency.

Aged Care Act 1997 (Australia).

Amenta, M. Weiner, A. and Amenta, D. (1984) Successful relocation of elderly residents, *Geriatric Nursing*, 5, 356-360.

Bright, L. (2000) Time to act on old age home closures, *The Guardian*, December 21, 2000.

Bright, L. (2001) Care home closedown, *Nursing Older People*, 12, 6.

Brindle, D. (2001) Charity urges protocols on care home closures, *The Guardian*, January 10, 2001.

British Institute of Human Rights (2002) *Inquiry into the definition of Public Authority: Implications for the Application of the Human Rights Act*, BIHR, London.

Brugler, C.J., Titus, M., and Nypaver, J. M. (1993) Relocation stress syndrome: A patient and staff approach, *Journal of Nursing Administration*, 23, 1, 45-50.

Care Homes Regulations 2001, SI No. 3965, HMSO, London.

Care Standards Act 2000, HMSO, London.

Carvel, J. (2002a) Care homes 'face £1bn funding gap', *The Guardian*, June 19, 2002, www.guardian.co.uk

Carvel, J. (2002b) Thousands of care places lost, *The Guardian*, July 19, 2002, www.guardian.co.uk

Darton, R. (2002) *1996 Survey of Care Homes for Elderly People: Comparisons of Homes that had closed with Those that Remained Open in 2001*, PSSRU Discussion Paper No. 1752, Personal Social Services Research Unit, University of Kent at Canterbury.

Department of Health (1993) *Local Authorities' Powers to make Arrangements for People who are in Independent Sector Residential Care and Nursing Homes on 31 March 1993,* LAC(93)6, Department of Health, London.

Department of Health (1998) *Community Care (Residential Accommodation) Act 1998*, LAC (98), 19, Department of Health, London.

Department of Health (2001a) *Care Homes for Older People: National Minimum Standards*, The Stationary Office, London.

Department of Health (2001b) *National Care Standards Commission (Registration) Regulations* SI 2001/3969, HMSO, London.

Department of Health (2001c) *Building Capacity and Partnership in Care: An Agreement between the Statutory and the Independent Social Care, Health Care and Housing Sectors*, Department of Health, London.

Department of Health (2001c) *Community Care Statistics 2001: Residential Personal Social Services for Adults, England*, The Stationary Office, London.

Department of Health (2002a) *Fair Access to Care Services: Practice Guidance*, www.doh.gov.uk/scg/facs

Department of Health (2002b) *Fair Access to Care Services: Guidance on Eligibility Criteria for Adult Social Care*, www.doh.gov.uk/scg/facs

Dickinson, D. (1996) Can elderly residents with memory problems be prepared for relocation? *Journal of Clinical Nursing*, 5, 99-104.

Gloucestershire County Council (2003) *Scrutiny Inquiry into Care Homes*.

Grant, P. R. (1997) The Relocation of Nursing Home Residents: An Illustration of the Advantages Gained by Planning a New Program and Designing an Implementation Evaluation Together, *Evaluation and Program Planning*, 20, 507-516.

Human Rights Act 1998, HMSO, London.

Knapp, M.R.J., Cambridge, P., Thomason, C., Beecham, J., Allen, C. and Darton, R. (1992) *Care in the Community: Challenge and Demonstration*, Ashgate, Gower.

Korman, N., and Glennerster, H. (1985) *Closing a Hospital: The Darenth Park Project*, Occasional Papers on Social Administration 78, Bedford Square Press, London.

Laing and Buisson (2001) *Care of Elderly People: Market Survey 2001*, Laing and Buisson, London.

Lancashire County Council and Chorley Borough Council (2003) *Lancashire Care Homes Case*, Press release, Tuesday 4th March 2003. www.lancashire.gov.uk

Lane, K. (1987) There are ways of closing a unit, *Social Services Insight*, 2, 18, 20-22.

Leonard Cheshire and Social Care Association (Education) (Undated) Closing homes: a staff guide on what to do in Leonard Cheshire and Social Care Association (Education) *Social Care Practice Handbook*, Leonard Cheshire and Social Care Association (Education), Surbiton.

McAuslane, L. and Sperlinger, D. (1994) The effects of relocation on elderly people with dementia and their nursing staff, *International Journal of Geriatric Psychiatry*, 9, 981-984.

McCourt Perring, C. (1993) *The Experience of Psychiatric Hospital Closure: an anthropological study*, Avebury, Aldershot.

National Assistance Act 1948, HMSO, London.

National Assistance Act 1948 (Choice of Accommodation) Directions 1992, HMSO, London.

National Assistance (Assessment of Resources) Regulations (1992) SI 1992/2977, HMSO, London.

Department of Health (2001) *National Care Standards Commission (Registration) Regulations* SI 2001/3969, HMSO, London.

National Health Service and Community Care Act 1990 (c.19) HMSO, London.

National Health Service Executive (1998) *The transfer of frail older NHS patients to other long stay settings*, Health Service Circular 1998/048.

Netten, A., Darton, R. and Williams, J. (2002) *The Rate, Causes and Consequences of Home Closures*, PSSRU Discussion Paper No. 1741, Personal Social Services Research Unit, University of Kent at Canterbury, Canterbury.

Netten, A., Darton, R., Forder, J. and Bebbington, A. (2001) *Care Homes for Older People: Volume 1. Facilities, Residents and Costs*, Personal Social Services Research Unit, University of Kent at Canterbury, Canterbury.

Nursing Home Reform Act 1987 (US), 42CFR483.12.

Prasad, R. (2003) Under observation, *The Guardian*, August 20.

Residents Action Group for the Elderly (R.A.G.E.) www.ragenational.com.

Sapstead, D. and Womack, S. (2002) Alice, 108, starves herself to death, *The Telegraph*, 02 July 2002

Smith, A. E. and Crome, P. (2000) Relocation mosaic – a review of 40 years of resettlement literature, *Reviews in Clinical Gerontology*, 10, 81-95.

Thorson, A. and Davis, R. E. (2000) Relocation of the institutionalized aged, *Journal of Clinical Psychology*, 56, 1, 131-138.

Washington Administrative Code, Chapter 388-98 (162; 595).

Whyld, C., Duff, P., Arber, S., and Davidson, K. (2002) Stress and strain of moving. *Community Care*, 18-24 April, 36-37.

Wiener, K., Stewart, K., Hughes, J., Challis, D. and Darton, R. (2002) Care management arrangements for older people in England: key areas of variation in a national study, *Ageing and Society*, 22, 419-439.

Williams, J., Netten, A., Hardy, B., Matosevic, T. and Ware, P. (2002) *Care Home Closures: The Provider Perspective*, PSSRU Discussion Paper No. 1753/2, Personal Social Services Research Unit, University of Kent at Canterbury, Canterbury.

Woolham, J. (2001) Good practice in the involuntary relocation of people living in residential care, *Practice*, 13, 4, 49-60.