
9 The Views of Professionals Involved in Admission to and Discharge from Care

There is a huge range of professionals who are involved in admission to and discharge from residential care. Many work in the health services, including general practitioners and their practice nurses, and community health care practitioners such as health visitors, district nurses and occupational therapists. The other main group of professionals are those who work in the social services. They include social workers, day centre staff and home helps. Hospital social workers are also important, and they will be employed by both health services and social services.

Professionals working in various voluntary organisations also play a significant part in providing information and in some cases in the allocation of places. The principal organisations are specific interest groups such as Age Concern, advice centres such as Citizens Advice Bureaux and support groups such as the Carers National Association. Of these, Age Concern also runs homes and is therefore involved in admission and discharge as well as the provision of information.

We wanted to obtain the views of the professionals about two sets of information needs: those of people who are considering moving into residential care; and those of the professionals themselves. In order to achieve this we conducted a series of in-depth individual interviews and organised a few small discussion groups. From the health services, we spoke to four general practitioners, two health visitors, and ten district nurses. From the social services, there were two social workers, two day centre workers, two heads of homes for young people with physical handicaps, the head of a day centre for people with learning difficulties, a neighbourhood centre outreach worker, two elderly support workers and a home care organiser.

We also talked to three hospital social workers, a hospital transfer programme manager, three Age Concern day centre leaders, an owner of a private residential home for Asian elders, and the ex-secretary of Survivors Speak Out.

What clients need to know about residential care and other services

The professionals who were interviewed suggested a number of aims of providing information about residential care. These can be grouped under three broad headings: providing clients with a full and realistic picture of what their new life will be like; enabling clients to make choices about their future; and ensuring that clients receive the services that are appropriate to their needs:

They need to be as fully informed as possible about the quality of care, quality of life they'll have.

Simply the aim of making sure that clients are in a position to make the best informed choice, or decision as a family.

To help them find a placement best suited to their needs, wishes.

In the view of those we interviewed, many clients will not have given much thought to the implications of moving into (or out of) residential care. In some cases it will be necessary to bring home some 'harsh realities', in others clients will have ill-founded preconceptions which need to be dispelled:

And we try to talk to clients about what they're giving up. They don't really know that they're giving up their privacy.

I don't think a lot of them know what it's like at all - they see it as the 'workhouse' - very negative views based on old ideas.

A related problem identified by the professionals is that some clients, particularly elderly people, will be under pressure from their families, who may be attempting to influence their decision by presenting a biased view.

Moreover, it is not only relatives who can have ulterior motives when providing information:

The health visitor should know more - as help to coax them into residential care - isn't that so?

The professionals felt it to be particularly important that clients appreciate the financial implications of moving into residential care. People should never have to move into a different home because they are unable to pay.

The desirability of enabling clients to make choices about residential care was widely acknowledged. However, it was clear that this was an ideal which was frequently not achieved. This seemed to be particularly true for young people, and for clients with special needs, such as people with learning difficulties:

In my experience it hasn't really worked out where people go and see and have a choice. Usually gets to stage where relative can no longer cope...then referred to Social Services and fitted into a vacancy.

We do not tend to have discussions with parents beforehand, because so often there is no choice. Often there is only one place...they can't stop the placement, but we'll enable them to understand.

Under the same broad heading of facilitating choice is the related aim of enabling clients to plan for the future. It is clear that in many, perhaps most, cases clients put off thinking about residential care until the last possible moment. As a result, the information-giving process takes place at a time of crisis. This will have detrimental consequences for the transfer of information, and ultimately for the degree of choice which the client is able to exercise:

They don't think ahead - they don't start looking until they're in a pretty bad way, and often they can't go and see them [residential homes].

They're probably just shipped off - often that's all you can do in a crisis.

The importance of ensuring that clients receive the appropriate services was also widely acknowledged. One of the main concerns was that clients should know enough about the alternatives to residential care - many assume that residential care is the only option and don't consider anything else. Informing clients about other services is essential if the provision of residential care is to be limited to those who really need it:

We start with the process of discussion about what it's best to do - we give options - people don't know about support/relief in the home - day centres, etc. The residential option will be the end of the process.

Many of the professionals believed that clients did not receive the information they required for these aims to be achieved. One of the reasons for this has already been mentioned - the fact that information is sought in a crisis situation. This was not the only problem in obtaining information in time to plan ahead:

[Do clients get enough information?] - Absolutely not. They have no idea about any homes that are available and what they do.

On the whole, information is given on a 'need to know' basis and at crisis points. It was not volunteered.

Other problems included the view that there was not enough information available, and doubts about whether the information that was available was what the clients needed. There was also concern that even when the appropriate information was available, clients were not able to obtain it:

Parents knew that information was available 'somewhere', and eventually they hoped they'd reach it. This is not a cost-effective way of doing things.

The professionals were particularly concerned about the lack of information about the financial aspects of the move into residential care, and of information about the availability of private homes.

There were, though, some exceptions to this view. One of the social workers felt that enough information was provided, on the grounds that so few options were available anyway. And another professional in the social services thought that the assessment period allowed clients to obtain the information they needed:

[Do clients receive enough information?] - Yes - now, because of the four week assessment period. The evidence is that of their own eyes.

The question of how much information was appropriate at a time of crisis is also relevant in this context. Nevertheless, the overriding view was that clients do not get enough information:

Right from the word go, from the initial contact with a GP, I doubt if people are given adequate information about what is going to be involved.

A number of professionals pointed out that there was more to the issue than just the availability of the appropriate information. One of the most important requirements

was that the information should be 'user-friendly'. It was also important to recognise that different people had different information needs:

You find that some old people know exactly what's going on; others need help - information is not always easy to understand.

The connection between providing information and giving advice or counselling was also evident. This seemed to be particularly important for clients and carers involved in the move out of care:

They need information/advice about what returning to the community actually involves - this is never said. They need counselling on what the process will be, meeting people's fears. I guess very little of this happens.

The particular needs of people from ethnic groups were also cited in this context. All the professionals who were primarily involved in working with people from ethnic groups drew attention to the cultural considerations which made the move to residential care especially difficult:

A lot of black people are frightened about residential care - we've visited homes and they're heartbroken - it's a dead end to them. They feel rejected by their families - it's very hard for black people to come to terms with this.

And black people with special needs, mental and physical handicaps, will have to use mainstream facilities, therefore they and their carers will have special anxieties, and special needs for information.

Also relevant here is the emphasis that was placed on the need to supplement written information with oral explanations:

During the admission process people are not given enough - *that* is when they need written information - about the hospital, the ward routine, and verbal explanations of it.

I think there should be someone here who specialises in this - an information officer who comes and speaks to them. It's alright handing out leaflets, but you have to explain as well - that's what we do here and make sure they understand.

What clients and their carers *want to know about residential care*

The professionals identified a huge range of things which clients and their carers want to know about residential care. They want qualitative information about what it will be like to live in a residential home, about the atmosphere or quality of life. They want more concrete information about facilities and activities, about food, and about the layout and location of the home. They want financial information - about fees, and about spending money. This latter concern is part of a widely manifested desire to know about the level of independence that they will be able to maintain, and so about rules and regulations.

Many of the things clients want to know were linked to the desire to continue with their own lives as far as possible. One of the most frequently cited concerns was whether they would have their own room, along with questions about how many of their own possessions they would be allowed to keep. They would also want to

know about visiting arrangements and whether they would be allowed out of the home.

Perhaps surprisingly, only one professional felt that clients would want to know about the staff at the home - about staff ratios and what the staff were like. Similarly, there was limited direct reference to information about the other residents. However, both these considerations would have been covered, in part at least, by the more widely cited desire to know about the quality of care that would be provided in the home.

It appeared that all client groups would share these concerns to a degree, but that specific groups would have their own particular priorities. The question of the permanence of the stay would be important to all residents, but particularly to young people, many of whom would know that they stay would be for a fixed period, and would want to know how long it would be. As one might expect, it was felt that for people with learning difficulties, physical handicaps and mental illness information about the quality of staff and the level of medical attention would be particularly important.

Carers and relatives would also have distinct information wants and priorities:

Will they be looked after, will the care be as good as I give?...Carers also ask 'how do I handle the move?

Especially the carers ask you for your opinion of the house, of the area.

Professionals working with people from ethnic groups stressed the importance of information about food, and there were a number of other specific requirements:

Information about diet is very important for Afro-Caribbeans - whether there is a choice, or any ethnic menus. Also how much they'll be able to continue with their lives in the community. Black people like to know that they can continue with their clubs, and church, and hairdressers - their own community facilities.

...and they also ask if they can get a nurse with their language - language is the main factor.

The majority of the professionals stated that clients and their carers did not come back for more information once they had moved into residential care. For those that did, the main reason was dissatisfaction with their life in the home:

Sometimes they say 'why did you let me come?'

It seems likely, though, that for most people, residential staff are the main source of information once the client has moved in.

The tendency for information to be sought at a time of crisis is re-enforced by the number of professionals who brought up the problem of clients and their carers not wanting to find out about residential care. A major reason was the understandable reluctance to accept that the move is going to be necessary. However, this was not the only explanation:

Visits are offered but client or carer often refuse visits. Old people who are retiring now see services as a benefit, a privilege, therefore they don't think they have the right to question.

They don't ask us lots of things - like about the level of care - can the place really cope - a lot is taken on trust from the GP or social worker...They usually ask remarkably little at first.

Asian patients are not aware of what can be offered by primary care - and there's the Hindu tradition of acceptance. And if you complain - they're afraid of the consequences.

These considerations also apply, to some extent, to people moving out of care and into the community.

Finally, as a reminder of how pervasive this procrastination is, here is a comment from one of the GPs:

Ideally they should have a better understanding of the options. I would certainly want this for my parents - I don't know where I'd go. This is an appalling admission - I won't think about it until I need to.

How clients and their carers find out about residential care and other community services

There is a huge range of sources of information about residential care. Those falling under the broad heading of social services, including social workers, were felt to be the most widely used and were generally regarded as being the most important. This applies to information about all aspects of residential care from basic information about what homes there are to more detailed information about vacancies and facilities, the financial implications of moving into residential care, and qualitative information about what living in a residential home will be like. The social services were also seen as one of the main sources of information about services available in the community. Two professionals working in the social services outlined their role:

It would be referred to me by one of the home care assistants - they don't have the information themselves although they share the local knowledge too. If I think the need is serious I ask the client if they want to see a social worker to discuss it in depth. Then there is a social worker visit and the social worker may take the client to see a chosen establishment. On the result of this the social worker prepares the case which goes to the fortnightly multi-disciplinary panel. If the case is not serious, I visit the client myself and may suggest alternatives depending on what they say. Often the home care staff's knowledge and experience of the client is essential.

If they come and ask us then we'll tell them. All elderly people would be referred to the elderly support worker by the duty officer - if they want nursing homes. The duty officer will give them some basic information about services if they have someone to help them, otherwise the client will be passed to a social worker.

Social workers were described by a wide range of professionals as the key people in the information-giving process. They were considered to be in the best position to convey information for a number of reasons. Their casework is more in-depth, so they have a more precise knowledge of the client's needs. They have access to the most detailed information, for example about the range of homes available. They will

be involved in the assessment of clients for residential care placements, which will provide them with access to information about admission criteria, vacancies and facilities. Social workers' training covers the financial aspects of living in residential care, and they will also be familiar with their local authority's policy on funding.

Furthermore, the importance of the social worker is set to increase:

At the moment though clients can apply (for funding) through social services, but the assessment for community care means that everyone will have to come through the social workers.

This recognition of the pivotal role of the social services was also manifested in the responses of other professionals, particularly GPs and community health professionals:

GPs refer to social workers; social workers play the key role.

If they ask us [district nurses] we will tell them to get on to social services.

99% [of social services elderly support worker's clients] have channelled through GP after a crisis - we're always the second referral point. GP-attached social workers are very important - especially in the future. They give immediate access from the beginning - clients can get misled by GPs who are not au fait with resources.

All the GPs referred clients to social workers for information about the financial aspects of residential care. However, there were some reservations about social workers' knowledge of admission criteria and vacancies. GPs also expressed more general misgivings:

Social services [are the most helpful] but I'm not sure how helpful they always are. I guess people can sometimes come to us when they've had little joy out of social services.

We have problems in referring to social services because of the changing personnel - it doesn't help the natural mistrust.

Hospital social workers are seen as playing a similarly pivotal role where clients have health problems. They have the same primacy of access to information as field social workers, and will have equally detailed knowledge of their clients' needs. The nature of these needs means that hospital social workers will have a significant role in conveying information about community services. There are a number of further factors which suggest that hospital social workers could have an especially significant role in providing information:

They can initiate Part 3 quicker than the area social worker, especially where someone is in a crisis. They can then scout around and look - the patient is in hospital and so the pressure to admit is off.

They know the prognosis too.

The link [with Age Concern Day Centre] is broken when someone goes into hospital. In most hospitals there are geriatric wards where people can return home, so information should be available to them about alternatives.

GPs and doctors also occupy an important position in the provision of information. Their role in making referrals to the social services has already been highlighted, but it is important to assess their value as a source of information in their own right. The professionals considered doctors to be particularly useful as sources of information about community services, and about what homes there were. They were not reckoned to know about vacancies and facilities, or about the financial aspects of residential care - doctors themselves were particularly forthright in disclaiming any role regarding financial information.

It was widely recognised that doctors were in a particularly good position to impart information, primarily because of the health component in many clients' reasons for moving into a home. This factor also meant that doctors would have a valuable insight into the level of care required by the client. In addition:

Clients see the doctor as the main access point - they already have a relationship with the GP.

However, a number of doubts were expressed about the ability of doctors to realise the potential of their position (doubts which were affirmed as much by doctors themselves as by other professionals):

There are too many demands on GPs - they're overworked - they have no time to talk about the services and so they refer the clients to the multi-disciplinary teams.

They see the elderly and are viewed as providers of social/medical care - but they are ill-informed.

They don't understand residential care - blinkered - they don't see clients as individuals - homes are just a generic service.

The GPs' practice nurse is seen as playing a significant part in providing information, and one that is likely to expand in the future. However, this channel of information was not without problems either:

Because of our contract changes we will be seeing the over-75s once per year, and it will be the practice nurse who will do this. The district nurses see a very limited number of people - the practice nurse will see the fit ones as well. They could give pro-active advice.

Some GPs are very isolated - especially Asian GPs - they don't expand their services, get practice nurses etc. Financially they're better off if they have four one-man surgeries.

The professionals' overall view seemed to be that while doctors enjoyed privileged access to clients and were able to impart some information, their primary value in the process was as a referral point for the social services - particularly for clients requiring residential care.

There are a variety of professionals in the field of community health who have a role in providing information about residential care and other services. The main ones are district nurses and health visitors, but community psychiatric nurses, occupational therapists, and physiotherapists are also involved. Much of what has been said regarding the role of GPs applies to district nurses and health visitors: they have access to clients because of health problems; they are frequently a referral

point for the social services; and they seem to be most widely used as a source of information about community services.

On the whole, district nurses were mentioned as information sources more frequently than health visitors, suggesting that they have a wider role - this is certainly the view of the district nurses:

We have a role in everything. Don't know much about vacancies, but we know where they could go.

Not the health visitors. The district nurses give a tremendous amount of information about the homes.

District nurses are important - top of the list. District nurses get it all first when there are problems. Wardens, occupational therapists, physiotherapists - help a lot with aids and services. Health visitors very occasionally involved, but it depends a bit on the area. Used to have health visitors for the elderly, but abandoned.

The latter comment brings out two of the main themes to appear regarding community health professionals. The first is that there has been a reduction in the number of health visitors - there is also a restricted supply of community psychiatric nurses, occupational therapists and physiotherapists. The second is that the level of involvement varies:

District nurses are a point of contact rather than providers of information.

They're so often in touch with the client. District nurses need to know the range of provision and where to refer the client. In rural areas district nurses often have a lot of detailed information, and they like to be able to recommend - and it's appropriate that they do because of their knowledge of the individual need for nursing care.

On the whole, it is clear that district nurses feel able provide some information on all aspects of residential care, and other community services, and that there is no reason why they should not do so:

District nurses doing one-stop health clinics can form relationships and give information.

District nurses who might be going into the home - and also they have more time than the GP to talk to the client.

Domestic services - principally home helps, but including others such as meals-on-wheels - were seen as having a role in imparting information about what residential homes there were, and about community services. They were not specifically mentioned as providers of detailed information about what life in a home would be like, facilities, vacancies and admission criteria, or the financial aspects of residential care. However, home helps were widely believed to have the potential to play a more significant part in the information giving process:

See them regularly, build up trust, get them to make phone calls - shouldn't do it really, but do. They provide more basic support than anything. Ring up and get info for people - could be written info - don't have to know about it to pass it on.

Yes, they do have an important role. They do have information, and need to be carefully supervised. The home help doesn't just clean, they have to get to know the client, to

promote confidence and get them to talk. The very good home help will know about benefits and go to their supervisor for more information. But the daily contact they have with the client is important.

On the other hand, there were a number of professionals who were sceptical about the potential utility of home helps in providing information:

They don't understand what's available - only know about social services.

They don't see it as their job to get involved.

The comment of one of the social workers probably gave an accurate summing up of the present position of the home help in the information-giving process:

Could be quite important. They'll know a lot about the person involved and can help in deciding the appropriateness of the facility. They are probably not used much - they're still not seen as 'proper professionals'.

The last of the major sources of information was the voluntary sector, particularly for information about community services, what homes there are, and financial information. Age Concern was the most frequently mentioned organisation, providing information in all these areas. Organisations which attempted to identify appropriate homes were obviously important:

Counsel and Care for the Elderly... can be quite good - have an idea of client's needs and issue two or three names of particular homes to cater for that kind of person. Quite good at matching. GRACE - outside London - were trying to do similar thing to CCE.

The role of the Citizens Advice Bureaux was also recognised, as was that of Survivors Speak Out, a users group.

The Carers National Association, and other carers' support groups, were cited as sources of information about services available in the community. Friends, relatives and neighbours also provided this category of information, and also details of what homes there are. Day centres and day hospitals also provided information on services, although some doubt was expressed about their own access to information.

Other sources included dental waiting rooms, church, hospital and the media - the latter especially in regard to information about what homes there are and what they're like. And of course the homes themselves were sources of information, in that clients were sometimes given lists and left to ring round for themselves.

Other ways of finding out about residential care

A number of professionals commented on the way in which clients found out about residential care, as opposed to naming sources of information. Probably the most obvious example is that one of the best ways to find out what a residential home is like is to go and visit one. It is possible to visit for just a day, or even a few hours - alternatively, the visit can take the form of a trial stay. However, it is not generally a simple matter of having a look and making a decision:

I think there's probably little choice. The visit comes at a late stage in the procedure, and if the client turned the place down it would be very difficult.

Every placement starts with a month's assessment - it's a two-way assessment and it's reviewed.

The principle of the 'trial stay' also applies to the move out of care:

Clients are taken on trips. Also they go out on a trial basis. Admissions are on a trial basis too. Community life may not suit some people - they get used to institutionalisation. Some people find two hours on their own at home too much.

'Word of mouth' was frequently mentioned as a way in which people found out about services and about what homes there were and what they were like. It is difficult to be sure just what is meant by this - in part it probably refers to some of the sources mentioned above, particularly friends and neighbours. However, there is probably a wider connotation which simply implies sources which are not formally involved in the health and social services, such as shopkeepers and teachers, for example, as well as people who are met by chance and happen to know something about residential care.

The issue of publicity of services and homes was also raised by some of the professionals, with the majority view being that it didn't play a significant part in informing clients:

We [social services] do publicise services, but it's very much a passive arrangement.

We have never needed to advertise ____ [private residential home for Asians]. We have so many referrals. We've never done any publicity. We're the only people catering for Asians with mental illness.

The exception to this was that voluntary centres for Afro-Caribbeans do publicise themselves, because Afro-Caribbeans do not feel comfortable in mainstream day centres.

Other client groups

What has been said so far refers primarily to how elderly people find out about residential care and services in the community. On the whole, the picture is the same for the other client groups. There are, however, a number of distinctions which need to be drawn. (These distinctions must be regarded as somewhat tentative, however, since they are drawn on the basis of a relatively small proportion of the responses. In addition, many of the comments apply specifically to the move out of residential care.)

If anything, the social worker is seen as fulfilling an even more central function for all the other groups - young people, people with learning difficulties, people with physical handicaps, and people with mental illnesses. This is for the same reasons as already mentioned, and because social workers are best placed to meet the severe needs of these client groups. Conversely, the social services were regarded by one of the GPs as being geared more to the elderly.

The most significant difference between elderly people and the other groups taken as a whole is that specialist voluntary organisations play a more significant role for people with learning difficulties, physical handicaps and mental illnesses:

Local MIND and other voluntary organisations are very helpful and they're developing this aspect of their work. Sometimes they employ information/advice workers. Local groups have begun to identify this need for an information service. There are advantages to having it outside social services - a quasi-independent group like MIND is more user friendly.

Specialist agencies because of their special understanding/ knowledge of specialised facilities.

It was also suggested that clients other than elderly people would be less likely to use informal information networks because they're more isolated.

Social workers were again the main source of information for young people, particularly regarding the more 'technical' areas of vacancies and facilities, and financial information. However, this was not the case for information about what homes there are:

A lot of people will come and find out themselves - increasingly they don't rely on social workers so much.

School nurses were also cited as important sources of information for young people, especially those in special schools.

For people with learning difficulties, the parents support network and the hospital social worker were mentioned in addition to the social worker and Mencap. Also, the potential value of the home help was again highlighted:

Home helps are potentially crucial and it is therefore vital that they have proper information. We need a policy about how much information home helps should give.

The specific requirements of people with physical handicaps meant that they too rely on organisations with specialist knowledge:

Day centres, specialised units, haemophiliac centres have a big role. Once a client gets to one of these facilities, things open up.

Voluntary societies, eg Multiple Sclerosis Society. Possibly education centres until 16/18. Less likely to approach GP - we don't see physically handicapped people very much.

For people with mental illness, the same considerations seem to apply. Social workers and voluntary organisations are the main sources, while doctors do not provide much information. People with mental illness were stated to have great difficulties in getting information about the financial aspects of the move into residential care.

There are also a number of considerations which are specific to the ways in which clients from black and ethnic groups obtain information:

The majority of people who come to us are private referrals. They hear of us by word of mouth. Even in the hospital out-patient clinics there are no signs in Asian languages. The DHA is being very slow in tackling information. It's still down to the laundry porters and domestics to translate. There's a complete lack of printed information....It's the voluntary groups who have done everything. But now we have the Asian media 'Sabras'

- an independent local radio station for Asians, and also Radio Leicester devotes five hours a day to the Asian community.

It was also felt that Afro-Caribbeans did not want to use mainstream facilities, and so would need to be sought out. In this context, the importance of conveying information by word of mouth was confirmed in regard to Afro-Caribbean clients.

Clients' ethnicity was not the only personal factor which was relevant to the way in which they obtained information about homes and services:

It's partly a question of personalities - some will find things out. It's connected with their status in the community (class), their IQ, and there's also the factor of pressure from relatives.

Our clients are a very wide-ranging group from the very articulate to the not-so-articulate - we need ways of informing them all in ways appropriate to their needs.

Being 'in the system'

One of the strongest messages provided by the professionals was the importance of being 'in the system'. This has already been mentioned with regard to people with physical handicaps, but it is applicable across all the groups:

One of the major problems is that lots of people in the community don't know where to get information...the issue comes up quite a lot - how do you make contact with the statutory services? If you are not within the system, people just don't know how to make contact.

It was for this reason that one of the GPs suggested that the clients with carers were the least well-informed - because they would be less likely to be in contact with social workers regarding a home help or meals-on-wheels, for example. Related to this is the necessity for organisation of information within the system:

If they come through the appropriate system, yes [they will get enough information]. But there has to be a structure within the organisation to provide the information'

There's no hard and fast answers. It's procedures that are needed.

One of the prevailing ways of providing this access to the system is by assigning a specific contact, or a key worker:

Basically what parents and consumers want is 'someone to tell them'...they should have a contact who could tell them specific things.

The key worker will be of increasing importance. Even if the client is in private care, he/she will still have a responsibility for maintaining standards, and it will be the key worker's responsibility to overview the individual.

Who gets asked about residential care?

The professionals were asked how often they were approached for information about residential care. The majority were approached often. Those who were approached seldom or never comprised the Asian project worker and the development worker for Afro-Caribbean elderly people, two of the Age Concern day centre workers, the neighbourhood centre worker, and one of the GPs.

The responses of the professionals were in line with what has already been said about sources of information. They fell into two broad categories - giving information or referring to social services or a social worker. There was fair amount of consistency among workers in the same sectors: GPs and Age Concern workers tended to refer; while social services workers, hospital social workers and district nurses gave information about options or made a recommendation.

What professionals need to know about residential care and services in the community

The most obvious point to make is that the information needs of professionals are determined by their particular role in the residential care system. For example:

We (health visitors) need very extensive information - in case of any complaints/tribunals.

[Social services elderly support worker] General facilities. Admission criteria.

What homes exist for a start. What type of people they deal with - specific or general. What facilities they offer. This would be enough for us (Age Concern day centre leader) - don't get involved case conferences and so on.

The attitude of the professional concerned is also relevant in this context:

Sometimes I will get adaptations made to existing facilities for a particular client - it's about what's possible sometimes, not just what's available. Proactive role.

Of course, a significant part of the role of all the professionals is the provision of information to clients. At the most basic level, this manifests itself in a broad correlation between what clients want to know and what professionals need to know. Furthermore, the aims in providing information which were discussed earlier will also be reflected in the information needs of the professionals. They will need qualitative information to provide a realistic picture of what it will be like; information about facilities, admission criteria, cost, availability and so on to enable choice; and information about the level of care in order to match the home to the clients needs:

It's a question of the quality of life. I've got lists of all the homes in the country - but I don't know what they're like.

Criteria for admission. What the availability of places is. And we'd like information on other areas - because some like to move to be near their families.

Residential homes are usually full of people with medical problems - they need good nursing care 24 hours a day. Staff must be able to know when to call for advice or send a client to hospital - and that they have a liking for old people and that they are tolerant/can cope.

The sort of thing that isn't put down on paper - that you get from observation - from knowing the officer in charge. It's the ethos, the attitude of the place you want to know. Then we can match the place and the client. It's far more complicated than just a piece of paper.

As this implies, a further specific category of information which is required by professional is information about the needs of their clients. Some doubts were expressed in this regard:

How imaginatively are care plans being looked at...Are people even being asked what they want? People still think in terms of services, rather than individual needs.

We get our perceptions of what someone needs - our viewpoint might be different - we can't understand why social services do certain things and vice versa. Therefore we can't impart accurate information.

Another distinct information need concerns the private sector. There were no problems obtaining information from the homes - but professionals were not confident about how to use it:

As regards the private sector we're inundated with brochures.

At first we had no guidelines on how to work with the private sector, for example how to respond to advertising overtures - I don't know if there are any now, but there should be...We have a huge file with brochures from the private sector.

Private homes send brochures - don't pass them on because I don't know how good they are.

There was, in fact, a more general concern over the question of brochures and other forms of written material. The main issue was the need for some kind of qualitative assessment, prompted by doubts about the objectivity of the information provided by the homes themselves. Written information was also seen as the solution to the problem of information about homes in other areas:

They [brochures from private homes] are slightly useful - they're a selling job and state the good points only.

We don't really want brochures, we need official reports. We need a regular bulletin with advice about which residential groups to use. Would this be legal? It's a very central issue.

I would appreciate a good homes guide - a sort of Egon Ronay. Qualitative assessments are only useful if you trust the source that is making them.

We'd like information on other areas - because some like to move to be near their families. We need something like a directory - with facilities and phone numbers. Social services have directories of these things.

The professionals were asked about the written information about residential facilities that they possessed, for their own use and for their clients' use. About half said that they had written information for their own use. In most of these cases, the information was in the form of brochures and leaflets collected from various institutions. The few who had more than this, for example files of standardised information, had collated the information themselves:

Have set up an A4 folder with four sheets per establishment containing a colour picture, with basic details of type of street etc, and some details of entry criteria - sex, facilities, level of support available, community facilities, staffing levels, day programmes, policies, etc...We have the 'Orange book' - help for handicapped people - this contained absolutely everything - we did it five years ago - and so now it is out of date. It was aimed at general public, professionals, staff, clients - anyone. It had wide distribution - libraries, used with students.

Less than half the professionals possessed written information for use by their clients. For the most part, this was the same information as they used themselves, ie mainly handouts and leaflets. It seemed that information specifically designed for clients' use was more readily available in connection with services in the community than for residential homes:

We did a leaflet for the Afro-Caribbean day centre. We kept the language simple and called the club ACE (Afro-Caribbean Elders), so that everyone knew who it was aimed at. Otherwise it was just like any other leaflet.

The day service here has a booklet. It gives the aims, contact numbers, describes the service. It's produced in-house. It's primarily aimed at interested parties - anyone who happens to visit. We haven't flooded the market.

However, one of the professionals in the social services was optimistic about the availability of written information for clients in the future:

Things will be even better in the future because every home is currently preparing a brochure about their facilities - aimed at clients.

Nevertheless, the overall impression was of limited availability of written information, and uncertainty about the merits of much of what was being produced:

We have very little information ourselves and very little to give them. I'm sure it could be improved.

How professionals get their information about residential homes

Two sources of information about residential homes stood out as the most significant - social services departments and the homes themselves. This was true of information about what homes there are, and more detailed information about vacancies, admission criteria, facilities and what the homes are like. It appeared that social services were primarily used as a reference point for other professionals, in that professionals accessed information by contacting social services rather than receiving information on a systematic basis:

We're in frequent contact with social services so on the whole we can get what we want.

The Team Manager [Social services department] gets a fortnightly bulletin on the vacancy situation - anyone can get an up-date any time.

The issue of communication between different categories of professionals will be examined in more detail later. For the moment, it is worth noting a doubt expressed by one of the GPs:

I wouldn't feel able to say much to people who asked [about what homes there are]. I'd go back to social services every time, which begs the question of how much information social services have.

The other main source of information is the homes themselves. Professionals approach the homes for information about vacancies and so on, and as has already been seen, brochures from homes are a widely used resource. It also seems clear

that private homes in particular do not need much encouragement in providing information:

They want us to act as brokers - the brochures come from all over the country - please sell us. Patients have a right to this information if they ask for it - but we don't promote it. Some private sector homes phone us daily - it's the difference between a business and a service.

A number of further sources of information were specified, such as GPs, district nurses and school nurses. The most significant point here is what this tells us about the ways in which professionals keep themselves informed. There is an important distinction to be drawn between information being made available via systematic communications between services, and information being accessed or accumulated through an individual's own initiative, or as a result of their personal experience. There was a strong impression that most of the professionals relied more on the latter than the former:

I have my own knowledge because of my own personal informal network - it's not because of a good formal system.

I usually know where to go for the answers - but I have been in the post for twelve years.

Information picked up in the course of performing their job was one of the most mostly widely cited sources. This covers information that is accumulated in the natural course of a person's work and information obtained as a result of fulfilling a particular role:

GPs are often looking after a patient at home, so they get knowledge of the home.

I've accumulated knowledge in this post but when I leave it will probably go. I have no written information about residential services in ____.

I know about admission criteria because I sit on the panels. I know about what homes are like from the care assistants I have, who used to work in the establishments.

I buy the houses so I know what the vacancies are. I'm also on the allocations panel so I find out where vacancies are, and I'm also on the MENCAP allocations panel to their own places. Wheels within wheels... My informal contacts are very important.

The individual's readiness to use their own initiative is also relevant in this context:

I ring up or go out...I write off for their brochures - I have to *go* for the information - you can't sit back - it doesn't come to you.

The value of having a known contact point is as applicable here as it was regarding clients' sources of information. This can be seen either as a means of acquiring information, or as a reason for not needing it:

[Do you have any difficulty in providing people with information about residential care?]
No - there's always someone I can get hold of who know.

[Are you able to keep your information up to date?] Yes - I always know who/where to ring.

This picture of individual contacts within organisations appears to be the positive side of the wider issue of communications between services. In terms of the organisational level, reference has already been made to the 'natural mistrust' between the health services and the social services - GPs also expressed concern about communication links between the services:

There's a horrible hinterland between health and social services.

If social services don't tell us there's going to be a new home, the arrival of 20-30 geriatrics on our patch can be quite a shock.

There was, however, some evidence of effective communication of information between organisations. One of the hospital social work departments provided the most striking example;

There's not much public information available on the private sector homes. I keep up-to-date information on all of them. The file started off for the social workers' use - for wide use. I make a list of homes which gets circulated to the area teams and to Age Concern...I also keep information on fees, beds. Sometimes the private sector homes contact me when a *nursing* home is needed. We keep our information about residential homes on a computer data-base. We enter 100 items of information on each home - number of beds, facilities available, whether pets, hairdressing, fire drills, nature of staffing...

Social Services Registration Officers send us information about all new homes registered. The Health Authority Registration Officer keeps us informed about new nursing homes. The real issue is how do people find us? This is why I send my list of homes to Age Concern. There's a fair network of professionals who know we have this information.

The other hospital social worker who was interviewed also received regular information, and there was a further example of a hospital social work department playing a leading role in co-ordinating information:

We have regular six-monthly updates from County Council of registered private homes - they're even quicker to inform us of deregulated homes.

Hospital social work team started forms for professionals in the area for general information exchange.

Two further sources of information should not be overlooked - the clients themselves and directories:

We do have clients who get to the stage where they need more individual attention, and we refer on to social services - but we keep in touch. Thus we have an idea about homes in the area and their reputations.

Sometimes we'll get feedback on a move into care - from neighbours and so on - if it's good feedback about the house, then you'll pass it on in future.

Uses a lot of directories - has a whole shelf of reference books, directories etc.

On the whole, then, the picture is of a variety of sources of information. While there are examples of systematic mechanisms to communicate information, professionals seem to rely primarily on their own experience, contacts and initiative:

Through the planning group of social services - I'm a member so we see where the gaps are and get involved in developing services... A lot of what I use is local knowledge - I've got contacts, a network. I work with lively proactive people and they share my knowledge of new developments. I read the journals. I keep in touch, follow people up as they move on. My job is a new job - I always think someone else has the rule book. I need to keep abreast of developments. The borough has a subscription to NISWA Information Service - occasionally I use this.

Knowing my area. Professional contact with community care, social services departments etc. Find out also by my own investigations - variety of housing associations in the area - can ring [housing association] and ask about vacancies, is client on the list? Also used Counsel and Care for the Elderly on behalf of people - got them to send information to carer. If I get no joy through local authority, I do my own research.

Problems encountered by professionals in providing information

When asked if they had any difficulties in providing people with information about residential care, the professionals were fairly evenly split between those who did and those who didn't. There was a fair degree of consistency over the different professions - the doctors and community health workers tending to have problems, while the social service workers did not.

Many of the relevant factors have already been discussed: the need for qualitative assessment, and for guidance regarding private homes as problems; having a contact as a solution, for example. The lack of information which was mentioned in regard to clients' needs is also a problem for the professionals:

First we did a trawl of what information was available. The results were dire. There was very little information produced by the borough, and very little from other sources.

When asked, the professionals were again fairly evenly split on whether they were able to keep their information up-to-date, although the split was not as clearly defined in terms of sector. Those who did feel able to keep up-to-date tended to rely on contacts, or the 'grapevine' to do so. It also seemed likely that the answer to the question depended on the standards of the person concerned:

We know the general trends, ie the rough length of waiting lists - but it's fluid. Night admissions or emergency admissions can change the picture very rapidly.

Clients wanting to move into a home in another area also represented a problem, because of the lack of information. And the Department of Social Security came in for some criticism from one of the district nurses:

The people who are not helpful are those who work at the DSS - they will not answer anything over the phone - they want you to write or go in - and often they're no use at all. They have no staff to follow up individual cases, and they can't understand the urgency of some cases.

What would be the best way of improving the access of clients to information about residential care?

Again, a number of the issues brought up in response to this question have already been mentioned. It is useful, though, to have an idea of the priorities for improvements.

The most frequently made suggestions were for specific contact points for clients, and more written information. To a degree, these were seen as complementary:

Sometimes they just need someone to talk to, but something written which people could take time over would also be helpful.

The importance of supplementing written information with oral explanations has also been discussed already. Nevertheless, there was a clear feeling that a wider distribution of leaflets would in itself be a useful way to convey information:

Put heaps of literature etc in surgeries, libraries, churches.

On the other hand:

We need advice centres, with advice workers - spreading a load of leaflets round the reference section of a library is useless.

The need for better communication between professionals has again been discussed above. The concern here was generally for details of who to contact, particularly in social services departments.

A problem which underlies a great deal of what is discussed here is the recognition of information provision as an issue for the services involved in residential care:

The boroughs as a whole don't think of information at all...If we were paid on results, we would be more concerned about information.

Information never gets done - it never has any priority and no one is responsible for it.

In this regard, it is worth noting that three of the professionals suggested the use of computers to help ensure that information was kept up-to-date. There was also a feeling that more could be done to publicise the availability of information, although there was little in the way of concrete suggestions as to how this might be achieved.

Better publicity of the homes and services was seen as important too. This could be achieved through the media or through the homes themselves improving their links with the community - by giving talks and holding open days, for example. This would do more than just provide information about the homes - it would help to break down stereotypes and so engender a more positive attitude towards the idea of residential care.

The importance of addressing the particular information needs of people from ethnic groups was again raised (again, primarily by professionals working with people from ethnic groups). The importance of providing leaflets and so on in the relevant language was emphasised, and use of a telephone helpline was suggested to help overcome problems to do with language.

Three of the four GPs suggested that some form of directory or register would be useful, for themselves and other professionals, and for clients. This would be particularly useful in countering the problem of providing information about homes in other areas. Finally, three professionals drew attention to the fundamental issue of the need for more facilities.

Key issues

Personal contacts/experience as opposed to information systems

It was very clear that the professionals who were interviewed relied heavily upon personal contacts and initiative to keep informed about residential care facilities. Sources included individual contacts in other sectors, access through the professional's role in allocation procedures, and the store of information accumulated through the professional's career. On the other hand, there was very little evidence of reliance on, or involvement in, formal systems for the accumulation and dissemination of information.

This is a fundamental point which impinges on a number of the key issues which follow.

What is needed - information itself or a contact point?

There are two related issues here. Firstly, the level of information needed by professionals varies according to their role in the 'caring system'. Social workers, for example, are primary providers of information, and are also involved in assessment and allocation. They will therefore have extensive information needs. However, there will be others who, for a variety of reasons, will not require this level of information. They may only need a rough idea of what community services and homes are available, and in some instances will only need to know who to refer the client on to.

The second issue is that even for professionals with a significant part to play in the process, it may not be practical for them to actually hold all of the information themselves. The alternative option would be for them to have a contact point which they could access whenever they needed more information than they possessed.

Being 'in the system'

A major factor in determining a client's access to information about residential care is whether they are already receiving some form of attention or assistance from the social or health services. People being cared for at home by relatives or other carers are less likely to have easy access to information than clients of home helps or day centres, for example. The fact that the professional or facility concerned will act as an information source is the most obvious point, but use of services will also provide access to other sources, such as other service users.

Different reasons for not getting information

Clients lack information about residential care for a number of reasons other than it simply not being available or their not being 'in the system'. There is the natural tendency to put off thinking about something which is perceived as unpleasant, and this in turn contributes to another reason - the fact that information is frequently sought in a time of crisis. Other aspects of people's attitudes towards residential care also discourage them from seeking information: they think of care as a benefit or privilege and so are unwilling to question; or they simply accept it as 'their lot'.

Information as an issue for concern

Some of the professionals pointed out that information provision was not given a high priority in the organisations where they worked. It seemed rare for anyone to have a specific responsibility for collating or disseminating information. This reluctance to address the issue of information provision was also reflected in the paucity of references to computerised information systems as possible solutions to problems of access.

Advice/counselling/information

Providing information about an issue as sensitive as moving into, or out of, a residential care home involves a great deal more than simply supplying a list of homes or details about fees. The client will need more than just facts - they will need advice on alternatives, and they and their carers will often need support in what is likely to be traumatic time. It is important, therefore, to consider the relationship between client and professional. For example, home helps will often have known the client for some time, and will have built up a trust which will assist the provision of information.

Focus on individual, not services

In working towards provision of information about services generally, those concerned must not lose sight of the fact that their clients will have different service needs and different information needs. There needs to be a two-way information flow - from clients to professionals about clients' needs, and from professionals to clients about the services which will best satisfy those particular needs.

Reasons for bias and coercion

There are many motives which may impede the flow of objective information about residential care and other services. Professionals may have reasons for wanting a client to make his or her mind up quickly, in order to free a hospital bed, for example. Carers may also have reasons for wanting to persuade clients to make a particular choice.

The relationship between health services and social services

It was apparent from the interviews that formal channels of communication between health services and social services were not widely in place. Given the general dependence on personal contacts and initiative, this is perhaps not surprising. However, there were suggestions of mistrust and lack of confidence which, if indicative of general feelings, clearly need to be investigated in more depth.

Printed and oral information

Written information and oral information complement one another - oral explanations help to overcome the impersonal nature of leaflets, while people do not remember everything they are told and so it is useful to have something in writing to refer to later. From the professionals' point of view, written information in the form of brochures and directories is of limited use, since they do not provide evaluative assessments (although directories are seen as the best solution to the problem of providing information about homes in other areas).

Private homes

Provision of information about private homes presents two particular problems. The first is the question of how information is obtained about the homes, given that they are outside the statutory sector and therefore are not part of the established network of communications. The second problem is the concern expressed by professionals that they need guidance on how to deal with approaches from private homes (this is perhaps linked to ideological attitudes towards private provision of residential care). Presumably these issues will be resolved, in part at least, under the new guidelines for registration and inspection.

Attitudes and requirements of people from black and ethnic groups

The obvious point here is that people from black and ethnic groups will need to know that their particular cultural requirements will be satisfied. Clients' cultural backgrounds will also influence how they approach the task of finding out about residential care: they may be more resistant to the idea of residential care in the first place, because of traditions of family support; and they are more likely to rely on informal networks of communication.

The role of voluntary organisations

Voluntary organisations play a significant role in providing information about residential care. This is particularly true of clients with special needs, where the specific expertise of voluntary agencies is vital. However, the fact that they are outside the statutory system means that their role as information providers is not linked with any influence in terms of allocation (with the exception of organisations like Age Concern which run their own facilities). Their voluntary status will also have implications for how they can best be fitted into any formalised information system.