This article reviews relevant literature by asking: ‘How can nurses assist and support relatives when a loved one makes the transition into a care home?’

Synergie, Ovid, PsychINFO, Academic Search Premier, the Cochrane Library and Google Scholar were searched, while organisations relating to the needs of carers were approached for information. The Relatives and Residents Association newsletter was chosen as most relevant. As the literature revealed studies built on earlier studies, a manual search was undertaken to identify these to add a historical perspective.

The keywords ‘relative’, ‘carer’, ‘transition’, ‘experience’ and ‘care home’ yielded 183 relevant articles. A review of titles and abstracts reduced this to 18. Ten articles were selected, supplemented with research undertaken by the Relatives and Residents Association. English language articles from 1990 to June 2006 that explicitly related to relatives’ experiences prior to, during and after placement in long-term care were considered, as were studies focusing on staff/relatives relationships. Any adult relative or partner of the older person was included.

**SEARCH STRATEGY**

Nursing Times; Nursing Homes; AbstrAct

**IMPLICATIONS FOR PRACTICE**

- This review challenges nurses caring for older people to reflect on the many diverse aspects that a care placement entails.
- There is value in taking a biographical approach to assessment, whereby nurses take into account the lived experiences of the older person, valuing their unique experiences.
- With integrated needs assessments, nurses working with carers are in a prime position to ensure a holistic assessment, including the needs of the carer, is undertaken.
- By using a biographical approach to care planning, viewing the individual as a whole with the emphasis on their own perspective, nurses can incorporate a humanistic way of working.

**FINDINGS**

**Prior to admission**

Transitional processes are filled with difficult emotional experiences for family carers. Reasons for admission include inability to cope, exhaustion and acute illness (Pearson et al, 2004; Lundh et al, 2000; Ryan and Scullion, 2000; Kellett, 1999a).

Issues around pre-admission include inadequate family support (Pearson et al, 2004) and feelings of letting their relative down (Lundh et al, 2000), with the cognitive process of separation starting at the decision-making phase (Sandberg et al, 2001).

All family carers interviewed by Ryan and Scullion (2000) (n=10) said the main reason for admission was deterioration in their relatives’ health, although some reported a deterioration in their own health because of their caring role (n=3).

Sandberg et al (2002) found decisions for admission were motivated by the realisation that caregiving was too burdensome or difficult, with adult children often initiating the placement. Lundh et al (2000) described spouses who carried on caring until they were exhausted, with the decision being initiated by professionals or adult children.

Clarke and Bright (2006) found adult children sustained and even improved their relationships with parents after placement. Spouses’ relationships often deteriorated with the feeling of losing a lifelong partner and no longer living as husband and wife.

**Adjustment and role redefinition**

Many issues arose for carers, with diverse findings relating to continuation of the caring role and readjustment. Three key themes emerged throughout the literature.

- **Maintaining continuity.** This is reflected in the carers’ wish to continue routines and practices they engaged in while their relative lived at home. Kellett (1999b) reported that carers placed great importance on continuing activities their relative enjoyed, ensuring particular likes and dislikes were prioritised (Sandberg et al, 2001). For some spouse carers, continuity focused on maintaining as near a normal relationship as possible to ease their loss and separation.

Hertzberg et al (2001) found that carers felt they had little effect in bringing about changes for their relative. Attempts to maintain continuity were often not facilitated or were blocked by staff (Lundh et al, 2000). Informants often felt staff did not listen as they tried to influence and contribute to care (Hertzberg et al, 2001; Lundh et al, 2000).

Relaying specialist family carer knowledge to staff appeared consistently. Knowledge of family, life history, values, desires and expectations enabled family members to redefine their role in this new context (Davies and Nolan, 2006; Kellett 1999b).

Practical aspects included personalising bedrooms (Sandberg et al, 2002) and maintaining socialisation, for example by sharing wine (Sandberg et al, 2001).
• **Keeping an eye.** This involves carers monitoring standards of care (Davies and Nolan, 2006). It involves direct observation as well as frequent phone conversations with staff (Sandberg et al, 2002). A few UK carers (n=4) were unhappy with standards of care. Where standards were seen as good, carers described fewer negative feelings such as guilt (Dellasega and Nolan, 1997).

  It appears standards of care are only an issue when carers feel staff fail to take account of their knowledge and wishes (Lundh et al, 2000). Carers’ feelings of working without goals, lack of staff knowledge about their loved one and ignoring suggestions to improve care contribute to uncertainty about the quality of care (Davies and Nolan, 2006; Hertzberg et al, 2001; Lundh et al, 2000; Dellasega and Nolan, 1997).

• **Contributing to community.** In Dellasega and Nolan’s (1997) study, carers saw themselves as having a real contribution to make to the resources in the home or adding to its social life. Many experienced anxiety in searching for ways to continue the sense of belonging and human connection (Kellett, 1999a). Bringing in a daily paper, regular visits and sharing information from family and friends was seen to be important in remaining close to a loved one (Lundh et al. 2000). Sandberg et al (2002) reported that adult children took an active role in keeping their parent in touch with the rest of the family. Dellasega and Nolan (1997) highlighted that, while carers initiated relationships with other residents and contributed to social activities, staff did little to facilitate or encourage this.

**Loss, separation and guilt**

Clarke and Bright (2006) found guilt was the most profound emotion in family carers. Dellasega and Nolan (1997) said participants often mentioned accepting defeat as the dominant emotion, which was directly linked to quality of care or financial concerns.

Spouse carers’ feelings of powerlessness coincided with the loss of a lifelong partner (Lundh et al, 2000). Adult children experienced similar feelings as a result of having increased involvement with parents, which left them questioning whether more could have been done to prevent admission (Sandberg et al, 2002). Davies and Nolan (2006) noted a distinction when a carer had been co-resident, saying most spouses described the devastating impact of no longer living with their lifelong partner. Ryan and Scullion (2000) said adult children talked of having lost their parent as if they had died.

**Communication**

Hertzberg et al (2001) said several relatives wanted to be given more information without having to ask for it, especially about relatives’ daily lives. In most studies, carers cited lack of professional advice and support, both before admission and after. Some asked to talk to staff in less stressful situations (Hertzberg et al, 2001).

Sandberg et al (2001) discussed a key theme, which they named ‘testing the water’. Here, carers evaluate the staff/carer relationship to assess the level to which staff would take on board their views. In one example, staff had given the impression of encouraging feedback on quality of care but rebuffed attempts to discuss concerns (Sandberg et al, 2001).

Pressure on hospital beds and emergency admissions into care homes often mean that limited information is given, which exacerbates feelings of loss, separation and guilt (Clarke and Bright, 2006; Sandberg et al, 2001; Lundh et al, 2000; Dellasega and Nolan, 1997). In one study, only two out of 10 carers received adequate information before admission and none indicated that their relative had any say in their own admission (Ryan and Scullion, 2000).

**CONCLUSION**

There are limitations as most sample sizes were small, however, qualitative studies provide rich data. Key characteristics varied and some studies had mainly female samples. In answering the review question, it is clear that nurses must support family relationships holistically, recognising and drawing on relatives’ knowledge of the older person. An understanding of the disciplines involved in the placement process and a clear knowledge when carrying out a biographical assessment are also needed.

**REFERENCES**


