

Transitional Care for People Living with Dementia: Perspectives of Long-Term Care Providers.

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Abstract

The purpose of this study is to examine transitional care of older adults living with dementia when transitioning from hospital or community settings into long-term care facilities. This study contributes to the current body of literature on transitional care by focusing on the experiences of long-term care providers and investigating how transitions occur, are negotiated, and stabilised through the service delivery system. This research not only provides a description of how transitional care occurs but also draws on interview data from long-term care providers and other professionals alongside documentary material, including policy documents, to understand the nature of transitional care.

Using Situational Analysis (SA), supported by Actor-Network Theory (ANT) as a complementary theoretical lens, allows a dynamic view of transitional care as an interaction between humans and nonhumans.

The participants in the study explained that transitional care is not a straightforward or logical process; instead, it is a complex and ongoing negotiation influenced by factors like time, paperwork, workplace culture, and scattered information. Formal systems were found to devalue the relational and experiential knowledge of long-term care providers while emphasising their accountability for high-quality care. Shortcomings were noted within the formal systems related to planning, assessment, and communication processes.

Furthermore, the study found that meaningful improvements to transitional care for individuals living with dementia would require structural and cultural transformations that recognise relational labour and foster a more collaborative and cohesive approach to transitional care. Finally, the study demonstrated that emotional and relational labour played a significant role in stabilising transitions in the absence of systemic coherence.

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Declaration

Statement on the use of generative AI tools

Generative artificial intelligence tools were used in a very limited capacity during the preparation of this thesis to support language refinement, proofreading, and clarity of expression. All intellectual content, research design, data collection, analysis, interpretation, and conclusions are my own work. I take full responsibility for the content and integrity of the thesis and declare that the work it contains has not been submitted for any other degree or professional qualification.

Where I have consulted the published work of others, this is always clearly attributed. Any assistance received in the preparation of this thesis has been acknowledged.

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List of Abbreviations and specialised terms

Key Acronyms

ANT - Actor-Network Theory

SA - Situational Analysis

SANA - Support and Needs Assessment

LTC - Long-Term Care

ESRC - Economic and Social Research Council

NHS - National Health Service

BPSD – Behavioural and Psychological Symptoms of Dementia

CHMT – Community Mental Health Care Team

IRS – Integrated Care Record

Methodology & research terms

Interpretivism - Research paradigm viewing knowledge as socially constructed

Narrative-discursive interpretation – Interpretive attention to how participants' stories, language and accounts construct meaning within their social and organisational contexts

Grounded theory - Iterative qualitative research approach

Constant comparison - Ongoing comparison during coding

Memoing - Writing analytic notes during qualitative research

Situational mapping - Mapping human/nonhuman actors in a research situation

Social worlds/arena map - Mapping organisational/social structures

Positional maps - Mapping debates and discourses

Distributed agency - Agency shared between humans and nonhumans

Flat ontology - Treats human and nonhuman actors equally

Sociomaterial - Interaction between social and material elements

Healthcare / social care terms

Transitional care - Movement between healthcare settings

Relational knowledge - Knowledge gained through relationships and experience

Person-centred care - Care focused on individual needs and preferences

Epistemic authority - Whose knowledge is recognised as valid

Emotional labour - Emotional work required in caring roles

Institutional logics - Competing organisational priorities

Commissioning - Purchasing care services

Funding thresholds - Financial eligibility criteria

Referral pathway - Process of moving individuals between services

Sociological / theoretical terms

Sociomaterial networks - Networks of human and material actors

Assemblage - Complex configuration of interacting elements

Discourses - Systems of meaning and language

Relational repair - Work to restore continuity of care

Temporal pressures - Time constraints shaping practice

System time versus care time - Efficiency versus relational-care temporalities

Multi-institutionality - Multiple organisations shaping care

Analytical concepts used in findings

Knowledge flows - Movement of information between organisations

Documentation as actor - Documents shaping behaviour

Epistemological hierarchy - Prioritisation of certain knowledge types

Silences (in data) - Missing or suppressed perspectives

Relational labour - Relationship-building work by practitioners

Distributed responsibility - Risk shared across organisations

Chapter 1

Introduction and background - defining dementia.

Dementia is a condition resulting from degenerative diseases of the brain that causes progressive deterioration in memory, cognition, emotional control, social behaviour and orientation in time and space. It is not an age-related disorder (WHO, 2012; WHO, 2017). Individuals with dementia may exhibit behavioural and psychological symptoms of dementia, such as depression, psychosis, aggression, and 'wandering,' in addition to cognitive decline (Department of Health, 2009d). As increasingly recognised as a terminal condition, dementia requires advanced, palliative forms of care (Mitchell et al., 2009; van der Steen et al., 2014).

Individuals with severe dementia, in the final stages of the disease, often present with extreme cognitive dysfunction, loss of verbal communication, and total dependency for everyday activities, including mobility and self-care. Many of these limitations result in secondary complications, including pneumonia, fever, and dysphagia (WHO, 2017). While these clinical manifestations of dementia significantly affect the individual and family members, they also represent the reason person-centred, comprehensive care is so important during transitions between different care settings.

Prevalence, mortality, and policy importance

Dementia is the largest single cause of death in the UK. There were over 75,000 deaths in 2023, more than 10% of all deaths nationally (Alzheimer's Research UK, 2024). An estimated 982,000 individuals in the UK live with dementia, but more than a third have not been diagnosed and this number is expected to increase to 1.4 million by 2040 (Alzheimer's Society, 2024). New cases of dementia occur annually (an estimated 209,600) (Dementia UK, 2023), approximately 1 per 3 minutes. Landerio et al. (2024) study described the overall and expected costs of healthcare, social care, and informal care for dementia, cancer, stroke, and coronary heart disease in the UK over the period 2018–2050. The figures indicate that the overall expenditure for dementia care in 2018 amounted to £11.7 billion, £18.9 billion for cancer, £12.7 billion for coronary heart disease, and £8.6 billion for stroke. Based on demographic change by 2050, with the population aged 65 years

and over expected to increase by 49%, the study forecast that the costs of dementia alone would increase by 100%.

Furthermore, approximately 70% of residents in long-term care (care homes) have dementia or severe memory loss (Alzheimer's Society, 2024), many having additional co-morbidities. Approximately 24% of all beds in hospitals are occupied by patients aged 65 and over who have remained in hospital for one week longer than necessary and are likely to have dementia while awaiting an appropriate arrangement to be made to allow them to leave hospital (NHS, 2018c). This rises to 31% for patients kept in for twenty-one days longer than they should be. This equates to nearly 29,000 people in one year (Alzheimer's Society, 2024). In total, keeping people living with dementia in hospital unnecessarily accounts for 584,080 bed days, with an estimated cost to the NHS of £328 million in 2024/2025 (NHS England, 2025). These statistics provide a measure of the magnitude of the issue and a motivation for improving collaborative care approaches, including coordinated care across different care settings.

Bed blocking – one of the biggest concerns in today's health and social care.

'Bed blocking' has been a persistent problem in hospitals in the UK for years, and it is now a major concern within NHS hospitals in England. Approximately 10,000 patients are said to be occupying beds in hospitals and are experiencing what is referred to as 'delayed discharge'. In other words, the patient is ready to be discharged from hospital but is not able to be sent to the next stage of their care (NHS Improvement, 2018b). Unfortunately, the term bed blocking has also been heavily criticised in recent health and social care literature for its dehumanising and stigmatising implications towards patients who are often older adults (Glasby et al., 2004). It can also have connotations that patients are seen as "obstacles" to the smooth running of hospitals, ignoring the organisational and social factors that contribute to longer lengths of stay in hospital. This includes a lack of available social care provision, shortages of trained healthcare staff, and delays in identifying suitable places for patients to go once they have finished their hospital treatment (Gaughan, Baxter, and Tarrant, 2019). As such, using this type of

language to describe patients contributes to the perpetuation of negative stereotypes regarding older people care and needing long-term care, and contradicts the core values of person-centred care, which emphasise dignity, self-determination, and a holistic approach to meeting the needs of individuals (Age UK, 2018; Jolley and Crichton, 2014). Therefore, many practitioners and academics now consider the term to be inappropriate and recommend using alternative terms to describe this situation, such as delayed discharge, or “extended hospital stays due to availability of care” (Manzano-Santaella, 2010, p.121).

Delays in discharge can occur for a number of reasons, including a shortage of temporary or permanent places in residential homes, rehabilitation units, small community hospitals, or a lack of an appropriate care package to enable the person to return to their own home (Moore et al., 2022). This is a system-wide problem, with up to 14% of beds in some hospitals in the South of England being occupied by patients who are medically fit for discharge but are unable to leave due to the lack of social care required to support them (NHS Improvement, 2018c). There is a simple equation: without beds or care home packages available to meet the needs of people leaving hospital, they will not be able to leave hospital.

However, delayed discharge can also cause a number of additional problems for people living with dementia as they are more likely to struggle with unfamiliar and often distressing hospital ward environments. Risks include worsening cognitive function, falls, infections, malnutrition, dehydration and poor mental health. One such example is the concept of ‘deconditioning.’ This refers to the physical decline of an individual that can occur during and after prolonged periods of bed rest. Deconditioning is most problematic for older people, people who are physically disabled and people with chronic illnesses. Prolonged periods of immobility can result in loss of function and mobility through reduced strength and muscle mass. Deconditioning can also result in increased risk of falling, problems with continence, cognitive impairment, and difficulties with performing everyday tasks and maintaining independence (Swinnerton et al., 2023). From my experience of working in this field, I have witnessed many examples of deconditioning occurring as a direct result of prolonged hospital stays. Conversely, rapid discharges from hospital to long-term care can also cause problems. Quick discharges can result in

poor transitional care and create avoidable adverse events as a result of inadequate care planning (Gillis et al., 2005). To avoid such adverse events, care home providers need to be better engaged in the discharge planning process and require access to timely information. Little is understood about the outcomes for individuals who are admitted to long-term care from their own home or from another care home, or about the perspectives of the health and social care professionals directly involved in the transition process. The numerous factors that affect each other during the transition process are complex and multifaceted, and they interlink as part of a web of meanings, communications and interactions between individuals and the assessment and admissions process. Without these factors, assessments and admissions would not be able to take place.

Hospital-to-home transitions, as well as transitions into long-term care, are major barriers to care for individuals with dementia. Persistent problems of delayed discharges continue to create barriers for people with dementia to enter residential and nursing care facilities, access social care and also access NHS community-based services (Glasby et al., 2012; NHS England, 2019; Alzheimer's Society, 2024).

Research indicates that transitions between care settings uniquely put individuals with dementia at risk. Fragmented services, inadequate systems, lack of effective communication and poor planning are frequent causes of poor outcomes for individuals with dementia (Alstveit et al., 2011; Glasby et al., 2012; Cole et al., 2020; Lawson et al., 2025; Zhang et al., 2025). Delayed discharges lower the number of beds available, creating hold-ups that affect other parts of the NHS and intensify pressures elsewhere. Thus, transitional care is a high-priority goal for both health policy and clinical practice with the aim of achieving more efficient, safer, and person-centred care pathways.

Case studies and research focus

This thesis uses case studies to investigate transitional care in practice. The following anonymised case examples are drawn from my professional experience and are presented to illustrate some of the challenges associated with transitions into long-term care for people living with dementia. The cases informed the

development of the research focus but do not form part of the study dataset. Each case study provides an illustrative example of the practical challenges associated with transitional care and helps to contextualise the development of the research questions. In this thesis, I review transitional care from the perspective of the care providers involved in the transitional care process. The emphasis will be on the difficulties faced by individuals living with dementia when they transition into long-term care, particularly those receiving publicly funded support from local authorities. This perspective allows the thesis to not only provide an overview of current practice, but also to critically evaluate how care systems, policy frameworks, and organisational structures affect the outcomes of a vulnerable population.

The case examples were based on genuine events that occurred during my professional experience in long-term care. I selected three events because they illustrated recurring challenges relevant to the developing research focus, particularly in relation to communication, information sharing, assessment, decision-making and the coordination of transitional care. The events were subsequently anonymised for presentation within this thesis, with identifying details and circumstances altered or omitted where necessary to protect the confidentiality of individuals and organisations. The cases were used to provide contextual insight into the development of the research problem and to illustrate the practical complexities of transitional care. They were not treated as empirical research data, were not included in the study sample, and did not form part of the subsequent analysis or findings.

Vocabulary used regarding those involved in transitional care.

To support an interpretative framework, it is crucial to maintain consistency in the terms used to describe individuals engaged in transitional care, as this helps clarify the meanings for all parties involved.

The research focuses on the movement of individuals living with dementia between care environments, primarily from hospital settings to long-term care homes. Throughout the thesis, 'long-term care' (LTC) will refer to care homes or

care facilities that offer ongoing care for older persons. The term 'care provider' and 'care home manager' will be employed throughout the thesis to describe those individuals who are responsible for the organisation of transitional processes and whose perspectives will provide the empirical basis of the study. The term 'practitioner' is used to describe health and social care professionals. Clear use of language is necessary to maintain analytical coherence and recognise the relational nature of dementia transitions. The term 'people living with dementia' will be used as a way to describe a group of individuals with dementia who transition between different forms of care. It was an intentional decision to use this phrasing based upon the principles of person-centred care, which affords the individual precedence over their dementia diagnosis and recognises that an individual's lived experience with dementia is significantly relevant, especially during times when they are transitioning from a hospital environment to a long-term care environment. Use of this terminology ensures that the adults involved in placement decisions are not solely characterising the person living with dementia under their diagnosis of dementia but rather seeing them as individuals whose identities, vulnerabilities and preferences are shaped and limited by the structures and processes of transitional care.

Scope of the study and contextualisation of care home transitions

This research was primarily concerned with transitions into long-term care, rather than with other types of transitions that older individuals diagnosed with dementia may encounter. Admission to long-term care was identified as the primary interest due to the fact that this stage is a critical point within the dementia care pathway which involves a usually permanent relocation from home or another form of care into a residential care facility.

Transitions to long-term care will typically involve coordination of various agencies/organisations, professionals, family members, assessments and care planning. Therefore, admission to long-term care represents a rich field of study in terms of transitional care, including the relational, organisational and sociomaterial complexities. Return transitions (such as discharge from hospital back to the

community or admission from long-term care into hospital) are important, but they would have greatly expanded the scope of the study and diminished my ability to explore the admissions process in detail. Thus, the aim of this study was to develop a detailed understanding of one very difficult transitional experience within dementia care.

Definition of transitional care

Transitional care refers to a widespread collection of services and care environments intended to enable the safe and timely transition of patients across diverse levels of care and care settings (Coleman et al., 2003; Naylor and Keating, 2008; NICE, 2015; Lawson et al., 2025; Zhang et al., 2025). However, the previously mentioned definition does not adequately account for the unique challenges faced by individuals living with dementia. For older adults with dementia, transitional care includes a coordinated set of temporary services and actions designed to create a continuous and seamless care experience during transitions between care settings (NICE, 2015). Care transitions depend on the creation of a complete and inclusive care plan and on the presence of healthcare professionals with knowledge of the management of chronic and acute illnesses that are complex. The professionals must possess contemporary knowledge of the preferences and medical conditions of individuals with dementia. Therefore, transitional care models require careful coordination and logistical planning among healthcare professionals involved in the transitional process.

As stated in the Clinical Practice Guidelines and Principles of Care for People with Dementia (Adaptation Committee, 2016, p.65), transitions in care, specifically transitions from early-stage care to later stages of care, are a major area that is in need of continued research. The guidelines highlight the need for research to “better understand the experiences of individuals with dementia, their caregivers and families during these transitions, as well as the best methods of support”.

Individuals with dementia, especially older frail individuals, typically encounter iatrogenic complications, uncoordinated care, and avoidable hospitalisations (LaMantia et al., 2010). Older, frail individuals with dementia are especially

susceptible to experiencing discontinuity in care that may lead to negative results because of poorly managed transitions (Coleman, 2003; Coleman and Boulton, 2003; Naylor and Keating, 2008; Tsilimingras et al., 2003). In general, the most favourable outcomes are achieved when a person-centred approach to care is employed, in which the care is guided by a complete comprehension of the unique requirements and preferences of older adults (World Health Organisation, 2017). However, because of the complexity of the needs of individuals with dementia and their cognitive limitations, a person-centred approach to care for individuals with dementia is difficult to implement. Because of fears related to the potential vulnerability of individuals with dementia and ethical considerations related to their participation in research, individuals with dementia are often under-represented in the literature (Carmody et al., 2015a). Individuals with dementia are often portrayed as having unstable cognitive capabilities and thus are viewed as being incapable of providing reliable accounts of their lived experiences (Capstick et al., 2015).

Excluding individuals with dementia from research creates an epistemological injustice, where individuals with dementia are denied the right to participate in creating knowledge and making decisions (Jongsma et al., 2017). Such injustices create a culture of oppression that effectively excludes individuals with dementia from patient organisations and other forms of support (Jongsma et al., 2017). Research reveals that during transition processes, people living with dementia are often without help when it comes to choosing their residential placement. These dynamics produce complex and unpredictable pathways for older adults in the healthcare system (Berntsen et al., 2019; Grimsmo et al., 2018). Transitions in care can pose risks to individuals with dementia, including the occurrence of falls, medication errors, and infections during and after discharge from hospital (Laugaland et al., 2014). Factors contributing to the risk of such adverse events include inadequate assessment of older patients' needs, failure of communication, and barriers to the organisation of care. In the UK, transitions between care settings are often the responsibility of healthcare practitioners and social workers, who convey patient information verbally and through written documentation across care settings as part of the individual's support and needs assessment (SANA). However, most care home managers only receive patient information via email,

which limits their ability to clarify the current health status of the person undergoing transfer. Traditional social work models of care provide continuous oversight; however, these models have evolved towards fragmented care coordination, where social workers are responsible for providing support to individuals at various points along the care continuum. Consequently, care home managers are often uncertain of whom to contact to obtain transfer information, which increases the likelihood of fragmented care.

According to the World Health Organisation (WHO, 2007), communication during patient care handovers is one of the top five patient safety initiatives.

Communication during transitions in care is a critical component in maintaining continuous care and preventing individuals with dementia from becoming misplaced or injured. Poor handovers can create discrepancies in patient history, thereby undermining the capacity of the healthcare system to protect vulnerable populations (Gandhi, 2005). A systematic analysis of transitional care by Richardson et al. (2019) revealed that the perspectives of all stakeholders, including care providers, are frequently absent in studies examining hospital-to-long-term care transitions for patients with dementia. The review demonstrated that the lack of preparation, communication, and quality of care in the transitional process adversely affected the experiences of patients, families, and healthcare practitioners. The limited knowledge regarding the transitional experiences of individuals with dementia and their care providers informs the focus of my research on care providers' perspectives on the transition of individuals with dementia into long-term care.

The CQC report "Cracks in the Pathway" (2014) was the first to expose the problems of substandard care during transitions between hospitals and care home settings. The majority of examples of exemplary practice highlighted within this report, however, indicated an inconsistent quality of care provided throughout transitions of care. In addition to an inconsistency in the quality of care, the report further indicated that there is also a lack of inclusion of individuals with dementia, along with their respective family members, when it comes to decision-making and assessment related to the delivery of care. As such, the report has made it a priority to develop better transitional processes for the benefit of both individuals living with dementia and their family members. A 2016 National Audit report into

discharging older people from hospitals found that, although national guidance existed (National Institute for Health and Social Care, 2015), there continues to be poor coordination of hospital discharges. These issues include unclear accountability for the process, poor communication and information sharing, and a misalignment of financial incentives between different systems that have all contributed to poor discharges of older adults from hospitals. Changes to adult social care integration have occurred since the Health and Care Act 2022 was passed to create an environment which fosters co-operation and collaboration between the health sector and the adult social care sector by recognising adult social care providers as strategic partners for developing and implementing improved collaborative models of delivery of adult social care services, including working collaboratively with voluntary organisations and NHS providers and local authorities (Hothersall et al., 2020).

The formation of collaborative relationships between partners is essential to deliver coherent health and social care services and improve the outcomes of individuals in their communities. The creation of 42 statutory integrated care boards (ICBs) in July 2022 by NHS England strengthens the initiative by establishing ICBs as statutory bodies with a mandate to develop projects and resources that align with the Health and Care Act 2022 (GOV.UK, 2022). Professor Vic Rayner OBE, Chief Executive Officer of the National Care Forum, expressed the need for care organisations to be included in local consultations and discussions regarding localised health and care crises, and stressed the strategic role of care organisations in ensuring that communities receive the care and support needed. Over 18,000 care homes operate in the UK, with 86% of them being run for profit (Laing and Buisson, 2010), and are therefore fundamental to the transitional care process. Professor Rayner emphasised that recent commissioning efforts should strategically place care organisations as equal partners in future.

This paper is written from the perspective of a long-term care provider, who views the provision of care as part of a whole-systems approach to delivering care for older adults to the NHS and Social Care sectors. The NICE guideline (2015) identifies key areas of best practice for care providers and emphasises the importance of developing partnerships with service providers for pre-admission

assessments. Developing such partnerships is necessary to fulfil statutory duties and deliver effective care and support for older adults. Care transitions are known to result in poor clinical outcomes, patient dissatisfaction and inappropriate use of hospital emergency services, post-acute and ambulatory services (Murtaugh et al., 2002).

Background

My professional background is primarily in nursing, and I am presently the director of two residential homes in the south of England that care for people living with dementia. Both care homes support self-funded and local authority funded residents. I have spent the last twenty-five years caring for individuals with dementia and have seen major changes in dementia policies, regulations, and care practices. This research therefore provides a valuable opportunity for me to gain a greater understanding of the mechanisms and challenges facing care home providers in supporting individuals with dementia during their transition to care homes. Therefore, my values and perspectives are inherent to the research process and may therefore shape the topic of investigation and my assumptions about it. In addition, I will have to acknowledge and be mindful of how my identity and experiences, including gender, race, class and values, influenced this study as a researcher. Finlay (2002a) explains that reflexivity is necessary in social care research because it allows researchers to recognise their own biases and assumptions and contribute to a more ethical, transparent, and honest understanding of the interconnected nature of social care. As Jacobson and Mustafa (2019) state, knowing my own position will not only determine what I am investigating but also how I relate to participants and analyse the data. A researcher's positionality can affect the relationship between the researcher and the participants; this relationship can result in perceptions of being either an "insider" or an "outsider". In general, when participants perceive the researcher as an "insider", they are more likely to feel comfortable sharing more personal and sensitive information than if they view the researcher as an "outsider" (Yip, 2024). I attempted to employ an 'insider' approach by using my shared life experiences, language, and cultural identity to establish a relationship of trust and rapport with

participants so that they felt comfortable enough to disclose more personal and sensitive information about themselves (Greene, 2014).

Being familiar with the research setting and the issues faced by participants will aid in conducting a more thorough and accurate analysis of the data collected during the study and will minimise the likelihood of misinterpreting the data collected (Yip, 2024). Familiarity with the research site will also assist in decreasing the amount of time and energy spent navigating the gatekeepers within the institution and other logistical barriers associated with participant recruitment (such as identifying the most ideal time and place to interview participants) (Holmes, 2020). Employing these benefits will require an elevated level of reflexivity, which includes being critically aware of one's own biases and assumptions and how they may impact the research process. Using reflexivity will also assist in mitigating risks, such as losing objectivity or drawing conclusions prior to completing the research (Berkovic, 2020). A research study's perspective (worldview) will directly influence an investigator's interpretation of their results (Rowe, 2014). Positional awareness enables the development of context for the data being collected, identification of possible biases in interpreting that data, and a deeper understanding of the complexities of the study results, which is an example of ethical practice because it represents the practitioner's commitment to openness, accountability and transparency (Sabre, 2024). By revealing my positional awareness, I aim to show the reader the context of my claims and the methods I have used to minimise the influence of my positionality on the research process.

Why this research

Through my lived experience and practice, I understand that the entry into long-term care is influenced by many factors, including those within the health and social care system, especially for those who rely on local authority funding (Cole et al., 2020). Over the past decade, hospitals have treated twenty-one per cent more people as inpatients (CQC, 2021). This trend has added pressure on the total number of available beds in the NHS and has resulted in older adults spending less time in the hospital, while others remain in hospital unnecessarily. In addition,

bed availability has decreased, staff shortages have persisted, and the focus of care has shifted towards community-based care (Friebel et al., 2019), resulting in clinical teams having to rapidly discharge patients once medically fit (Moore et al., 2022). Both the NHS and social care sectors have been subject to extreme pressures in recent years, due to years of low investment, the effects of Brexit, and the COVID-19 pandemic. These factors have also led to work stoppages for frontline employees who are seeking better working conditions. This is especially significant today, as the UK government has recently implemented a new hospital discharge plan that includes funding for beds in long-term care facilities for intermediate care; this will allow for patients aged 65 or older diagnosed with dementia, or those without a dementia diagnosis, to be provided with care in their homes upon discharge from the hospital in an attempt to alleviate bed blocking in the National Health Service (NHS). Bed blocking is defined as when older patients are discharged from hospitals but are unable to leave due to a lack of adequate care packages for them to use once they are discharged. Although this NHS response may be viewed as a temporary 'sticky plaster' solution, it has led to the discharge of thousands of patients into care homes and other settings on short-term contracts, thereby freeing up much-needed beds. Nevertheless, this approach may place additional pressures on care providers to accept more complex cases under the constraints of an underfunded, under-resourced, and understaffed workforce.

Through my practical experience, I questioned the existing practices around new referrals, and the decision-making processes in the transitional care framework. The notable lack of communication and collaboration between referral teams and care home providers has created barriers for my team in obtaining the required information in a timely and transparent manner. My team often relies on a SANA (Support and Needs Assessment) document to assist us in making informed admissions decisions, but this document has a heavy influence on our decisions, and we are pressurised to prioritise the system's needs over the individual needs and preferences of the prospective residents. This approach was focused on achieving a blanket strategy of 'best value' rather than 'best interest' for the prospective residents, and care homes willing to take individuals at the cheapest rate were more likely to receive referrals. As I continued to explore the

complexities of this situation, I realised that there was a disturbing 'Dutch Auction' element to the situation that led me to question whether I was the only one frustrated with the organisational processes used to make these referrals.

The role of funding in supporting choices when considering moving to a care home.

It is worth highlighting the critical role that funding plays in enabling individuals to exercise some degree of choice when considering moving to a care home. Cole et al. (2020) studied how both social care practitioners and care home managers felt that people with dementia "should be able to decide for themselves whether they wanted to go into a care home and if so, when" (p.140). However, this choice is reserved for those who are self-funding. Those who rely on local authority funding do not qualify for support until their needs reach a level that satisfies the local authority's threshold, and usually at a crisis point and later in the course of dementia diagnosis, thereby limiting the opportunity for proactive planning and choice. In my lived experience of providing care, I have found that individuals in the earlier stages of dementia often elect to sell their property and move into the care home of their choice. This finding supports the findings of Cole et al. (2020) who stated that individuals make these decisions to prevent the potential distress associated with a future move in the disease progression and to maximise control over their current and future care. However, one of the drawbacks to this decision is that if the private funds are depleted, the individual will be placed in a care home willing to accept local authority funding.

Types of long-term care provision

There are multiple participants taking part in this study, and those individuals are coming from various locations of care homes. Many variations exist among all forms of care delivery (residential and nursing) for the two categories of care, but perhaps the most critical difference exists because nursing care homes deliver 24-hour nursing care via registered nurses as part of their service delivery, whereas residential care homes primarily offer housing and support to people requiring varying levels of assistive services.

The differences described above may affect how care home managers admit and assess people living with dementia, how their care plans are developed, how risks are managed, and how they interact with other healthcare providers. Some of the differences in service provision may also be reflected in participants' descriptions of the transitional process (communication, information exchange, continuity of care, organisational coordination, and decision-making). However, given the consistency of the data across participants, I elected to consider the transitional issues across these settings collectively rather than compare or contrast participants' experiences according to the type of care home.

Referrals to care homes

In England, the referral and admissions process to care homes is governed by a structure of legislative frameworks, national guidance, and the oversight of regulatory bodies such as the Care Quality Commission (CQC). The specific procedures differ dependent on whether the individual is funded by a local authority or self-funds. A care home admissions policy involves a multi-stage process, including referral, pre-admissions assessment, site visit, and a final decision based upon the individual's needs and the home's capacity. The Care Act 2014 directs this process to ensure that the care home can meet the individual's needs and that admissions are person-centred and in the best interests of the resident.

In my area, the current referral process has developed over the past couple of years to involve an email process whereby needs assessments for prospective residents are sent directly to a variety of care homes by the social services department, via the brokerage team. The council's brokerage team is pivotal in securing funding and arranging placements for older adults requiring long-term care. Their responsibilities include assessment, fiscal management, provider coordination, and ongoing support, all of which are necessary to ensure that older adults receive timely and effective care. The brokerage team will forward the referrals to the care home providers, who must then determine whether they can meet the prospective resident's needs. From my experience of practicing, I have

observed that care home managers are often presented with patient information with little opportunity to inquire about the health status of the individual transferring to the care home. Historically, social workers provided longitudinal care oversight and were able to answer any questions concerning the referral, but current practices often require social workers to become involved with individuals at different stages of the care process, and as such, they are responsible for fragmented communication and confusion for long-term care managers concerning whom to contact for transfer information. The lack of established methods for continuous coordination and communication with primary care teams may inadvertently add to the fragmentation of care.

Additional pressures exist when the brokerage team require rapid responses, and as a consequence, the care home providers are often expected to respond within a few hours, despite the need to consider a number of factors such as the staffing levels, the appropriateness of the care home environment and the resources available to meet the prospective resident's care needs. Time pressures are one of the primary concerns that I will develop throughout this section. Care providers wait for a response from the brokerage team, including the cost of placement, as to whether they would be contacted to proceed with an assessment. If no contact is made with the care provider within a period of two days, it is assumed that the care provider's bid for placement has been unsuccessful. Furthermore, in some situations, care home providers may be invited to conduct an assessment of an individual in the hospital, and other care home providers may also be invited to conduct the same assessment.

Traditionally, referrals were made through telephone conversations with the brokerage team, and as such allowed for an interaction exchange of essential information, and an opportunity to ask relevant questions regarding the individual's social history and family involvement. The direct communication established strong relationships between the care home providers and the brokerage team, and they understood the type of care the home could provide and their fee structures, as long as the home could meet the prospective resident's needs, placements were likely to occur. The way things operate today, in my experience, the process has changed. Even though it may be faster, it is often viewed as an auction for the

cheapest provider, and the brokerage team's first priority is finding the best value, or the least expensive option, which will meet the person's needs at an affordable price. However, care providers do recognise that the brokerage teams also have pressures and limitations of trying to stay within budget limits when they purchase a long-term care placement. The increasing costs of social care and extended hospital stays have compelled the NHS and local authorities to work together to commission and deliver discharge services that are economically viable within the constraints of their existing budgets.

Although encouraging older adults to live independently is welcomed, there will undoubtedly be instances where older adults with advanced dementia need to be placed in long-term care, particularly if there has been a failure of care or unmet needs resulting in crisis conditions, thus prompting a search for specialist care services. Cases like these are often characterised by having high-level or complex needs and therefore, the allocation of additional resources, increased staffing levels, and specialised training to accommodate the specific needs of these individuals, are essential for care homes providing care to state funded residents. A study conducted by Cole et al., (2020), demonstrated that both social care workers and care home managers emphasise the importance of including individuals with dementia in the decision-making process. However, involving individuals with dementia in decision-making processes becomes increasingly difficult in the later stages of dementia, especially during times of crisis, as many individuals may be too distressed, physically unwell, or lack the cognitive ability to engage in decision-making processes. Through my personal experience working with individuals with dementia, I have seen that few individuals with dementia have any input, let alone choices, regarding their residential options during the transitional process.

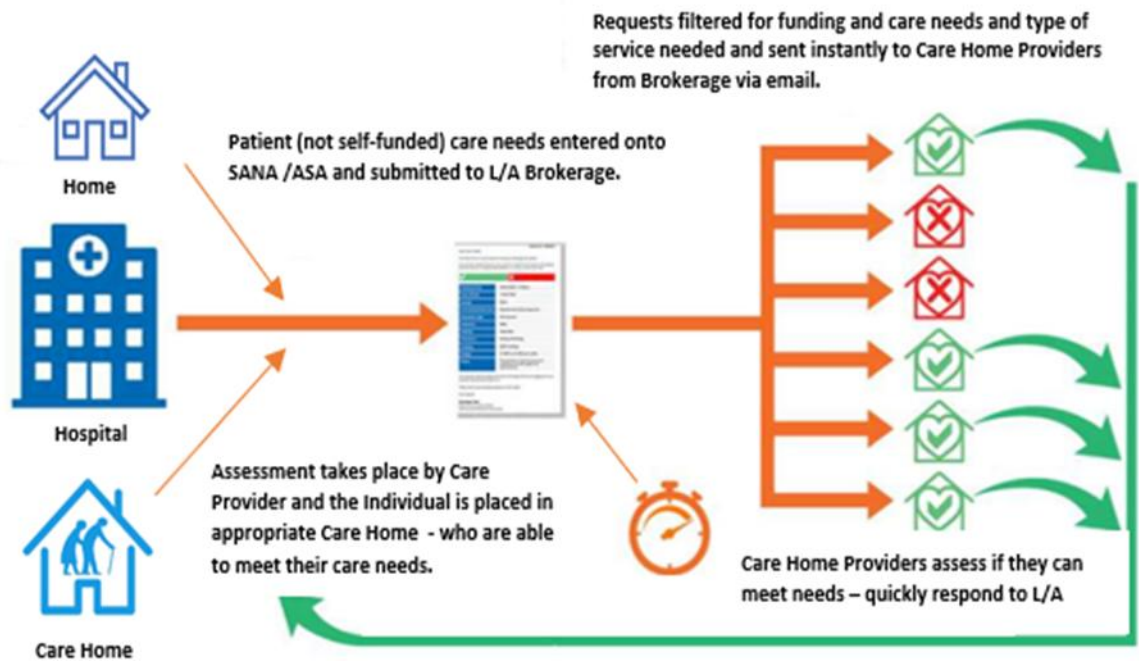


Figure 1- Flow chart showing L/A brokerage referral process to care homes (my own depiction)

Case Studies

The case examples of Mrs B, Mrs C and Mr D are based on genuine events arising from my professional experience and illustrate the complex, unpredictable paths that individuals living with dementia may experience through the healthcare system (Berntsen et al., 2019; Grimsmo et al., 2018). These cases are not unique and illustrate some of the challenges that care home providers, including myself, have experienced when assisting residents with transitioning to long-term care.

Mrs B - Poor communication

After our care home received a referral request for Mrs B, we soon discovered that we had previously completed an assessment for her several months prior and had agreed to offer her a place. Unfortunately, the admission never happened. The circumstances surrounding Mrs B's delayed placement illustrate challenges that can arise; without adequate follow-up communication from social services, and the brokerage team regarding the outcome of the assessment and no confirmation of

the placement; as the care provider, we assumed that Mrs B had been placed elsewhere.

As mentioned in our initial assessment, Mrs B had been hospitalised for seven months. She had suffered significantly from deconditioning over these months. During her second evaluation with us, Mrs B indicated that she wanted to be discharged from the hospital and stated that "her son was looking for a suitable nursing home" for her. The delay in Mrs B's placement occurred after a junior social worker thought that Mrs B could safely return to her home with a care package. Although the family and hospital staff had recommended against returning Mrs B to her home due to past incidents, the social worker asked for permission to override the hospital's refusal to discharge Mrs B to a care home based on Mrs B's wishes documented from ten years previously when she stated she did not want to go into a care home. Ten years earlier, Mrs B was able to make decisions about her care. However, at this point in time, Mrs B was much frailer and had a dementia diagnosis that limited her ability to advocate for herself.

In this scenario, we see how Mrs B did not get to participate in the decision-making process surrounding her care. The social worker could have used the opportunity to speak with Mrs B about whether or not she would accept residing in a long-term care facility. It is possible that, if the social worker had engaged Mrs B in these discussions, Mrs B would have shown acceptance of this choice, which is what she had expressed to us during our assessment. There is substantial research demonstrating how older people with dementia, along with other older adults, are typically ignored when expressing their 'voice', and how the voices of family members and professional staff are prioritised (Lloyd-Sherlock et al., 2019; Rhynas et al., 2018). While the inclusion of individuals with dementia in the decision-making process is not a novel concept (Young et al., 2021), the timing of such engagement may require consideration, particularly in post-diagnosis settings when proxy decision-makers are appointed. Consultation with individuals with dementia is not only an ethical obligation, but research has demonstrated that such consultation facilitates a smooth transition to a long-term care setting (Sury et al., 2013).

Poor hospital experiences for individuals with dementia

Mrs B's extended hospitalisation and poor experience are not uncommon among people living with dementia. Research conducted by Cowdell (2010) has demonstrated that persons with dementia typically report negative hospital experiences and a greater likelihood of developing negative health-related outcomes, including an increased risk of falling and contracting infections, compared to non-dementia populations (Canadian Institute for Health Information, 2018). Individuals with dementia have more frequent hospitalisations (Canadian Institute for Health Information, 2018). To better meet the needs of individuals with dementia who enter hospital, there is a need to understand the hospital environment and how it affects their experiences (Munsterman et al., 2024). The term 'environment' represents the conditions and context in which perceptions and experiences evolve, consisting of sociopolitical, relational, and physical aspects (Rycroft-Malone et al., 2002). The collective contribution of these elements, such as building design, social norms, formal policies, and documentation systems, contributes to the practice of healthcare (Rycroft-Malone et al., 2002; Squires et al., 2019). Contextual aspects influence how individuals with dementia perceive and experience their hospitalisations (Reilly and Houghton, 2019; Borbasi et al., 2006; Nolan, 2006). A qualitative study, also conducted by Reilly and Houghton (2019), identified that the physical environment of hospitals and a lack of person-centred care approaches were both poorly suited for individuals with dementia.

Mrs C - Insufficient communication systems and processes

Another example is the case of Mrs C, in which a care provider was asked to assess Mrs C while she was in the hospital. During this process, the care provider and the social worker discussed the weekly fee, and although the care provider indicated that the initial fee was too low, they agreed to discuss increasing the fee. The social worker assumed that the indicated cost would be acceptable and told the care provider to complete the assessment, which confirmed that the care home could meet Mrs C's needs. After conducting the review of the case, the social worker called the care home to tell them that funding for Mrs C was still pending, at which point the care home stated they could not accept Mrs C until the

funding had been agreed. A few days after this phone call, the care home received an email informing them that the designated social worker was now on annual leave and that the funding decision for Mrs C had been sent to her line manager. Seven days later, a brokerage officer telephoned the care home to ask how Mrs C was settling in; when the care home replied that she had not arrived because there were still outstanding funding issues and that no funding confirmation had come through, the care home were told that this would be promptly investigated. The next day, the hospital rang the care home and informed them that Mrs C had been discharged and that she was making her way to the care home. When the care home contacted social services to clarify the funding arrangement, they were informed that funding had been approved; however, the actual weekly fee for Mrs C could not be provided because it was not documented. This resulted in an unnecessary extension of Mrs C's hospital stay by at least two weeks. The absence of agreement on payment responsibility and unclear communication led to delays, frustrations, and misunderstandings. This case illustrates a number of systemic errors and the mismanagement of client expectations and process. Although Mrs C did arrive at the care home, the delays could have been mitigated if there had been greater communication and cooperation among all the parties involved. This case also demonstrates the need for coordination among all parties involved in a client's care plan, including the parties involved in funding, timelines, and policies, before decisions regarding the client's discharge and care are made. Care providers are confronted with the fact that once a new resident is admitted to a care home, funding becomes 'fixed,' and 'non-negotiable,' and rarely revised. Care providers may therefore have to accept residents at a lower fee than usual, as was the case with Mrs C.

Mr D - Breach of duty of Candor

The following case of Mr D shows how complex situations can occur due to a lack of effective communication and transparency when moving clients from one service provider to another. Within a span of 46 days, Mr D transitioned between

three different care homes after his discharge from hospital, only to be readmitted shortly thereafter.

A self-funded gentleman, aged 86, Mr D was initially admitted to a larger long-term care home for 21 days. However, due to his difficulties with behavioural and psychological symptoms of dementia (BPSD) he was then moved to a second, much smaller care home. Unfortunately, the smaller care home was not given adequate information regarding Mr D's complex needs and therefore were unable to appropriately provide Mr D with the support he required. Mr D remained in the small care home for just one week before he was moved again. Information regarding Mr D either disappeared or became distorted during this move. Fortunately, the third care home, which was a specialist dementia care home, quickly identified that Mr D's needs went beyond his dementia and included long - standing mental health issues that the previous care homes had not addressed. In addition, Mr D's family reported that Mr D rarely visited his GP, suggesting that Mr D had slipped through the safety net of the primary healthcare system.

The third care home established contact with the community mental healthcare team (CHMT) to arrange for specialty consultations. Unfortunately, before the CHMT were able to evaluate Mr D, he experienced a psychotic episode and attempted to harm himself, resulting in his transfer back to the hospital. The ward called the care home four days later to let them know that Mr D was now ready for discharge. However, the care home declined to readmit Mr D knowing he still required essential psychiatric evaluation and further care. Remarkably, during Mr D's hospitalisation, social services made two additional attempts via brokerage referral to request a placement back to the home.

This case is an excellent illustration of the lack of communication and understanding of Mr D's condition, which continued to exist through the course of Mr D's care transitions, as evidenced by the failure to document timely relevant information in the Strengths and Needs Assessment (SANA) submitted by brokerage for each of the subsequent care homes. Therefore, Mr D unnecessarily spent six months or more in the hospital while a suitable placement was located for him, while his voice was silenced throughout the entire process (this occurred in 2023).

Assessment policy, regulation, and reform in England

Significant shortfalls have been identified in the assessment processes employed in the UK, particularly with regard to the identification of needs amongst vulnerable populations (Hoe et al., 2006). Shortcomings in assessment processes are commonly linked to the overuse of risk-based assessment tools, culturally incompetent care, inadequate time to conduct assessments, and the lack of involvement of multiple stakeholders in the assessment process (Rafferty et al., 2015). Poor assessment practices can result in individuals failing to engage effectively with services, and exacerbate existing inequalities (Dixon-Woods et al., 2014). Individuals entering care homes are influenced by national and local policy developments, which consequently affect care planning practices. The COVID-19 pandemic resulted in the dramatic changes to hospital discharge protocols, and subsequent requirements for detailed assessments and risk management strategies to reduce the risk of transmission of infections during transitions from home or hospital to care settings (World Health Organisation, 2020). In general, individuals enter care homes at a later stage in their lives than previously, typically having developed compound disabilities and/or impairments and/or having difficulty in accessing the required support. These factors frequently result in them no longer being able to live independently at home.

It is surprising that despite the importance of the assessment process, the process remains a neglected area of care management and practice, with minimal consideration of the assessment process in inspections and inspection reports. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, known as the 'Fundamental Standards', provide limited focus on the assessment process, offering indirect reference to the assessment process in the new quality statements that constitute the Care Quality Commission's (CQC) single assessment framework. The omission of the assessment process from the Fundamental Standards is particularly concerning given the importance of establishing a well-planned and well-managed transition to a care home for the individual. CQC's 'Regulation 9', relating to Person-Centred Care, and 'Regulation 11', which relates to the 'Requirement for Consent', imply the standards that should be achieved during assessments; however, they do not explicitly define

them. Consent is particularly important for individuals who lack the mental capacity to make decisions about their transition into a care home and therefore invokes the provisions of the Mental Capacity Act 2005 and potentially the Deprivation of Liberty Safeguards (DoLS). The way in which assessments are planned, implemented, and experienced has a profound effect on the overall care outcomes for the individual concerned. Hence, developing robust assessment processes and associated formal procedures is necessary to ensure that individuals entering care homes receive appropriate care and support tailored to their individual needs. Developing a more robust regulatory framework and implementing person-centred practices during the assessment process will provide better experiences and outcomes for individuals transitioning to care.

Discharge-to-access and transitional support services

The analysis found that local transitional assistance structures (including, for example, Trusted Assessor Models and Admiral Nursing) were crucial. While both of these are localised structures (i.e., they are designed to work within the local system), it is essential to view them from the perspective of the larger national policy framework for integrated care and hospital discharge reform. Specifically, both are supportive of the goals of "discharge to assess," where assessments and the development of care plans occur outside hospitals (in community settings). These roles appear to have provided important relational and coordination functions, supporting continuity across organisational boundaries and bridging gaps between health and social care services.

Intermediate care was an additional component of the overall transitional environment that included long-term placements. Intermediate care routes frequently influence assessment processes, discharge planning and whether individuals go on to long-term placement. However, because this analysis focused on transitions into long-term care and not evaluations of intermediate care models, the relevance of the models to this study is in terms of their role in the network of organisations, services and decision-making processes that led to admission decisions.

These services were particularly relevant to the present study because they illustrate how transitional care is supported by roles and structures that operate across organisational boundaries, rather than being contained within a single service or professional group.

History of assessments and policies related to transfers of care.

Transitions of care, including the transfer of care responsibility, are addressed in current policies that seek to promote the integration of health and social care. The Care Quality Commission (CQC) guidance emphasises the importance of joint planning and collaboration between health and social care organisations during transitions of care. Much of the CQC's guidance focuses on hospital discharge arrangements and the need for integrated follow-up of individuals once they have been discharged from hospital. Guidelines from CQC suggest that when a person is transferred between services, the providers should inform each other of the transfer so that the person receives safe care. In addition to informing each other of the transfer, if there are two or more service providers involved in providing the care to the individual, then the service providers should also produce partnership plans outlining the way in which they will work together to provide the best possible care. Comprehensive risk assessments are essential to provide adequate support for individuals who are being transferred between services and to ensure the individuals' safety throughout this process. Poorly developed transitional policies regarding care have been influenced by numerous factors, including, but not limited to, organisations' failure to comply with the enforcement of existing policies and operate within their own policies and procedures. External pressures, such as staffing shortages and financial constraints, can also hinder organisations' ability to develop effective policies and procedures to guide care transitions (Rafferty et al., 2015). Although policies and regulations exist, they are often difficult to enforce and subject to variation in their interpretation by organisations locally. The inconsistency highlighted above demonstrates the need for stronger policies that articulate the complexities of transferring between services. Improved clarity and consistency in enforcing policies and regulations could improve the

integration of services and the quality of care experienced by individuals during these critical transitions.

Assessment of older people has been the focus of various government departments in the UK. Post the introduction of the Community Care reforms in 1989, outlined in the White Paper, 'Caring for People', local authorities were designated as the lead agency in planning community care with health service providers. The 'core components' of community care were:

'Services that respond flexibly and sensitively to the needs of individuals and their caregiver'.

'Services that offer a range of options'.

'Services that only intervene to the extent that is necessary to encourage independence'.

'Services that target the needs of the most vulnerable individuals" (Department of Health, 1989)'.

Then, in 2001 came the National Service Framework for Older People in England and Wales, with the primary goal of achieving person-centred care through the implementation of a 'single assessment process' (SAP). This proposes that the Council is responsible for assessing the needs of an individual and developing an appropriate plan to meet those needs. This is still in place and includes 'a survey of a standardised domain of need' (DoH, 2001). The assessment process provides clear guidelines for the assessment of older people. It clearly states that a full assessment should be completed prior to an older person (who will be publicly funded) entering a care home. The National Minimum Standards for Care Homes (DoH, 2001b) also provide a basis for assessing the needs of an older person entering a care home that is privately funded. However, the domains of assessment included in these two approaches are different, and there is no overarching framework for the single assessment process after an individual has moved into a care home (Worden et al., 2006). Later, the National Dementia Strategy: Living Well with Dementia (2009) was produced followed by the

Dementia Assessment and Improvement Framework in 2017. The framework provides support to leaders of NHS provider organisations, such as consultants, charge nurses, and allied health professionals, to deliver 'excellent' care to people with dementia in acute, community, and mental health settings and the importance of person-centred care (Alzheimers.org). The framework recognised eight standards, of which care homes are mentioned once under the 'involvement and co-design' standard whereby it states that care homes should be actively involved with discharge plans. This was followed closely by the National Institute for Health and Care Excellence (NICE, 2018) document, 'Dementia: assessment, management, and support for people with dementia and their carers', which was similar in context, outlining how dementia should be assessed and diagnosed, whilst emphasising the importance of person-centred care and support. The focus regarding care homes was on the assessment of older people before they were placed in a care home, to ensure that those who were placed in long-term care were those who needed that level of care. Of interest, upon examination of this document, it is evident that it does not include recommendations for NHS staff and social workers regarding assessment for people who are living with dementia.

In July 2025, the government developed another plan for dementia health and social care, the Modern Service Framework (MSF), a new document to be implemented in 2026/27 with the goal of reducing unwarranted variability in dementia care across England and establishing national standards for specialists, general practitioners and social workers. The MSF is one of four tools under the 'Major Conditions' part of the 10-Year Plan, which was designed to improve the quality of care and productivity of services provided to older adults (GOV.UK). Alzheimer's Society has offered to work with the NHS and Government on the development of the framework (Keen, 2025).

From analysis of policies, frameworks and guidelines, the long-term care home sector has received little attention in policy development, and even less consideration was given to the wider use of the information collected through assessment. This contrasts with the United States and Canada, where a systematic assessment tool called the Minimum Data Set / Resident Assessment Instrument (MDS/RAI) has been mandatory for use in care homes (Worden et al.,

2007). The data from the assessment tool can be used for two purposes: as a resource for research and for quality measurement (Morris et al., 1990). In order to ensure that all long-term care homes complete a full assessment before admitting an individual and annually thereafter, these regulations were enacted.

The lack of standardised, systematic assessments for the admission of patients to care homes in the United Kingdom may lead to inconsistent management of the admission process. Such inconsistency may contribute to the risks of transition into long-term care (Carpenter & Dickinson, 1999). There is some literature available regarding the nature and content of assessments used to assess older individuals residing in the community, but little is currently understood about the views of social care providers and the pre-assessment processes for UK care homes. There are several countries, such as the US and the Netherlands, which are showing an increasing interest in enhancing the use of assessment tools during transitions to minimise misplacement in care homes and to maximise the possibility of rehabilitation (Worden et al., 2007). In the United Kingdom, a major development in the care for adults with social care needs was the publication of the National Institute for Health and Care Excellence (NICE) guidelines entitled "Transition between inpatient hospital settings and community or care home settings for adults with social care needs." The NICE guidelines acknowledge shortcomings in the pre-admission process and suggest that changes such as the use of person-centred care and collaboration during transitional care would help improve the transitions into long-term care. These guidelines highlight how services should collaborate with the individuals and their families to achieve timely, appropriate, and safe transitions (National Institute for Health and Care Excellence, 2015). Health and social care practitioners, care providers, commissioners, service users, and their caregivers are the intended recipients of these guidelines. The guidelines provide recommendations for best practice. The NICE guidelines were published in response to a growing body of evidence that demonstrated the challenges experienced during the transition of patients from acute hospital settings to either community or care home settings. Some of the challenges included the anxiety experienced by patients and families, delayed transfers of care due to the poor coordination of health and social care services,

and the subsequent cost burden to the public purse (National Institute for Health and Care Excellence, 2015).

These guidelines emerged within a rapidly developing legislative and guidance framework following the passage of the Care Act 2014. The Care Act and other relevant legislation outline the roles and responsibilities of organisations, whereas the guidelines provide a set of practical recommendations for fulfilling those obligations and providing support and care. In fact, prior to the serious case review in Orchard View in 2011, guidelines such as the ones developed in this project did not exist. The Serious Case Review of Orchard View (2013) emphasised the importance of involving service providers in pre-admission assessments to prevent neglect and institutional abuse. The Serious Case Review of Orchard View also highlighted the issue of inconsistent communication across disciplines during the assessment phase contributing to neglect and poor care, therefore demonstrating the necessity of better collaboration to achieve comprehensive assessments prior to admission.

Assessing individuals with dementia presents significant challenges.

Pre-admission assessments can improve the quality of care provided through identifying individual needs, enhancing outcomes, enabling monitoring of case mix, and aiding in the allocation of resources (Challis et al., 1995); thus, supporting the development of needs-led care plans which promote accountability and continuity of care. However, the role of a multitude of healthcare professionals in relation to the eventual outcome of the referral assessment during a patient's hospital stay is a key factor. Due to the involvement of many professionals and the various aspects of the transition process that each manages, there is an increased risk of losing essential information. Additionally, many of the details collected during the admission process to long-term care facilities are often untrustworthy and/or lacking sufficient detail to properly identify the behavioural manifestations associated with dementia.

As a care provider in the area of long-term care, the primary admission referral document used in my area of practice is the Support and Needs Assessment (SANA). The SANA is a document that represents the individual being assessed for placement into a long-term care setting and includes all of the information collected from the Integrated Care Record Service (ICRS) generated by the NHS. As long-term care providers do not have access to the ICRS, they are left to rely upon the information transferred during the transition. In my experience, much of the information collected is fragmented and often is lost in translation, especially for individuals labelled as experiencing BPSD, which results in individuals with complex needs facing greater difficulty in locating a suitable long-term care placement. Although individuals with dementia often face barriers to remaining in or returning to their home, the preferred approach of maintaining the independence of older adults is becoming increasingly popular, as evidenced by the “ageing-in-place” model. This approach is believed to decrease the use of hospital beds and long-term care facilities and reflects societal beliefs in Western countries regarding the importance of independence and autonomy as individuals grow older (Wiles et al., 2012). However, the “ageing-in-place” approach can create numerous challenges for many older adults with dementia, including placing an undue burden on informal carers and raising concerns regarding the safety and self-care of the older adult (Thoma-Lürken et al., 2018). Therefore, older adults with dementia may require additional support as they continue to age (Stockwell-Smith et al., 2019). When the home-based support becomes inadequate, many older adults transition to a long-term care facility to gain 24-hour assistance from a professional (Cepoiu-Martin et al., 2016; Toot et al., 2017).

While the concept of aging-in-place is viewed as the optimal method for older adults to maintain their independence, many older adults use hospital services and eventually transition to a long-term care facility (Phelan et al., 2012). Hospital bed occupancy rates can reach up to 25% at any given time (Boaden, 2016). The most frequent causes of hospitalisations for older adults are injuries caused by falls, respiratory and urinary tract infections, and exacerbations of chronic illnesses (Prince et al., 2016). During the last decade, there has been significant focus placed on improving the process of transitioning patients out of the hospital, with the goal of reducing unnecessary hospitalisations and reducing the length of time

patients spend in the hospital before being discharged (Pellett, 2016). The transition from the hospital to a care facility has been recognised as a critical area of concern, and numerous studies have demonstrated the need for improvement in the care provided during these transitional phases (Toles et al., 2016; King et al., 2013; Shah et al., 2010; Caruso et al., 2014). Transitions in care for older adults can create a myriad of negative outcomes, including poor quality of care and fragmentation, which can lead to errors, breaches in patient safety, readmissions to the hospital, and ultimately, an increase in the rate of mortality (Coleman, 2003; Lamantia et al., 2010; Laugaland et al., 2012).

Decisions concerning the transfer of an older adult to a long-term care facility are often made in response to a crisis, resulting in a lack of opportunity for professionals and care home managers to assess the situation and make informed decisions. Based on my experiences, the majority of assessments conducted with an older adult with dementia when entering a long-term care facility are incomplete. The main reason for this is the reduced mental capacity experienced by many individuals with dementia at the time of needing to enter a long-term care facility. All of the information required to complete an admission assessment regarding the health, life history, preferences, dislikes and any other relevant information of the older adult with dementia is usually gathered through a proxy. The proxy is often a spouse or family member, or a healthcare professional or social worker. There are many reasons why an older adult with dementia may not participate in the assessment process, including the stigma experienced by older adults with dementia and the perception that they may be unable to know or communicate their thoughts and feelings because of cognitive decline and communication difficulties. Many older adults with dementia live independently and safely in the community.

However, there comes a time when the older adult with dementia requires additional support, because of increased anxiety, behavioural challenges, disorientation with regard to time and place, and lack of support and supervision, resulting in the need to transition to a long-term care facility. All of these examples represent triggers that prompt the need for an assessment to consider placement into a long-term care facility.

Delivering care and support to individuals living with dementia and the vast differences in symptoms each individual experiences is a complex and individualised process. For example, no two individuals diagnosed with Alzheimer's disease experience the progression of the illness in the same manner in terms of symptoms and behaviours or have the same prognosis. This uniqueness makes assessment and planning for care a challenge. The variability in the delivery of care to individuals living with dementia has resulted in significant variations in practice, with necessary adaptations made to deliver person-centred care to individuals living with dementia. According to NICE guidelines (2018), several areas present challenges to services and practitioners, including:

- Coordinating care and support among different services.
- What support carers need, and how it should be provided.
- Staff training.

Complexities of patient assessment

Patient assessment is a fundamental mechanism in the United Kingdom for determining the best option for an older adult in terms of their long-term care options, whether this is a residential home, a dementia care facility, or a nursing home. The type of long-term care facility chosen for an older adult impacts the funding allocated by local authorities. Typically, nursing homes receive the highest weekly payments because of the increased care needs of the residents that require nursing interventions, followed by specialist dementia care homes and then residential care homes. This case-mix-adjusted payment model provides compensation to care providers based on the assumed level of care needed. Controversially, from my experience, I have witnessed brokerage teams trying to seek a placement in a residential dementia care home for older adults presenting with mild cognitive impairment who are often bed bound due to physical disabilities, but given their ailments, clearly and chiefly require long-term nursing care. Although I acknowledge that this could be due to budget constraints. This trend can result in inappropriate placements, emphasising the need for care home managers to have a good understanding of the assessment processes and

organisational logics. The thoroughness of an assessment is heavily dependent on the skill and knowledge of the assessor who interprets the findings of the assessment. Identifying, assessing, planning, and treating the problems of the individual are key elements of the process of facilitating successful placements during the transition from hospital or home to long-term care. In the South West, we are fortunate to have the services of several Admiral Nurses in Devon and Bristol. The focus of the Admiral Nurse service is on case management for individuals who live with dementia and their families, to improve the quality of their care and to address their needs from admission to discharge. Once the individual is in the hospital, the Admiral Nurse conducts a comprehensive, holistic assessment of their needs, promotes a culture of positive risk management amongst the staff, and models biopsychosocial interventions that affect length of stay. It is intended that there will be a 'home first' approach, but the programme will also include working with other professionals to share relevant information across care boundaries to enable personalised care. Six weeks of intensive post-discharge support involves working together with care providers and the family to improve coping skills and prevent placement breakdown and carer breakdown to reduce readmission to hospital. There is also the provision of trusted assessors in Dorset who are not nurse-trained but offer a similar service to streamline care and assist care providers during transitions for older people living with dementia when leaving the hospital and entering long-term care, although they do not provide any follow-up with any post-discharge support. Trusted Assessors are not implemented as a national standard, in the same way as with the Admiral Nurse programme.

Professionals involved in conducting assessments emphasise various aspects of the care. Social workers often focus on the ability of the older adult to perform daily activities, whereas medical professionals focus on the physical and mental condition of the older adult. Each profession applies different assessment tools designed to collect specific information. For long-term care, there is a need for coordination across multiple sectors that can employ their own language (Kane and Kane, 2000). Not only do professions use different terminology, they also have differing philosophical views of care (Couture et al., 2016). Conflicting goals and pressures to provide services in a timely manner can be created by philosophical

differences regarding how to approach caring for individuals with dementia and other degenerative conditions, and as such can cause barriers between the health and social care sectors. Assessment is the cornerstone of long-term care, and its value lies in the actions taken subsequent to the assessment. One of the defining characteristics of an effective assessment is its ability to convert findings into actionable items, including the need for 'watchful waiting' when appropriate (Kane and Kane, 2000, p. 324). Fragmentation within long-term care is apparent in the diversity of assessment tools used (Hirschman et al., 2018). Most assessment tools are based upon the 'Activities of Daily Living' (DoH, 2002), which is also the foundation for the Strengths and Needs Assessment (SANA) or Adult Supported Assessment (ASA). Local authorities may use different names for the assessment summary, but the format is similar.

The completed prospective resident report is electronically transmitted to the care home from the social services department (via brokerage), and it is at this time that the care home manager must decide if they can accommodate the care requirements of the prospective resident. Each care home has its own criteria for admitting residents, and some care homes are willing to accept more complex residents than others. The thoroughness of the assessment and the process involved in making the decision regarding whether or not to admit a prospective resident are critical factors in determining who will receive a placement. Although there are numerous studies regarding the types of assessment tools used to evaluate the needs of older adults residing in the community (Carpenter and Dickinson, 1999), there is a significant gap in the literature concerning the perspectives of social care providers regarding the assessment processes used prior to the admission of prospective residents to UK care homes. In practice, there are few standardised assessment tools used by care homes during transitional care and consequently, the assessment process lacks cohesion. Typically, the social care report is reviewed, team members discuss the report, and decisions are made based on multiple factors at the time. Decisions regarding the admission of prospective residents have far-reaching implications for the prospective residents and their long-term care trajectory. An understanding of the rationale for decision-making by adult social care providers would be beneficial, particularly given the limited number of assessment tools currently available.

Comprehensive assessments are linked with the development of care plans; they promote accountability for continuity of care and provide support to planners transitioning (or discharging) individuals during the transition process.

Unfortunately, the completion of pre-assessments is often insufficient in the admissions process, with the completion of full assessments of needs occurring after the transition has taken place. The pressure of data collection time limits exacerbates the likelihood that evolving needs will not be addressed as the individual's dementia continues to progress. The failure to conduct adequate pre-assessments may be due to the lack of policy, regulatory, and external guidance for care homes in the UK to govern the admission processes (Worden et al., 2007). Care homes are faced with financial pressures to fill vacancies in a financially challenging environment. The idea of 'accept now, deal with later' has appeal to some care homes, which could lead to unintended consequences, as illustrated in the case study of Mr D in his initial placements. The case studies demonstrate the complexity and challenges of care home providers during the admissions process. The failure to have a duty of candour and a lack of adequate information contributed to the adverse outcomes described above. Consequently, my research focuses on the management of transitions in care and the complexities involved.

Importance and relevance of research

This doctoral study represents a significant opportunity to improve our understanding of the mechanisms and challenges of supporting people living with dementia to successfully move into long-term care. Understanding care provider views about the transition process is crucial in facilitating collaborative working relationships and successful outcomes for people with dementia. The value of this research is based upon understanding the knowledge gap regarding perceptions of care, collaboration, and care processes between health services and long-term care homes when transitioning people with dementia between diverse types of care settings (i.e., informal, formal, individual's own home, hospital, long-term care facility). As such, a full appreciation of these processes is necessary for developing effective strategies to support people with dementia at each stage of

the transition process, from hospital discharge to entry into a care home. Effective collaboration and communication among all stakeholders is required to meet the increasing care requirements of people with dementia and maintain their quality of life during transitional care. This research aims to provide insight into the critical issues surrounding this aspect of transitional care and to inform the development of practice that is more responsive to the experiences of people living with dementia, while supporting more integrated approaches to service delivery.

Research aim

This research has been grounded within the Interpretivism Paradigm, seeking to understand how long-term care providers view and experience the transition process of older adults living with dementia into long-term care, and the associated challenges and complexities. Further information regarding how the interpretivism paradigm has influenced the research design is contained within Chapter 3: Methodology. The principal objective of this study is to understand and describe the transition pathways from either a person's home or hospital into long-term care from the point of view of adult social care providers. The investigation will take into account the inter-organisational systems involved and assess whether person-centred pathways have become systematised, and the implications for individuals with dementia, although they are not directly participating in this study. The overarching research question addressed by this thesis is:

How do the interactions between human and nonhuman 'actors' contribute to social care providers' roles and create the transitional care path for older people living with dementia transitioning to long-term care?

To answer this overarching question, the following supporting questions were identified:

Supporting questions

1. What are the views of social care providers regarding the transitional care process for older adults living with dementia who enter long-term care?

2. What are the perceived barriers and facilitators to providing care for individuals with dementia during transitions into long-term care?

3. How can situational analysis increase understanding of the interactions among human, nonhuman, organisational and discursive elements involved in transitions into long-term care?

Summary and structure of the thesis

Now that the background context and objectives of the study have been described, it is also important to give a brief summary of the methodology approach that underpins the thesis. A detailed description of these methodological decisions will be presented in Chapter 3 and will offer a concise overview of the analytical path of the research to help the reader navigate through the research.

The present study adopts an interpretivist research paradigm recognising that the transition of individuals from home to long-term care is a socially constructed experience created by the meanings that are attributed to the process by care home managers, local authority staff, and other professionals who engage in the process. A qualitative methodology was used for the study. Semi-structured interviews were carried out, along with documentary materials. Situational analysis was used as the primary methodology to analyse both types of data. ANT provided a complimentary theoretical lens through which the relationships between people (human), organisations, services, information technology and other nonhuman elements within the transitional-care situation could be examined. Reflexivity was integrated into each part of the methodological framework throughout to identify my professional history, positionality and developing comprehension of the transitional-care environment. The analytical strategy employed in this study followed a cyclical process that included coding, memo writing, comparative analysis of interview data and documentary evidence, and the development and refinement of situational maps.

This process enabled an examination of what occurs during the transition from one form of care to another as individuals progress through the transition phase of care; however, it also facilitated an investigation into how healthcare professionals

perceive their roles, responsibilities and limitations within the broader framework of dementia care.

Structure of this research study

Chapter 1: Introduction and background - defining dementia

In Chapter 1, I have provided background information about the transitional care provided to individuals living with dementia (including the policies and current practices and research) including case studies as well as identifying why the study is important. The purpose of the research, specific research questions and my perspective have also been discussed.

Chapter 2: A Literature Review

In Chapter 2, I examined critically the body of evidence related to transitions in care for individuals with dementia (i.e., transitions from one service or care setting to another), including transitions into long-term care settings, person-centred care and organisational issues which affect transitions between services. I have highlighted the conceptual and empirical gaps identified in the previous chapter and established the theoretical basis for this research study.

Chapter 3: Methodological Approach

Chapter 3 explains the research paradigm – interpretivism, used to guide this study and outlines the reasons behind the research methodology and intent. In addition to describing the qualitative methodology selected for this study, namely situational analysis, I explain how actor-network theory provided a complementary theoretical lens through which the relationships among human, nonhuman, organisational and material elements could be examined. Furthermore, I describe the data collection methods, sample selection process, recruitment strategies, and ethical issues and positionality that influenced the research. Finally, I discuss how other agencies (such as care home providers, brokerage teams, trusted assessors, and local authorities) have impacted both the research environment and the conditions under which the data was collected.

Chapter 4: Data Analysis

Chapter 4 presents the empirical data generated through semi-structured interviews and documentary material and analyses these data through situational analysis and its associated mapping processes. This chapter illustrates how participants constructed meaning around transitional care, person-centredness, the organisational constraints, and the lived experience of persons living with dementia transitioning into long-term care.

Chapter 5: Discussion Part 1 – Interpreting the findings

In this chapter, I connect the findings of this study, the relevant literature and the theoretical frameworks used throughout. The findings of the study have been used to demonstrate the significance of the findings in terms of understanding transitional care processes, relational dynamics, and systemic influences, and to contribute a new way of thinking about transitional care. The challenges described by participants are shown not to be random, nor solely due to individual failure, but to be associated with the way in which organisations, artefacts, and time coordinate care. By revealing these mechanisms, this chapter provides a base for designing transitional care systems that are more ethical, sustainable, and responsive to persons living with dementia.

Chapter 6: Conclusion

Finally, in the last chapter, I have summarised the major contributions of the study, described implications for policy, practice, and future research, and reflected upon the methodological strengths and limitations of this study. I have emphasised the need for relational, ethical, and organisational responsiveness in the transitional care of individuals with dementia transitioning into long-term care.

Chapter 2: A literature review

Literature review process and methodological framework

In Chapter One, I began to evidence the complexity of transitional care, in understanding the challenges of transitional care for the older person living with dementia, the difficulties social care professionals face through referral pathways and assessment processes for this vulnerable group. I demonstrated the role that care home providers play in the transitional care journey of older people living with dementia. However, there is a paucity of research that takes the care home provider perspective. I asked myself the question of ‘how do care providers navigate the process of admission which is fraught with multiple influences? The importance of doing this cannot be overstated. For effective assessments, and admissions to take place, so many of these actors and elements become connected through interpretations, communications, and responses, or do not, and consequently the process fails. The admission process is complex, by virtue of the multiple players involved with and in the admission, and the multiple connections that surround them.

In this Chapter, I attempt to turn my attention more fully towards my topic through a literature review of ‘transitional care for the older people living with dementia’, including policy and practice. I use Actor-Network Theory (ANT) and Situational Analysis (SA) to develop the understanding of the complexity involved and in doing so, take the step towards acknowledging what I can learn about how organisational logic and systemic influences are experienced by care home providers.

Scope and limitations

I read widely on my research topic to try to understand more about transitional care for older people living with dementia. My inability to access other perspectives based on insufficient data means that there is a significant knowledge gap in the literature relating to the roles and experiences of care home providers involved in transitional care. While there are many studies exploring the experiences and trajectories of people living with dementia on transfer from

hospital to a care home and/or the community, exploring the perspectives of people, family and health and social care professionals, I found a lack of research focusing on perspectives of the care home providers that offer support during transitions in to long-term care.

Given my narrow search criteria, which used terms such as ‘perspectives of long-term care providers’, ‘perspectives of transitional care’ and ‘transitions to long-term care’, I decided to look more broadly for an understanding of the issues pertaining to transitional care for people living with dementia including barriers and facilitators to person-centred care.

Methodological framework and results

I discuss my chosen review methodology and provide a description of why I elected to pursue a narrative review. I describe the search strategy used to identify the literature and the approach used to assess the quality of the articles included in the review. In addition, I will present details regarding how I determined those findings and describe three emergent themes from the literature review; stakeholder/professional perspectives, communication and collaboration (across boundaries), and safety/risk. These are not mutually exclusive but rather are interdependent.

Contribution of this review

There is limited research explaining exactly how someone decides to go into a care home, what this involves and especially who is involved. My review is about understanding the need to explore the perspectives of care home providers, who will undoubtedly have their own insights into transitional care. This review will provide further insight into the perspective of long-term care (LTC) providers on the transition process for people living with dementia from hospital or community into long-term care homes, an area that remains under-represented in the literature. By laying out this perspective the aim of this study is to explain how care and considerations are negotiated for, what barriers are identified and can be

mitigated, what are some systemic facilitators to transitional care and what must be considered to move towards more person-centred transitional care for the older person (and their families). Understanding these dynamics is crucial; by including the perspective of providers' of care homes we hope to contribute to existing knowledge of transitional care of individuals living with dementia.

Methodological rigor: Interpretivism and narrative review

While conducting my literature review, I reviewed relevant literature that relates to my selected paradigm, which was interpretivism. Qualitative research often uses interpretive paradigms to understand social phenomena from the perspective of those directly involved. I will discuss in greater detail the influence of this paradigm in my methodology chapter. Awareness of interpretivist influences allows me to attend to literature that meets my study criteria as to the perspective of care home providers in transitions for individuals living with dementia entering long-term care. I reflected on the study's limitations in capturing the point of view of participants and understanding the social context of transitional care (Ulz, 2023) by asking how far these studies explain these positions. Indeed, understanding the given literature in the context of different research paradigms makes us better able to criticise in a productive way, and this will, in turn, reflect in our own research (Guba and Lincoln, 1994). This helpful critical lens informed my assessment of studies based on how closely they aligned with my interpretivist approach. Zhang et al. (2025), for instance, employed a similar qualitative methodology to that of this study, thereby informing my decision to include their study in this review.

Interpretivism and narrative review methodology

Unlike the strict protocol of a systematic review that allows for thematic organisation of the literature, a narrative review provides greater flexibility and opportunity for critique of the literature. A narrative review provided a more suitable methodology for examining the meanings, perspectives, and contextualising factors inherent within the existing literature. The nature of narrative reviews permits the researcher to engage in the judgement and

interpretation processes when selecting, sequencing and analysing the sources, and therefore permitted me to evaluate how authors conceptualised transitions into long-term care, as well as how their views aligned with or conflicted with the interpretivist paradigm that guided both my worldview and study design. Green et al. (2006) recognise that narrative reviews necessarily involve researchers' judgement, preferences and interpretation when selecting, ordering and analysing literature. However, they also demonstrate how the reporting and interpretation of literature can frame what is known and unknown about the subjective experiences of those represented within it. In this study, this was particularly important in considering the experiences of care home providers supporting people living with dementia, whose perspectives have received comparatively limited attention within the literature. Through this, I started to notice repeating themes, threads, tensions, and gaps across the field, followed by refining my research questions, and supporting the development of an analytic lens through the study. The narrative review was used as a springboard on which to locate my research in the academic and policy landscape, and how studies that came before me shaped, cemented, or left out the interpretivist concerns that fill the work of this thesis.

Methodological considerations: Actor-network theory and situational analysis

Part of my review was of exemplary health and social care literature using methods I thought looked like appropriate approaches for meeting my aims, so that I could a) become familiar with this literature and b) think through which approaches looked like appropriate candidates for me to employ. Findings from this search are not incorporated into my results but are discussed in Chapter 3, setting out Actor-Network Theory and situational analysis in health and social care. I have found little work that investigates 'how' those involved in health and social care 'do' what they do, how they become embedded in each other's care networks. Employing Actor-Network Theory 'could' conceptualise the dynamics, interdependencies, interactions, governance processes, and power networks of those involved in health and social care. In a UK context, few studies have

employed ANT-informed approaches to map and investigate the care networks around individuals living with dementia.

Aim and objectives of the review

I aim to review transitions in care between the secondary care services and care providers for older people within health and social care. I intend to be mindful and develop a sensitivity to the complexity of transitional care for older people living with dementia entering into long-term care, adopting the perspective from care home providers but also of inter-organisational pathways and inter-professional communication of hospital professionals dealing with community social workers and care home managers.

The objectives of the review are to:

- a) Develop an understanding of how policy is situated in relation to transitional care for older people.
- b) Examine what the literature says about communication, risk, collaboration and challenges in relation to how older people living with dementia undergo transition into long-term care from the perspective of health and social care providers.

One striking thing in the literature, despite the advances made in the concept of transitional care in the US, is the limited number of studies adopting the perspective of long-term care providers on how transitional care is practised (n=18 or studies that my search terms identified) - how decisions are made, and what the consequences are between pre-admission and admission. The studies I reviewed range from the 2000s through to 2025, and emerge from Australia, Norway, the US, and the UK. Most studies I found include a plethora of stakeholders and multi-professional perspectives and transitions from weeks of hospitalisation to short stay care facilities, but I was able to extract the perspective of long-term care staff in some of the studies to achieve the focus of this aim of the research.

Literature search strategy and review process

The literature review involved an iterative and structured searching strategy for identifying relevant studies and information about the following topics: (1) dementia; (2) transitional care; (3) care home admissions; (4) care providers' perspectives; (5) discharge planning; (6) continuity of care; (7) relational care practices; and (8) sociomaterial approaches to understanding healthcare. The literature review did not constitute a systematic review of the literature according to established methodologies. Rather, it constituted a critical synthesis of all relevant literature that was empirically based, theoretically informed, or policy-focused and applicable to the objectives of this study. Literature searches were performed electronically during the years 2002-2025 using electronic databases from disciplines related to health, social work, nursing and interdisciplinary research. A total of seven electronic databases were searched, which included CINAHL, MEDLINE, Scopus, Web of Science, PsycINFO, ASSIA and Google Scholar. In addition to searching these electronic databases, additional searches were performed to identify references in lists of cited articles, in government reports and documents related to policies affecting individuals living with dementia, and via hand searches of top-tier journals related to dementia care, transitional care and organisations providing healthcare services.

As is common when performing electronic database searches for literature related to specific research topics, the search terms used in these searches were developed iteratively. Also, as is typical for electronic database searches, these search terms were developed by combining different keywords and phrases using Boolean logic. Some examples of search terms include:

- * Dementia and Transitional Care
- * Dementia and Care Home Admission
- * Hospital Discharge and Care Home
- * Continuity of Care and Dementia
- * Transitions in Care and Older Adults
- * Transitional Care and Long-Term Care

When developing search terms, truncations and synonyms were used where feasible to maximise the retrieval of relevant studies. The primary time period for the literature review consisted of studies that were published between 2002-2025 inclusive. The reason for focusing on studies published since 2002 is due to significant advances in dementia-related policy, integrated care, transitional care research, and changes in the organisation and delivery of healthcare services. However, some earlier foundational literature that contributed theoretically, methodologically, or conceptually to the subject matter being researched was also included in the review.

In order to be eligible for inclusion into the review, studies had to meet at least one of the following criteria:

- * The study had to be written about either dementia, older adults, transitional care, care home admissions, care providers' perspectives, discharge planning, or continuity of care.
- * The study had to report empirical research or theoretical research or have reported on an influential policy guideline or set of recommendations.
- * The study had to be located in a peer-reviewed journal or recognised source of policy information.
- * The study had to be available in the English language.

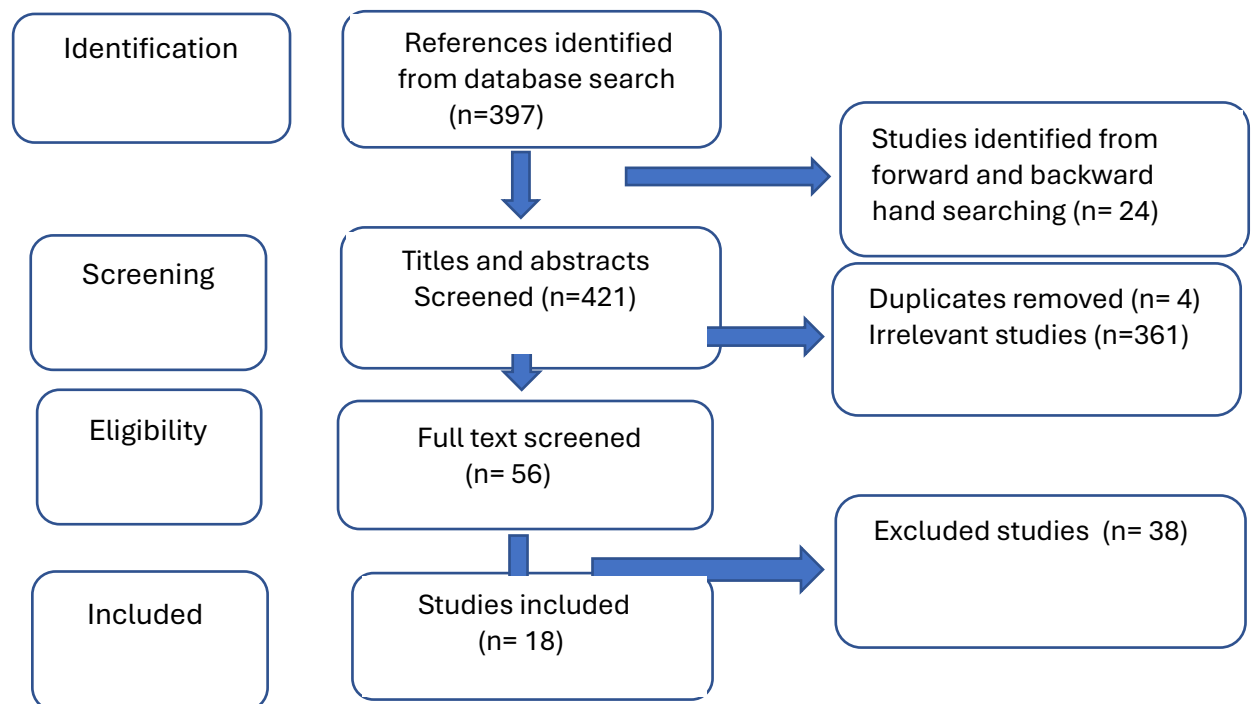
However, the following types of studies were excluded from the review:

- * Studies that focused solely on transition care in non-adult populations.
- * Studies that examined transitions in healthcare that were not relevant to the study's focus.
- * Studies that were not relevant to dementia care, transitions into care homes or coordinating care in healthcare settings.
- * Studies consisting solely of opinions without substantive empirical research or theoretical/conceptual contributions.

All studies included in the review were selected based on their relevance to the study's research questions and the continued development of the study's analytical framework. As part of this iterative process, new literature searches

were conducted multiple times throughout the course of completing the doctorate. Conducting multiple literature searches allowed the reviewer to include newly-emerging evidence and policy developments as they became available. This ensured that the final product would remain current with the most recent findings and contribute significantly to both the conceptualisation and theorising aspects of the study.

Figure 2 - Literature search and study-selection flow diagram (using a PRISMA-informed presentation). Note: 'S', 'Pi' and 'E' refer to 'Sample', 'Phenomenon of Interest' and 'Evaluation', respectively, in accordance with the SPIDER framework.



Findings

A literature search produced 397 references written between 2002 and 2025. Following application of the inclusion and exclusion criteria, 18 studies were included in the review that satisfied all of the inclusion criteria. A second and third search using a technique called 'snowballing' or 'forward/backward hand searching', added twenty-four additional references. There were eighteen studies

selected for inclusion in the review, based upon a total of 421 studies. The studies included in the review used multiple types of research designs, i.e., grounded theory studies (n = 2), narrative research designs (n = 2), an action research study (n = 1), a single case study (n = 1), seven qualitative studies using thematic analyses (n = 7), three systematic narrative reviews (n = 3), one Realist Review (n = 1), and one study that did not identify a specific methodological design.

The quality of each of the qualitative studies was assessed using the CASP Qualitative Checklist for Quality Assessment. The CASP Qualitative Checklist is a commonly accepted tool for assessing the quality of qualitative studies (Critical Appraisal Skills Programme, 2017). All eighteen studies clearly described their research questions and methods to investigate those questions, and the qualitative methodology employed was considered suitable for investigating the research question. In the results and discussion sections of this paper, the value of each individual study, especially with regard to question 10 of the CASP checklist ('Is the research valuable'?) has been incorporated. This will provide a detailed and nuanced evaluation of how much each individual study contributes to the body of knowledge in the area of transitional care for older adults. Since the field of transitional care is still evolving and is characterised by an ongoing debate about the validity and relevance of qualitative syntheses, a textual-narrative approach was employed to synthesise the results of the included studies. This approach allows for a preservation of the originality of each individual study while allowing for respect of the unique context and elements that define each study. Narrative and tabular analyses of the studies included in this review were conducted to create three discrete categories that illustrate a greater understanding of transitional care for older adults. The categories were developed by comparing the findings and areas of emphasis across the included studies and grouping recurring issues that were directly relevant to the review objectives.

1. Professional/Caregiver Perspectives: The nine studies examining the views of professionals/care workers about transitional care for older people moving from hospital to long-term care are important because they inform us about the challenges and difficulties faced by care providers when patients transfer from one care setting to another.

2. *Multi-Professional Communication*: Studies examining the need for effective communication between different professional groups when older people move into long-term care (six) demonstrate the need for a coordinated approach to care among different health professionals to provide continuity and achieve good outcomes for older people.

3. *Quality of Care/Safety Issues*: Studies investigating risk factors for older people transferring into long-term care (three) will be helpful in identifying ways to improve the quality and safety of care provided to older people during transitions. The inclusion of qualitative studies in the review above may reflect the fact that the review question was concerned primarily with the nature of social science aspects. The 18 studies that are summarised in Table 1 below represent the breadth of the findings and insights that contribute to the overall theme of transitional care for older adults.

Table 1 – Summary of studies that met the research criteria

Author (Year) & Title	Methods	Sample	Study Aim	Context Settings	Findings
1. Allen et al., (2013) 'Multi-professional communication for older people in transitional care: a review of the literature.'	Systematic Narrative review	15 publications	To synthesise research-reporting literature about multiprofessional communication between health and social care professionals within transitional care for older people, with particular attention on outcomes, enabling contextual factors and constraints.	Australia	Improved multi-professional communication reduces rates of re-admission and length of stay demonstrating great cost and efficiency for the health and social care systems. Systems of care highlighting education, information exchange and negotiation between stakeholders enable communication in transitional care contexts for older people. Equally, lack of dialogue and lack of understanding of others' roles are barriers to communication in transitional care' (Allen et al., 2013).
2. Alstveit et al., (2011) 'Addressing Risk Factors for Transitional Care of the Elderly - Literature Review'	Systematic Narrative review	49 Publications	The aim of the study was to focus upon care transitions between primary and secondary providers' within elderly health and care, identifying and raising awareness towards factors that are critical to	Norway	Despite an increase in studies focusing on transitions, there are still gaps in the literature in terms of how patient information should be transferred in a way that reduces risk and strategies to improve transitional care are lacking (La Mantia et al., 2010), The literature suggests that preventable adverse events are likely to occur with transitional care of the elderly due to breakdowns in communications across care providers. Even if there are on-going evidence-based interventions

			patient safety. The study also focused upon inter-organizational pathways, from hospital to community and the reverse, interprofessional communication from hospital-based nurse to community-based nurse.		aimed at improving the safety of transitional care handovers, these are plagued with age-old problems of not translating the findings of research into improved practice' (Johnson and Arora, 2009).
3. Baxter et al., (2020) 'Delivering exceptionally safe transitions of care to older people: a qualitative study of multidisciplinary staff perspectives'	Qualitative study: A pen portrait Approach	Six doctor surgeries, four hospitals, 157 multidisciplinary staff	The study explored staff perceptions of how high performing general practice and hospital speciality teams deliver safe transitional care to older people as they transition from hospital to home.	UK	Staffed perceived that safe transitions were underpinned by three key themes: knowing the patient which involved gathering a holistic picture, building trust and rapport and a shared understanding across health care teams. knowing each other which meant feelings were valued and listened to, building relationships across clinical / professional boundaries, and trusting one another. Bridging the gaps within the system; by enhancing communication, adjusting patient expectations, and adapting to evolving services and competing priorities by understanding the challenges and pressures that other teams face. Staff faced various challenges in achieving these three themes, some of which they could only attempt to overcome when caring for patients that had particular complex health and/or social care needs'. (Baxter et al. 2020).
4. Britton et al., (2017) 'Care Transitions between Hospitals and Skilled Nursing Facilities: Perspectives of sending and receiving Providers.'	Qualitative Study, data analysed by coding team using the constant comparison method	Hospital nurses (n=25) Long-term care facility nurses (n=16)	The study was conducted to identify the perspectives of sending and receiving providers regarding care transitions between the hospital and the long-term care facility.	US	Four main themes emerged: increasing patient complexity, identifying an optimal care setting, rising financial pressure, and barriers to effective communication. The data highlighted hospital and LTC providers shared concerns about patient-level risk factors and escalating costs of care. It also identified issues that separate hospital and LTC providers, including different access to resources and information. The concerns of both hospital and LTC providers must be considered in order to develop practices that can improve the quality, cost, and safety of care transitions'(Britton et al., 2017).
5.Cole et al., (2021) "Professionals' views on the "optimal time" for people living with dementia to move to a care home.	Qualitative phenomenological approach	Semi-structured interviews with (n=20) social workers and (n=20) care home managers in England.	The study investigated social workers and care home managers views on whether there is an "optimal time" for a move.	UK	Four overarching themes emerged from the data: 1) staying at home for as long as possible but avoiding crisis, 2) balancing risks proactively and anticipating triggers, 3) desires for the person living with dementia to be involved in the decision and 4) the significance of funding in enabling choices about a care home move.

6. Coleman, (2003) 'Falling between the Cracks: Challenges and Opportunities for Improving Transitional Care for Persons with Continuous Complex Care Needs.'	Article		The article was written to discuss the challenges and opportunities for improving transitional care for persons with continuous complex care needs	US	The many adverse effects of poorly executed transitions on patients and their informal caregivers are potentially preventable with the implementation of evidence-based and clinically sound interventions' (Coleman, 2003).
7. Eika and Hvalvik, (2022) 'Municipal healthcare professionals' interprofessional collaboration during older patients' transitions in the municipal health and care services: a qualitative study.	Descriptive, interpretive design	Three Focus group interviews. Focus group 1 - nine participants - Leader group (4 RNs, one physio, 3 GPs, 1 OT). Focus group 2 - eight participants front-line staff (3 RNs, 1 Physio, 2 aux, two assistants). Focus group 3 - six participants, front line staff (1 Physio, 1 RN, 2 aux, two assistants). Individual interviews	The study aimed at exploring and describing what influenced municipal health care providers' interprofessional collaboration during older patients' transitions in the municipality.	Norway	"Health care providers in LTC facility, and in particular RNs felt squeezed and of less worth in the municipal health and care services. It was a strain on them experiencing unplanned and often rushed patient transition into LTC facility. Focusing on municipal inter-professional and inter-facility collaboration during patient in transition to LTC placement is vital to maintain the patients, and the health care providers working in these facilities" (Eika and Hvalvik, 2022).
8. Gilmore-Bykovskiy., (2017) 'Transitions from Hospitals to Skilled Nursing Facilities for Persons with Dementia: A challenging Convergence of Patient and System-level Needs.'	Grounded dimensional analysis	(n= 40) nurses from 11 LTC facilities	To describe long-term care home nurses' perspectives on the experiences and needs of persons with dementia during hospital to LTC transitions and to identify factors related to the quality of these transitions.	US	Hospital-to-LTC transition were dominated by dementia-related behavioural symptoms that were perceived as being purposely under-communicated by hospital personnel in discharge communications. LTC nurses described people living with dementia as having unique transitional care needs, which primarily involved needing additional discharge preplanning to enable preparation of a tailored behavioural/social care plan and physical environment prior to transfer. LTC nurses identified inaccurate/limited hospital discharge communication regarding behavioural symptoms, short discharge periods, and limited nursing control over LTC admission decisions as factors that contributed to poorer-quality transitions producing increased risk for resident harm, rehospitalization, and negative resident/carer experiences' (Gilmore- Bykovskiy et al., 2017).

9. Kable et al., (2015) 'Health professional perspectives on systems failures in transitional care for patients with dementia and their carers: a qualitative descriptive Study.'	Qualitative descriptive study	(n= 33) health care professionals in four focus groups	The aim of the study was to report acute, community and residential care health professionals' perspectives on the discharge process and transitional care arrangements for people with dementia and their caregivers.	Australia	Participants identified critical issues: pressures on acute care health professionals to discharge PwD early, the requirement for junior doctors to complete discharge summaries, the demand for post discharge services for PwD exceeding supply, the need to modify post discharge medication prescriptions for PwD, the need for improved coordination with residential care homes, and the need for routine provision of medication dose decision aids and home medicine reviews post discharge for PwD and their carers' (Kable et al., 2015).
10. King et al., (2013) 'The Consequences of Poor Communication during Transitions from Hospital to Skilled Nursing Facility: A Qualitative Study.'	Grounded dimensional analysis	(n= 27) RNs in five LTC facilities	To examine how care home facility nurses transition the care of individuals admitted from hospitals, the barriers they experience, and the outcomes associated with variation in the quality of transitions.	US	"Long-term care nurses rely heavily on written hospital discharge communication to transition individuals into the care home effectively. Nurses cited multiple inadequacies of hospital discharge information, including regular problems with medication orders, little psychosocial or functional history, and inaccurate information regarding current health status. The communication inadequacies necessitated repeated telephone clarifications, which created care delays, increased LTC home staff stress, frustrated individuals, and family members, contributed directly to negative LTC home image, and increased risk of hospitalisation. LTC home nurses identified a specific list of information and components that they need to facilitate a safe, high-quality transition" (King et al., 2013).
11. Lawson et al., (2025). 'Do Hospital-to-Home transitions work for older adults with multiple long-term conditions including dementia? A realist review'	A realist review	(n= 68) peer-reviewed and 2 grey literature documents were reviewed.	The aim of this realist review was to synthesise existing literature to explore how, for whom, and to what extent hospital to home transitions work for older adults with multiple long-term conditions including dementia.	UK	The findings showed fragmented care pathways and poor collaboration led to delays, unsafe discharges, and increased reliance on carers, exacerbating service gaps. Carers faced emotional distress and decision-making conflicts, often managing care responsibilities without adequate training, increasing risks of readmissions, particularly for unmanaged conditions.

12. Olsen et al., (2021) 'Crossing Knowledge Boundaries: Health Care Providers' perceptions and experiences of what is important to achieve more person-centred patient pathways for older people.'	Qualitative study - thematic analysis	(n= 20) health care professionals	The aim of the study was to explore healthcare providers' perceptions and experiences of what is important to achieve more person-centred patient pathways for older people.	Norway	" A thematic analysis resulted in five themes which outline central elements of the health care providers' perceptions and experiences relevant to achieving more person-centred patient pathways: 1) Finding common ground through the mapping of the patient journey; 2) the importance of understanding the whole patient pathway; 3) the significance of getting to know the older patient; 4) the key role of care home providers in the patient pathway; 5) ambiguity toward checklists and practice implementation" (Olsen et al., 2021).
13. Payne et al., (2002) 'The Communication of Information about older people between Health and Social Care Practitioners.'	Systematic review of qualitative and quantitative literature	Publications (n= 53)	To provide an evidence base for strategies, and effectiveness of the transfer of patient information between hospital and community for older people with physical illness.	UK	The most effective strategy for transferring information is the appointment of a 'key worker', who can provide a point of contact for workers from hospital and community. Nevertheless, problems have arisen because both settings are under pressure and pursuing different goals. Neither setting is fully aware of the needs, limitations, and pressures of the other (Payne et al., 2002).
14. Popejoy et al., (2014) 'Hospital to Nursing Home transition challenges- Perceptions of Nursing Home Staff'	Qualitative study - Cross-sectional Web-based Survey	178 surveys were returned from Nursing homes from all seven geographical regions of Missouri. Participants included nurses, directors of nursing, minimum data set coordinators, doctors, social workers, case managers/ administrators, Physiotherapists, and Occupational Therapists.	The aim was to describe the types of problems encountered by nursing homes when admitting residents from hospitals.	US	Hospitals have difficulty in finding nursing homes that will accept patients with complex health care needs such as mental health needs. In general, nursing homes stated that communication with hospitals was problematic. However, nursing homes are willing to accept challenging residents from hospitals provided they are given adequate information about equipment, medications, and behavioural needs, so that the correct resources can be arranged and put into place prior to the patients' transition.
15. Reed and Porter., (2002) 'Improving communication between Hospitals and Care Homes: The development of a daily plan for older people.'	Action Research Approach	3 groups; first group x (n=37) nurses from 6 wards; second group (n=19) nursing home staff; third group x (n=19) older people who had transferred from hospital to a care home.	The study set out to develop a user-led daily living plan (DLP) in partnership with older people and staff from health and social care settings. The DPL was designed to facilitate communication of the daily preferences of older people, ensuring that continuity of care and support could	UK	"In the process of developing and implementing the DLP, more effective person-centred communication between hospitals and care homes was achieved, and some of the hospital staff's ideas about care homes changed" (Reed et al., 2002).

			be maintained and that their future care can be planned on an individualised basis when they move from a hospital to a care home.		
16. Richardson et al., (2019) ‘	Systematic review of qualitative and quantitative literature	(n= 9) publications, which included 257 stakeholders: 37 people living with dementia, 95 family members and 125 health and social care professionals. These studies took place in Australia, Canada, USA, and the UK.	The review aimed to understand the experiences and outcomes of care for people living with dementia who undergo a transition from hospital to care home from the perspectives of key stakeholders; people living with dementia, their families and health care professionals.	UK	"Four themes were identified as factors influencing the experience and outcomes of the transition from the perspectives of stakeholders; preparing for transition; quality of communication; the quality of care; family engagement and roles. The evidence suggested that transitions between care settings are challenging for all stakeholders and that people with dementia have specific needs which need attention during this period" (Richardson et al. 2019).
17. Rhynas et al., (2018)	Case Study Narratives	(n= 10) case studies chosen from a cohort of 100 individuals.	To gain an in-depth understanding of the decision-making processes involved in the discharge of older people admitted to hospital from home and discharged to a care home.	UK	"Care home discharge decision-making is a complex process involving stakeholders with a range of expertise, experience and perspectives. Decisions take time and considerable involvement of families and the multidisciplinary team. There were significant deficits in documentation which limit the understanding of the process and the patients' voice is often absent from case records" (Rhynas et al., 2018).
18. Zhang et al., (2025)	Qualitative Study	3 groups; first group x (n=6) older people planning to move to LTC; second group c (n= 11) family/friends carers; third group x 10 social care practitioners	The aim of the study was to explore the challenges experienced by older people, their caregivers and social care practitioners during transitions and to examine ways to improve transition-related practice	UK	Four key themes were identified: 1) transition-related challenges and unmet needs for older people and their carers; 2) barriers to effective practice and relationship-centred care, such as communication issues, sourcing funding, and system challenges such as fragmented health and social care; 3) strategies for improving transition-related practice, including person-centred, strength-focused approaches, better understanding of diverse care settings, effective communication and information access, and proactive support and engagement and 4) the need to support social care practitioners.

The findings of the narrative literature review are presented in terms of an evaluation of the literature in relation to stakeholders perspectives. I present the questions and results under three identified themes.

Table 2 - Themes development

THEMES		
Stakeholder / professional Perspectives	Collaboration & Communication	Risks / Safety
Lack of transparency about behavioural needs. Red flags were not often communicated or hospital staff underemphasized them because individuals with such flags were difficult to place. Lack of highly tailored care plans to meet the behavioural needs of people with dementia. Lack of Social / personal information to help 'understand the person' with dementia when transitioning from hospital to LTC home. Lack of information systems designed to facilitate the timely transfer of information. Lack of feedback processes and knowledge of the role of key workers on other teams. 'Professional Tribes.' Lack of time given before admission to fully prepare for the individual's needs, such as environment, resources. Lack of control over admission process decisions. Lack of quality and consistency of information sent from hospital, including medication, instructions for care and patient history. Lack of person-centred information or psychosocial plan to manage individual care needs especially those with dementia. LTC nurses felt embarrassed having to ask families for information about the individual as it was not passed on during transition from hospital to care home. Lack of 'joined up working.' Staff were unaware how care is delivered in other parts of the system and how their actions	Hospital-based practitioners lack understanding of community services and the community and social care context, limiting their ability to inform older adults about availability of community resources. Collaboration is a complex endeavour involving patient involvement, coordination, multiprofessional collaboration, documentation, information, and communication. Hospital-based practitioners report transmitting timely discharge communication to care homes, but community providers report rarely receiving adequate information upon admission of older people to long-term care. Building relationships across boundaries enabled information to flow more easily via informal routes and staff felt valued, particularly if they came from different professional backgrounds. Staff drew upon relationships across boundaries to elicit the action they required, particularly if they were concerned about a patient or when prompt action was required. LTC Home nurses felt devalued and that their work was less appreciated in the community as if it were a domain outside the main sphere of nursing and interprofessional collaboration. Across all settings, staff attempted to 'bridge' gaps within the system to improve transitions of care. They did this by trying to enhance communication and by adapting to evolving services and competing priorities. Interprofessional collaboration (IPC) across all contexts was hampered by geography, organisational and individual	Fierce prioritisations being made due to time constraints. Lack of communication between primary and secondary care settings is insufficient and lacks real teamwork, leading to adverse events involving medication, follow-up errors, procedure related errors, nosocomial infections, falls, diagnostic errors, which in turn could lead to poor clinical outcomes, missed diagnosis, incorrect treatment, dissatisfaction among patients, inappropriate use of healthcare services, rehospitalisation, death. LTCF nurses described the influence of under-communicated behavioural symptoms as adversely impacting patient safety and the care home, regardless of antipsychotics, as behaviours sometimes resulted in patient harm for which the staff and care home were held responsible despite their inability to prepare for these events. Discontinuities in care arising from poor information transfer and faulty communication patterns led to care being most vulnerable during transitions. LTCF nurses observed that there was increasing patient complexity at time of admission to a care home and that people were coming out of hospital quicker and sicker. They emphasized the structural differences between the hospital and LTCF including reduced doctor presence, lower nurse-to-patient ratios and limited access to pharmacy, equipment, and specialised professional services such as physio, OTs, and dieticians. Care homes do not operate in the same way as hospitals do due to the lack of support. LTCF providers have to carefully consider the potential economic loss or gain when assessing

positively or negatively impact this. Different perspectives regarding what defines a successful transition. Each sending and receiving party tends to focus on its own tasks and resources rather than the system as a whole, even though the older person transitioning should be a part of the entire process. Hospital time pressures to discharge patients quickly. Differing views regarding the impact of transparency about behavioural symptoms and associated care needs led to mistrust in information received. Patient and family engagement in planning for the transfer is lacking.	factors including financial conditions, differences in professional power, knowledge bases, and professional culture. Differences in the degree of emphasis on medical and social/behavioural needs between hospital and LTCF settings. Components of care that are lacking during transfers to care homes: Timely prepared transfers. Follow up care. Communication about health and medication between settings. Communication consisted of three levels: the delivery system, the healthcare professional, and the patient. Hospitals and LTC homes recognised that Communication worsened by a lack of knowledge about LTC homes.	patient referrals for placement. How are the patients funded? The weekly cost from both sources can be comparatively the same on admission, but much consideration is given when taking local authority funded clients because the weekly rate will not increase annually as the private funded clients do. Also, the fees do not increase for higher dependency and increased care needs. Poor preparation for transition can contribute to anxiety and dissatisfaction and places a greater burden on the patient and care provider. Poorly executed care transitions can lead to greater use of hospital, emergency, post-acute and ambulatory services. Nursing shortages can also lead to poorly prepared care transitions. LTCF nurses identified several factors that impacted the quality of hospital-to LTCF transitions for People with dementia including, inaccurate/limited hospital discharge communication regarding behavioural symptoms, limited nursing control over LTCF admission decisions, short discharge timeframes and lack of engagement with family caregivers prior to and during the transition. LTCF nurses described instances in which they did not have the information they needed as “working blind.” LTCF nurses also employed a strategy of “using caution” when caring for people with dementia if informational sources appeared inaccurate. Nurses commonly discussed these situations as dangerous for individuals and staff, especially in the case of “aggressive” behavioural symptoms. Management of behavioural symptoms during the early transfer period was also described as being relevant to the greater social environment. An addition of a new resident could often disrupt/impact other residents
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		“actual lives.” Collectively, these additional complexities contributed to the perception of hospital-to LTCF transitions for People with dementia as being especially difficult, resource intensive, and requiring more time and planning.
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Stakeholder/professional views of transition process - long-term care

Transition of older people with dementia from hospital to long-term care (LTC) is complicated with many systemic issues, resulting in negative effects on the transitional care experience of residents, according to participants from numerous studies (Coleman, 2003; Kable et al., 2015; Allen et al., 2013; Alstveit et al., 2011; Eika and Hvalvik, 2022; Cole et al., 2021; Gilmore-Bykovskyi, 2017; King et al., 2013; Lawson et al., 2025; Payne et al., 2002; Popejoy et al., 2014; Reed et al., 2002; Richardson et al., 2019; Rhynas et al., 2018; Zhang et al., 2025). These results show the complexities of transitional care, particularly for those experiencing dementia, and how these complexities are shaped by the organisational policies and practices of hospitals.

Many participants reported that LTC homes experienced considerable obstacles in providing for the unique needs of individuals with dementia. Among the main barriers were collecting comprehensive and accurate information about an individual's history and the creation of a personalised behavioural and psychosocial care plan based on that information (Coleman, 2003; Kable et al., 2015; King et al., 2013; Richardson et al., 2019; Rhynas et al., 2018). The creation of a tailored physical space for the individual in LTC, effective communication with family members and social workers, and the resolution of issues related to missing or lost information between hospitals, social workers and family members were frequent themes throughout the studies. (Allen et al 2013; Alstveit et al., 2011; Britton et al., 2017; Coleman, 2003; Eika and Hvalvik, 2022; Gilmore-Bykovskyi, 2017; Kable et al., 2015; King et al., 2013; Olsen et al., 2021; Payne et al., 2002; Popejoy et al., 2014; Reed et al., 2002; Zhang et al., 2025).

These systemic issues create barriers to the transitional care process and can result in unsafe transitional care for older adults with dementia. A consistent theme throughout the studies was the low degree of participation by individuals living with dementia in the transition process. The lack of 'voice' of the older individual in decision-making processes concerning their lives necessitates further person-focused, transitional care pathways (Coleman, 2003; Allen et al., 2013; Alstveit et al., 2011; Cole et al., 2021; Eika and Hvalvik, 2022; Gilmore-Bykovskyi, 2017; Kable et al., 2015; King et al., 2013; Lawson et al., 2025; Olsen et al., 2021; Payne et al., 2002; Popejoy et al., 2014; Reed et al., 2002; Richardson et al., 2019; Rhynas et al., 2018; Zhang et al., 2025).

The exclusion of the older adult's voice is detrimental to the quality of the transition experience and creates an ethical concern regarding the older adult's autonomy and the respect for their preferences. Participants of these studies also stated that they felt that they were 'working blind' and therefore could not rely on the full range of information available regarding individuals with dementia who were residing in hospital settings. Participants identified the transition process as a cyclic one that is both time-consuming and inefficient. The results of these studies support the need to improve communication and collaboration between healthcare professionals (King et al., 2013; Richardson et al., 2019; Baxter et al., 2020; Kable et al., 2015; Gilmore-Bykovskyi, 2017; Rhynas et al., 2018). Participants in the studies also reported feelings of devaluation, stating that their role was often overlooked in the hospital setting and that this created a sense of separation from the transitional process. The perception of being a mere recipient of information versus an active participant in the transition emphasises the need to foster an environment of collaboration where all stakeholders, including LTC providers, are actively engaged and valued in the care continuum (Britton et al., 2017; Coleman, 2003; Eika and Hvalvik, 2022; Gilmore-Bykovskyi, 2017; Kable et al., 2015; Popejoy et al., 2014; Reed et al., 2002). As an overall assessment, these studies demonstrate the necessity of addressing barriers to transitions from hospital to long-term care (LTC) for older adults living with dementia, as well as the wider challenges associated with transitional care for this group.

In terms of specific recommendations, transitional care should be strengthened through improved communication and collaboration between stakeholders, greater

involvement of all those involved in the transition, and greater consideration of the unique needs of older adults. The findings provide an evidence base for developing more inclusive, person-centred and integrated transitional care models for older adults living with dementia, while ensuring that their dignity, preferences and wishes are respected throughout what may be one of the most significant transitions in their lives.

Communication / cross-site communication and collaboration

The studies consistently showed that inadequate communication during the transition of older adults with dementia had a negative impact not only on the older adult and their family but also on LTC staff and facilities (Allen et al., 2013; Kable et al., 2015; Eika and Hvalvik, 2022; Lawson et al., 2025; Richardson et al., 2019; Zhang et al., 2025). Lack of adequate, complete, or consistent information delayed the delivery of care to a great extent because of the time-consuming process of gathering and reconciling necessary information to develop a safe care plan (Allen et al., 2013; Kable et al., 2015; Reed et al., 2002; Zhang et al., 2025). The lack of communication and collaboration between LTC staff and hospital staff prevented LTC staff from developing a person-centred plan during the transition period, which in turn delayed LTC staff from identifying and addressing behavioural and safety concerns that normally occur on admission and from assessing the suitability of the LTC home for individuals with dementia (Eika and Hvalvik, 2022; Payne et al., 2002). Poor communication and inadequate hospital discharge summaries also resulted in LTC staff having an unclear understanding of the individual with dementia. Essential information about the individual's functional status, existing behavioural issues, triggers, favourite activities, and social preferences were often absent or not fully understood before and during hospitalisation (Allen et al., 2013; Eika and Hvalvik, 2022; Kable et al., 2015; King et al., 2013).

In summary, these studies have demonstrated the importance of removing the systemic barriers related to transitions from hospital to long-term care (LTC), particularly as it relates to the older adult population experiencing dementia. A number of recommendations are presented to address transitional care challenges, including better communication, increased stakeholder involvement,

and acknowledging the special needs of older adults through the use of person-centred and integrated transitional care models. These studies provide a body of evidence to support the development of more inclusive, person-centred transitional care models that will not only assist with the transition experience of older adults with dementia but also honour their dignity and wishes as they undergo one of the most significant changes in their lives. Therefore, the inability of LTC staff to access high-quality and timely information concerning the individual with dementia created an unsafe environment for those with dementia, potentially creating a risk for falls and injuries to other residents or staff members which may result in the need for readmission or placement in another LTC facility (Allen et al., 2013; Eika and Hvalvik, 2022; Kable et al., 2015; Payne et al., 2002). As a consequence, individuals with dementia who displayed "problem behaviours" were often labelled as "red flags," hindering their placement in LTC settings. This approach to labelling problem behaviours during the information transfer process, perpetuated a cycle of misunderstandings and miscommunication (Allen et al., 2013; Eika and Hvalvik, 2022; Kable et al., 2015; Payne et al., 2002).

As a result, the studies identified several key themes associated with cross-site communication and stressed the need to establish shared goals for communication among healthcare professionals in hospital and community settings. The studies found that communication barriers, such as communication failures and role ambiguity, were similar to those found in previous studies. In addition, the studies demonstrated that discharge coordinators, technology-based systems and multidisciplinary care coordination teams could contribute to increased quality of life and overall satisfaction with the services provided to older adults compared to traditional hospital discharges (Baxter et al., 2020). As a result, it is essential to create care systems that foster education, negotiation, and the exchange of information among all parties involved in transitional care to facilitate communication. Although insight has been gained through the studies, there is still a significant gap in the literature concerning studies conducted in a United Kingdom context examining factors that influence inter-professional collaboration (IPC) among care home providers particularly concerning the transition of older persons from secondary care services to the independent sector. The relationship between these two care sectors is not clearly understood particularly the views

and opinions of professionals working in these sectors. While many studies on IPC have considered its functioning inside or among various healthcare systems (Popejoy et al., 2014; Zhang et al., 2025), there exists a shortage of research that fulfils all inclusion requirements. The studies further emphasised that “interagency/intersectoral planning and collaboration (IPC) is necessary to ensure continuity and comprehensiveness in patient care pathways” (Lawson et al., 2025, p. 9).

Older adults may undergo simultaneous transitions in later life and independent care providers in various contexts can provide significant contributions to ensure safe and healthy transitions to long-term care. Additionally, the development of an integrated service model can be quite challenging due to the sheer number of services, agencies, and sectors that are involved. Collaborative planning and action are required among and across health and social service agencies and between the public and private sectors. The research from the studies indicates that many times, relationships between the staff in the public and private sectors are not mutually beneficial to the older adult who is transitioning between these two sectors (Lawson et al., 2025; Alstveit et al., 2011; Allen et al., 2013) since the staff in each sector typically function independently with their own focus on their own resources and responsibilities. This independence creates barriers to accountability for health and social care providers when issues arise (Allen et al., 2013). One researcher called these kinds of situations ‘the tribes of professionals’ (Allen et al., 2013). Formal relationships between care sites represent a major barrier to effective communication and collaboration across sites of care (Eika and Hvalvik, 2022). Healthcare providers working in hospitals often lack an understanding of community-based services and other social care services; therefore, they are unable to provide assistance to older adults and their family members in identifying available community resources (Kable et al., 2015). In another research study it was reported that hospital-based health care professionals view community service information positively and can learn about community services when given access (Baxter et al., 2020). In addition, researchers have found that, at least in the case of hospital-based practitioners, they often overestimate the quality of the discharge information (Britton et al., 2017; Allen et al., 2013), thus creating a disconnect between what the practitioner

believes was transferred as information and what actually was transferred regarding transitions. Additionally, there appears to be little emphasis on understanding care plans developed before admission to long-term care or ensuring that they are implemented after discharge (Kable et al., 2015).

A number of themes were identified as being associated with boundary crossing and interagency working/collaboration and, more generally, developing relationships between those providing hospital-based services and those providing social/community care services is seen to be important. The development of trust and effective communication between service domains is critical to address the gaps that exist within the system, and to respond to the pressures and competing priorities that exist at a system level (Baxter et al., 2020).

Risks / safety

Each of the studies that met the search criteria identified key factors contributing to adverse events in older adults with dementia transitioning from hospital to long-term care (LTC) that include ineffective care processes, poor communication and a lack of collaboration between primary and secondary care settings (Allen et al., 2013; Alstveit et al., 2011; Britton et al., 2017; Coleman, 2003; Eika and Hvalvik, 2022; Gilmore-Bykovskyi, 2017; Kable et al., 2015; King et al., 2013; Lawson et al., 2025; Olsen et al., 2021; Payne et al., 2002; Popejoy et al., 2014; Reed et al., 2002; Richardson et al., 2019; Rhynas et al., 2018; Zhang et al., 2025). The transition process was characterised as lacking sufficient team work to prevent adverse events such as medication errors, procedural errors, nosocomial infections, falls and diagnostic errors (Gilmore-Bykovskyi et al., 2017). These issues can cause serious clinical consequences, including incorrect treatment, missed diagnosis, unnecessary deployment of healthcare services, patient dissatisfaction, rehospitalisation, and death (Alstveit et al., 2011; Coleman, 2003). Long-term care staff have stated that the lack of communication of the behavioural manifestations of dementia presented a significant challenge to the safety of patients and the overall integrity of the LTC facility. For example, the previously described case of Mr D demonstrated that his behavioural manifestations led to

harming himself and that the facility was consequently accountable for his injuries, even though they were not adequately prepared due to a lack of time, insufficient information, and communication (Gilmore-Bykovskyi et al., 2017). Often the lack of preparation and implementation of care during the transition to long-term care results in an increase in use of hospital, emergency, post-acute, and ambulatory services creating greater anxiety and dissatisfaction for patients and further burdening both patients and care providers (Alstveit et al., 2011; Coleman, 2003). Long-term care providers have expressed a growing concern that older adults were being discharged from hospitals "quicker and sicker" (Britton et al., 2017; Payne et al., 2002). The differences in environment between long-term care and hospital settings lead to an imbalance of resources (Alstveit et al., 2011; Eika and Hvalvik, 2022; Kable et al., 2015). Care homes do not have the same availability of physicians, carer-to-patient ratios, pharmacy services, equipment or specialised professionals such as physiotherapists, occupational therapists and dietitians. As a result, long-term care settings cannot provide the same level of support as hospitals (Alstveit et al., 2011; Britton et al., 2017), which directly impacts the quality of care available (Alstveit et al., 2011; Britton et al., 2017).

Overall, long-term care nurses felt that their ability to address the complex needs of individuals with dementia was severely constrained. Nurses indicated that the constraints often put new residents at risk because of poor communication about behavioural symptoms between hospitals and long-term care settings, low levels of authority given to long-term care nurses in making admission decisions, short hospital discharge timelines, rapid transfers and failure to engage family caregivers prior to and during the transition (Alstveit et al., 2011; Britton et al., 2017). To manage the challenges related to the transition, long-term care nurses practised caution in providing care when it was risky, or when the reliability of information from other sources seemed questionable. Cautionary behaviour was particularly emphasised by long-term care nurses when dealing with individuals with dementia exhibiting 'aggressive' behaviours that were deemed to be harmful to either the patient or the caregiver (Kable et al., 2015; Gilmore-Bykovskyi, 2017).

In summary, the transition from hospital to long-term care for older adults with dementia is plagued with problems due to a lack of effective communication, inadequate preparation, and little or no collaboration between care settings. These

issues do not only create risks for the safety of older adults, but they also place additional burdens on long-term care facilities that are already under-resourced to address the complex needs of newly admitted residents. To ensure improved care for vulnerable populations, it is essential to develop new and innovative ways to manage transitions.

What research studies show

Studies examining transitional care interventions have shown a clear focus on reducing hospital readmissions, improving communication, and demonstrating cost savings for healthcare providers. A large number of studies in this area have been conducted in Australia, North America, and Europe, with many studies examining older adults that have been discharged from hospitals to their homes, and some studies examining individuals living with dementia that have been discharged from hospitals to short- or long-term care settings (Mockford et al., 2017; Naylor et al., 2014; Kind et al., 2016). Studies have used varying terminology when discussing care transitions, but the term "transitional care" was coined in the US in the early 1980s and referred to a broad range of activities to promote continuity and coordination of care as individuals transitioned between care settings (Coleman, 2003).

Transitional care can be divided into three phases: the pre-transition phase, which encompasses the period of time beginning when an older adult's admission to a nursing or residential home is initially discussed and concluding when a care home is selected (Lord et al., 2015; Afram et al., 2015; Sussman and Dupuis, 2012, 2014); the mid-transition phase, which includes the time frame when an older adult prepares for the move, when placement assessments take place, and when the physical relocation occurs (Hainstock et al., 2017; Sussman and Dupuis, 2012, 2014); and the post-transition phase, which includes the time frame when the older adult adjusts to and accepts the new living arrangement, which begins the day after the placement (Afram et al., 2015; Hainstock et al., 2017; Sussman and Dupuis, 2012). Most of the studies examined in this review applied qualitative research methods to address research questions concerned with subjective experiences. Data collection methods were typically limited; for example, using

interviews, focus groups or surveys to collect data from individuals who had volunteered to take part in the research and were therefore selected by means of a 'purposive' sampling strategy. While these strategies produce rich qualitative data, they are often based on how researchers interpret the data collected. The use of observational methods was significantly lacking in this review, due to the difficulties in conducting observational studies in transitional care settings from the hospital to the long-term care facility. Three interconnected matters of significance were identified regarding the transition from hospital to long-term care from the analysis: (a) stakeholders and care providers' perspectives, (b) communication and collaboration across boundaries, and (c) associated risks and safety concerns. All of the studies reviewed indicated inadequacies in each of the above-mentioned areas from the perspectives of various stakeholders and highlighted the detrimental effects of these areas on all parties involved.

Recommendations for enhancing the experience and improving transitional care pathways from the perspective of individuals living with dementia and their families were also discussed in the review. In addition to focusing on the primary objective of the literature review, it was also important to acknowledge some of the studies that included the views of individuals living with dementia and their families. They were at the centre of the transitional care process. Seven studies specifically addressed individuals with dementia during their transfer from hospital to other short- or long-term care providers (Coleman, 2003; Cole et al., 2012; Cole et al., 2021; Gilmore-Bykovskyi, 2017; Kable et al., 2015; Lawson et al., 2025; Richardson et al., 2019; Zhang et al., 2024).

Only one study in the UK studied the narrative accounts of individuals with dementia and examined the themes that affected their decision-making processes regarding moving to a care home (Richardson et al., 2019). The decision to move into a social care setting is often regarded as a daunting and stressful experience for individuals, characterised by feelings of fear, anxiety, loss, frustration and anger (Redwood, Ely, and Gaughan, 2016; Newson, 2011; Tanner, Glasby, and McIver, 2015; Glasby, Allen et al., and Robinson, 2019; Leyland, Scott, and Dawson, 2016). It is particularly important to recognise and deal with a person's emotional aspects. People need time to adjust to their new circumstances and to understand what it means for them. The O'Neill et al. (2020) authors outlined five key areas of

concern in terms of transitions in long-term care. The first area is the inevitable nature of transition, "I had to come here." The second area is moving to long-term care, "abrupt departure." The third area is about the process of deciding on and implementing transitions in long-term care, "what can I do?" I have no choice," (d) maintaining identity, "holding on to self," and (e) maintaining connections, "I like my family to be near." These findings demonstrate the degree of lack of autonomy experienced by older individuals during the transition process. Health and social care staff are instrumental in advocating for older adults, highlighting the need for policies and practices that emphasise autonomy and choice to avoid older adults feeling "at the mercy" of others during the transition to a new home (O'Neill et al., 2020). Advocacy for older adults living with dementia will require the ability to honour the choices they have made. Three studies (Kable et al., 2015; King et al., 2013; Gilmore-Bykovskiy, 2017) explored nurses' perceptions of decision-making about transitions for individuals with dementia based solely upon the nurses' opinions and views rather than including the views of the individuals with dementia. The majority of studies appraised viewed dementia through a biomedical lens.

A single UK-based study (Cole et al., 2021) conducted interviews with social workers and care home managers to determine the optimal time for individuals with dementia to transition to care homes. Overall, twelve studies focused on older people in general to gather the perspectives of health and social care professionals on transitional care. Many studies indicated that improved co-working among the health and social care sectors, empowering older adults, and assisting them in successfully navigating transitions are key components for enhancing transitional care experiences for older adults (Glasby et al., 2012; Hanratty et al., 2014; Hillcoat-Nalletamby and Sardani, 2019; O'Neill et al., 2022; Richardson et al., 2019). Similar to previous reviews, the findings were not unexpected as the same major concerns existed for health and social care professionals working together to assist older adults during transitional care for approximately twenty-five years.

Richardson et al. (2019) stressed that it is important to take into account the views of both ends of the transitional-care continuum, as well as develop multi-professionally collaborative ways to improve the transitional-care experiences of

older adults (especially those with dementia). Additionally, Glasby et al., (2012) emphasise the cruciality of implementing collaborative and unifying approaches to improve transitions and address the multiple challenges that older adults encounter during transitions. However, the existing literature has shown that there is little development or implementation of interventions to address the 'disconnect' between hospital and social-care staff and thus indicates that multi-professional communication and collaboration in transitional care for older adults with dementia is "highly complex and difficult to change" (Allen et al., 2013, p267). The intricacy of this issue is mostly attributed to the lack of integration between the health and social care sectors, resulting in a structural gap (Long et al., 2013) between health and social care providers'.

Effective communication depends on the construction of 'bridges', negotiating with brokers, and crossing barriers to allow for the flow of information and transactions between separate units that have no verbal or physical access to each other (McCartney, 2016). Dense networks in terms of structure (such as can be seen in health services) are often able to pass information more rapidly and reliably than sparse networks (i.e., care providers'). Creating a link between structurally disjointed entities allows for the dissemination of information among them; however, that does not necessarily mean that this will occur efficiently. Long et al., (2013) observed that the health sector comprises numerous isolated clusters or 'silos' and 'professional tribes', which require increased connectivity, a problem that also exists in the social care sector.

The literature also identified several research gaps, particularly with regard to the role of key workers or coordinators during transitional care. Although national UK guidance supports the role of professionals who specialise in discharge planning, research on the effectiveness of this role following transition is limited. The lack of follow-up by designated discharge planners following transitions to long-term care represents a critical juncture between the health and social care sectors.

Chapter Summary

A review of current literature suggests an 'us versus them' paradigm exists in the way that the health and social service sectors view themselves and provide services for older adults. Many factors have contributed to this division, including the historical separation and the physical separation of the two sectors, the methods in which each sector has been funded, and the distinct professional culture of each sector. These factors have led to a model of two sectors that are expected to work together collaboratively yet have not been structured to do so. Organisations operate based upon established norms and structures (Scott, 2014), which leads to cultural divides between the medical and social models of care (Reay et al., 2009). Over two decades ago, researchers began identifying shortcomings in transitional care and proposed solutions to improve the process, but minor change has occurred, often requiring policy reforms to facilitate integration. Although there is a growing emphasis on person-centred care in policy, few studies have sought to elicit the perspectives of individuals living with dementia, their families, and stakeholders involved in the transitional care process. However, studies have consistently identified the same concerns among diverse stakeholders with respect to transitions, including the need for effective communication, adequate planning, quality care, and family engagement during the transition to long-term care.

The qualitative narrative review emphasises the need to understand the experiences of long-term care providers in order to develop evidence-based recommendations for care practice and future research. The findings indicate that support for individuals living with dementia and their families should be offered during transitions from hospital or community settings to long-term care, including opportunities for shared experiences, joint decision-making, and maintenance of social connections. Ensuring these conditions exist will contribute to supporting individuals living with dementia and their families within both community and long-term care settings. Studying trusted assessors would also be a worthwhile endeavour, as I am fortunate to have access to their services in my area. These professionals have a background in both health and social care and act independently to facilitate transitions. A trusted assessor is someone who can help

an older person transition successfully, including through follow-up after the transition, while also assisting in reducing the risk of potential negative effects, inappropriate placement and re-hospitalisation. Although there are trusted assessors throughout the UK, access to them varies greatly.

Chapter 3: Methodological approach

The overall goal of this study was to understand the perspectives of care home providers regarding the transitional care process for people living with dementia who were transitioning from an acute hospital setting to a long-term care home. This chapter describes the research paradigm that underpinned the study. A research paradigm can be understood as a framework of ideas and beliefs concerning the nature of reality, how knowledge is acquired and how research should be conducted (Harvey and Land, 2021). A research paradigm therefore provides a philosophical framework that influences the research process, including the formulation of research questions, the selection of methodological approaches and methods, the collection and analysis of data, and the interpretation of findings.

Several research paradigms are used within health and social care research, including positivism, post-positivism, interpretivism, constructivism, pragmatism and critical approaches. These paradigms offer different ways of understanding social phenomena and have implications for how knowledge is understood and how research is conducted. Positivist approaches are generally associated with objective and measurable understandings of reality and quantitative methods, whereas interpretivist approaches emphasise subjective meaning, multiple interpretations of reality and qualitative approaches (Harvey and Land, 2021).

Given that the aim of this study was to understand care home providers' experiences and interpretations of transitional care, an interpretivist paradigm was considered appropriate. The following sections therefore explain the ontological and epistemological assumptions underpinning the study and how these informed the methodological approach and methods adopted.

Definitions of research paradigms

Positivism: Views the world as having an objective, single truth that can be identified and measured through quantitative scientific methods. The researcher is viewed as being outside of the research subject and objective.

Post-positivism: Also views the world as having an objective truth; however, post-positivists acknowledge the potential limitations of human perception and measurement in scientific methods. Post-positivists also accept that a researcher may have their own biases and therefore attempt to identify statistical correlations rather than causal relationships.

Interpretivism/Constructivism: These approaches view the world as having no single objective truth and believe that reality is socially constructed and dependent upon individual interpretation. Interpretivism/constructivism assumes that the researcher and participants collaborate in constructing knowledge, leading to an intertwined relationship between them.

The historical development of social care research paradigms is complex and multifaceted.

Historically, there has been no single philosophical research paradigm in social care research, as much research has used a variety of research traditions. Positivist research in early social science was prominent, but social care research today uses an array of research traditions, such as interpretivism and critical theory, to better comprehend the complex and person-centred nature of social phenomena. There has long been recognition among the social sciences that the meanings individuals attach to their life experiences are shaped by the social context(s) in which those experiences occur (Denzin and Lincoln, 2018). A paradigm influences or informs how data are interpreted rather than completely dictating interpretation. Thus, given the same data, different philosophical traditions may offer alternative interpretations of what the data represent. Therefore, I chose to adopt an interpretive paradigm for my study since this paradigm best suited the goals of examining the firsthand experiences and social context of care home providers. In addition to being focused on understanding individuals' perspectives of their social world through social interactions, interpretivism recognises that individuals construct their own "knowledge" of reality. The goal of interpretivist research is to gain insight into how individuals interpret their experiences and how they make sense of their lives within specific

social contexts. Since care home providers hold direct experience-based knowledge of the transitional care process and have learnt about its practical and organisational challenges through their work, an interpretive paradigm allowed me to explore the subtle and nuanced views of care home providers concerning their experiences with transitional care for people living with dementia (Ankers et al., 2023). A qualitative methodological approach was most suitable for this study due to its ability to provide in-depth insights regarding the experiences of participants in relation to the transition from hospital to long-term care, the problems and challenges encountered during this transition, and the wider social and organisational factors that influenced the transitional care process.

Core components of a research paradigm

For any research project, a researcher should identify, consciously or subconsciously, the four key philosophical elements of a research paradigm (Bryman, 2016) as follows:

Ontology: Study of reality and being

This involves the question of 'what is the nature of the reality we are researching?' Ontology is concerned with whether there is one single, objective reality or multiple, socially constructed realities.

Epistemology: Study of knowledge

Epistemology is the theory of knowledge and deals with how knowledge is gathered and from which sources. In research terms, the researcher's view of the world and of knowledge strongly influences their interpretation of data; therefore, their philosophical standpoint should be made clear from the beginning (Gray, 2014).

Methodology: Strategy and plan of action

This includes asking questions about 'What are the different ways to carry out this research?' The methodology is a systematic way to investigate a phenomenon

based upon an investigation's assumptions regarding its ontology and epistemology.

Axiology: Study of ethics and values in research

This includes asking questions like, 'What values/ethics does the researcher hold?' 'How do the researcher's values/biases affect the research process?' 'How are the findings interpreted?' Axiology is the study of how the researcher's values and biases affect the research process and the results of the study.

Methodological intention

The objective of this study was to understand how care home providers experienced the transitional care process for people living with dementia transitioning from an acute hospital environment into a long-term care home. To achieve this, I asked care home providers to describe their roles and experiences in relation to transitional care for residents. Based on the objectives of the study, I identified the interpretivist paradigm as appropriate because it was consistent with the epistemological and ontological assumptions underpinning the research. Specifically, these assumptions recognise that individuals develop their own understandings of reality and that knowledge is generated, developed and continually modified through dialogue, communication and the negotiation of meaning with others (Ankers et al., 2023). The interpretivist paradigm enabled me to gain insight into the experiences of care home providers in relation to transitional care and to explore these experiences through qualitative methods, including interviews. The interpretivist perspective also supported a methodological approach that enabled me to identify patterns, meanings and relationships within participants' accounts and to interpret these in relation to the broader transitional-care context.

Data collection and analysis

Qualitative data collection techniques were employed for this study. Semi-structured interviews were used to collect qualitative data from participants involved in the provision of long-term care. Semi-structured interviews permitted participants to provide rich and detailed descriptions of their experiences and perspectives concerning their involvement in the transitional-care process, thus enabling an understanding of the complexity of participants' experiences. The use of semi-structured interviews provided sufficient structure to permit examination of all areas relevant to the research questions while allowing participants to introduce additional topics or experiences they considered pertinent to their involvement in the transitional-care process. This flexibility allowed the discussion during each interview to evolve according to the participant's experiences while remaining focused on the transitional-care process.

The semi-structured interview data were analysed using situational analysis. Initial coding was undertaken to identify and organise significant elements within the collected interview data. Memoing and iterative comparisons of the interview data with documentary materials and situational maps supported the development and refinement of the analysis. Memoing and iterative comparison of the collected data, documentary materials and situational maps informed the development and refinement of the four mapping strategies used in situational analysis: situational maps, relational maps, social worlds/arenas maps and positional maps (Clarke et al., 2018). Therefore, the analysis moved beyond identifying common themes in participants' accounts of transitional care and examined the relationships among the human, nonhuman, organisational and discursive components that comprised the transitional-care situation

Initial discussion of appropriate methodologies for this paradigm

Phenomenology was initially considered because of its emphasis on lived experience and the creation of meaning, which is consistent with the interpretivist orientation of this research. However, phenomenological methodologies differ in

the way they treat researcher pre-understanding and the degree to which context plays a role. The emphasis of this study moved beyond the subjective experience of individual care home providers towards the relational, organisational and material configurations of transitional care. Therefore, a phenomenological methodology would have provided insufficient insight into the many distributed and heterogeneous influences affecting individuals during transitions into long-term care.

Grounded theory was also evaluated for this project because it offers a systematic procedure for developing concepts and theoretical explanations from empirical data (Glaser and Strauss, 1967; Charmaz, 2014; Clarke, 2005). Grounded theory's focus on iterative theory generation through systematic coding was relevant to developing an understanding of participants' perspectives of the transitional-care process. However, the different forms of grounded theory, ranging from classical objectivist to constructivist approaches, raised epistemological considerations. Additionally, the primary focus of grounded theory on social processes and the development of categories did not fully account for the numerous human, nonhuman and discursive elements that formed the core of this study.

Discourse analysis was also reviewed because of its capacity to examine how language, professional discourse and policy narratives shape meanings and guide actions (Potter and Wetherell, 1987; Fairclough, 2013). Although discourse analysis offered a useful means of examining the discursively constructed aspects of transitional care, it did not provide the most comprehensive framework for analysing how discursive components interact with the material, organisational and relational components of transitional-care situations.

After evaluating these approaches, I concluded that actor-network theory (ANT) provided a potentially appropriate theoretical and analytical lens for this study because it provides a relational approach to examining complex networks consisting of human and nonhuman actors, together with other material and spatial elements (Law, 1992; Latour, 2005). These elements included care home staff, residents, documentation, policies, equipment, time and space. Unlike phenomenology, ANT does not separate individual experiences from the wider configuration of practice. Unlike conventional grounded theory, ANT does not seek

to reduce the complexity of a situation to categories of basic social processes. In contrast to approaches focused primarily on discourse, ANT enables discursive, material and organisational elements to be examined together within a relational analysis.

To strengthen my analytical approach, I chose to integrate situational analysis (SA), an extension of grounded theory (Clarke, 2005; Clarke, Friese and Washburn, 2018), into my methodology. Situational analysis allowed me to shift my analytical attention away from individual actions towards the broader situation as the unit of analysis. Furthermore, situational analysis directly addresses human, nonhuman and discursive elements and their relationships. Situational analysis also provides mapping strategies for identifying and examining the diverse elements that constitute a situation. Clarke, Friese and Washburn (2018) describe four mapping strategies: situational maps, relational maps, social worlds/arenas maps and positional maps. I employed all four mapping strategies in this study to examine different facets of transitional care.

Therefore, combining the principles of ANT with the mapping strategies of SA provided a coherent approach for examining the complexity of transitional care. SA enabled me to map and analytically examine the situation in relation to its human, nonhuman, organisational and discursive elements. The ANT theoretical lens provided a complementary means of examining the relationships among these elements. Together, these approaches enabled me to investigate the experiences and interpretations of transitional care described by care home providers within the wider relational, organisational and material configurations involved in transitions into long-term care for people living with dementia.

Why use situational analysis approach?

A primary assumption of situational analysis is that situations are constituted by multiple heterogeneous elements, including human and nonhuman actors, discourses, organisational arrangements and other material and symbolic elements. For instance, documents such as discharge care plans can limit and

define how people interact with one another in health and social care settings. Therefore, from an actor-network perspective, it is reasonable to view human and nonhuman actors as relational.

Glaser and Strauss (1967) first developed grounded theory as a methodological strategy for developing theory based on qualitatively analysed data. An emphasis was placed on identifying patterns of social action and developing conceptual and categorical frameworks rooted in the data. Strauss and Corbin (1991) and later Charmaz (2006) built upon Glaser & Strauss' work by introducing alternative methods of coding and developing theory, including constructionism and more systematic forms of interpretation of grounded theory. Clarke (2005) then developed situational analysis as a means of extending grounded theory but expanded the scope of analysis from merely basic social processes and human action to include the situation as a whole and the relationships between all of the human, nonhuman, and discursively active elements.

Situational analysis was chosen in order to be able to identify how transitional care is a socially constructed transition that occurs as a result of interaction among many types of human (healthcare provider), organisational (acute and community health organisations), policy (legislation) and documentary (written documents) and material elements such as equipment and the physical environment. The responsibility of providing support to individuals with dementia while transitioning from one setting of care to another (e.g., acute hospital to long-term care) is shared by various healthcare providers, organisations and services. Therefore, situational analysis provided an effective methodology for identifying how all of these various components interact and contribute to the transitional experience as opposed to limiting the analysis to the behaviours or actions of the individual participants.

In addition to the original work of Clarke (2005), the second edition of *Situational Analysis: Grounded Theory After The interpretative turn* (Clarke et al., 2018) further advanced this methodology. As Clarke et al. (2018) stated, situational analysis can be utilised independently to analyse and interpret situations. Additionally, situational analysis can be utilised along with other theoretical approaches or analytical strategies as long as they add some additional

understanding of certain aspects of a situation. As stated above, Clarke et al. (2018) indicated several theoretical approaches such as theories of assemblages, rhizomes, actor networks, and scapes could be complementary to situational analysis. Therefore, using actor network theory (ANT) in combination with situational analysis will allow for a supplementary way of examining the relationships between human and nonhuman actors within the transitional care situation.

As noted by Clarke et al. (2018), situational analysis differs from traditional grounded theory analysis by changing the analytic focus from creating categories and developing theoretical explanations of basic social processes to creating maps of the larger situation. However, situational analysis also utilises coding. Descriptive or topical coding (Saldaña, 2016) can be utilised to extract relevant situational elements from your data for situational mapping based on extracting elements that are important to the situation (Clarke et al., 2018). I used coding to organise relevant situational elements extracted from data and memoing and situational mapping to examine the relationships and integration between elements extracted from data in relation to the larger transitional care situation.

Four complementary mapping techniques are utilised in situational analysis: situational maps of key elements; relational maps of relationships between these elements; maps of social worlds and their arenas of commitment; and positional maps that illustrate positions taken/not taken on critical issues within a situation (Clarke et al., 2018). These mapping techniques enabled me to take my analysis beyond just identifying individual behaviours and actions and examine how the human, nonhuman and discursive elements involved in transitional care relate to each other. Coding, memoing and situational mapping enabled an iterative analytical process where situational elements and their relations were identified, examined and refined. This type of analytical process enabled me to comprehensively analyse the transitional care situation and its complex/diverse nature, inclusive of relations between human/nonhuman/discursive elements (Clarke et al., 2018).

Research examples of using situational analysis in the UK.

'Mapping the Information-Coping Trajectory of Young People Coping with Long Term Illness: An Evidence-Based Approach.' Sen and Spring (2013) used situational analysis to identify how young people cope with long-term health conditions. The researchers employed situational mapping to identify the significant elements of the situation, including both human (young people) and nonhuman (illness) components. The researchers also employed social worlds/arenas and positional maps to comprehend the intricate relationships and discourses of the situation.

A study conducted at King's College London, 'Social Care Workforce Wellbeing During the COVID-19 Pandemic', investigated the experiences of health and social care workers in the United Kingdom during the pandemic using analytical methods aligned with a situational approach. The study concentrated on the wellbeing, burnout, and coping strategies of the staff, and mapped the interrelated factors, such as increased workload, limited resources, and ethical dilemmas, which created a challenging work situation.

'Situating support for people living with rarer forms of dementia', was a recent article by Sullivan et al. (2023), which used situational analysis as an opportunity to problematise how 'things came to be' (Clarke, 2005) for people living with a rare dementia who are positioned within broader and complex social environments.

Several studies of UK public policy and system dynamics employ analytical frameworks that are consistent with the premises of situational analysis although do not name it as their methodology. The UK government published a technical report in December 2022 on "*using data for 'situational awareness' during the COVID-19 pandemic*", written by the UK's Chief Medical Officers, Government Chief Scientific Adviser, UK Deputy CMOs who were involved in the pandemic response, and the CEO of the UK Health Security Agency.

Why is situational analysis relevant to social care in the UK?

Situational analysis assists social care researchers in exploring the numerous interdependent components that contribute to the complexity of a situation.

Situational analysis considers the narratives, discussions and discourses surrounding an issue, including how particular discourses may support, constrain or shape the perspectives of individuals and groups within a social care setting. It also explores the relationships and interactions between the people, organisations and other elements involved in the situation. Situational analysis is therefore useful for examining how different perspectives are expressed, supported or marginalised within a social care context. This is achieved through the development of maps that assist in organising the analysis of the various elements within a situation and visually representing social worlds and arenas, relationships, positions taken and not taken, and areas of disagreement or contention. Because situational analysis extends grounded theory while broadening the focus of analysis to the situation as a whole, it provides a useful approach for social care research where experiences and outcomes are shaped by interactions among individuals, organisations, policies, documentation, technologies and wider social and organisational processes.

Four mapping strategies of situational analysis

Clarke, Friese and Washburn (2018) describe situational analysis as involving four main mapping strategies—situational maps, relational maps, social worlds/arenas maps and positional maps—together with memoing to document and develop the analysis.

The first mapping strategy of situational analysis ‘situational maps’ entails the identification of key players in the particular area of inquiry in a random and disorganised manner, including both inanimate objects and people contributing to the situation under examination, discursive elements in the situation and analysis of the relations among them. For this study, the perspectives of social care providers were examined, identifying the primary human and nonhuman actors in the network involved in the transition of people with dementia to long-term care, including consideration of the relationships between the individuals, other people or objects, through an extension of relational mapping to classify all the actors identified.

The second mapping strategy, the relational map, builds on the situational map by examining the relationships among the elements identified within the situation. Rather than simply identifying human and nonhuman actors, relational mapping considers how these elements are connected and how particular relationships may shape or influence the situation under investigation (Clarke, Friese and Washburn, 2018). In this study, relational mapping was used to examine the relationships among care providers, hospitals, social workers, families, assessment processes, documentation, policies, technologies and other elements involved in the transition of people with dementia into long-term care.

The third mapping strategy, the social worlds/arenas map, examines the collective actors, organisations and institutional worlds involved in the situation and the arenas in which they interact and negotiate. This provides a meso-level perspective on the structures, processes and organisational relationships shaping the situation (Clarke, Friese and Washburn, 2018). In this study, the social worlds/arenas map was used to examine the organisations, professional groups and institutional structures involved in transitions into long-term care and how these shaped the experiences of people living with dementia and those providing their care.

The fourth and final mapping strategy of situational analysis, positional mapping, examines the discourses within the situation that shape and define reality, drawing on sources such as ethnographic observations, interview transcripts and extant discursive materials, including websites, documents and other historical and visual materials. Positional maps make visible the range of positions taken and not taken within the situation, including areas of agreement, disagreement and contention (Clarke et al., 2018). All maps are continually produced and modified throughout the research process, supporting theorising that captures the multiplicity and complexity of social life and takes into account the human, nonhuman and discursive elements of the situation (Clarke et al., 2018). The primary function of the maps is to provide what Park (1952) referred to as “the big picture” of the situation being analysed. Together, the four mapping strategies provided complementary perspectives on the research situation, although they were not necessarily used with equal intensity or given equal prominence in the final analysis.

Actor-network theory with Situational Analysis

ANT appeared relatively uncommon within the care home literature reviewed for this study. The limited use of ANT in this type of environment provides an opportunity to examine transitional care from a viewpoint that emphasises the relationships between human and nonhuman elements from the perspectives of care home managers.

ANT has gained popularity primarily in the fields of information systems and technology and healthcare technology. ANT has been utilised to analyse how technologies and material elements shape social processes. For example, Cresswell, Worth and Sheikh (2010) discuss the application of ANT to healthcare information technology and how ANT can be used to examine the relationships between technological and social elements.

However, there has been some concern regarding the practical implementation of generalised symmetry in ANT and its ability to treat human and nonhuman elements without presuming that human actors are always more influential. In addition to generalised symmetry, ANT has been criticised for providing limited analytical tools for examining issues of power. Specifically, ANT has been criticised for providing limited scope for analysing structural inequalities and broader political contexts that may exist beyond the immediate network being studied. For example, care homes function at many different levels within health and social care systems, making it difficult to limit the analysis of power to only the immediate network being studied (Whittle and Spicer, 2008).

In addition to these two challenges, generalised symmetry and the treatment of power, another challenge lies in determining the scale and boundaries of the network under investigation. Since ANT involves analysing associations among heterogeneous elements, researchers need to determine which networks should be included and analysed. Furthermore, since ANT encourages researchers to follow associations as far as possible, decisions need to be made regarding when to stop tracing associations and which nonhuman elements should be included within the analysis. Cresswell, Worth and Sheikh (2010) noted that pragmatic applications of ANT require researchers to remain focused upon their research

question and avoid becoming lost in excessive detail. In addition, since the researcher is an active participant in constructing an account of the network, the researcher's position, assumptions and analytical choices require considerable reflexivity.

Additionally, ANT has been criticised for its predominantly descriptive and relational orientation and for providing limited critical explanation of power and domination (Amsterdamska, 1990; Whittle and Spicer, 2008). While these criticisms do not render ANT unsuitable for use in this study, they do highlight the importance of using ANT both pragmatically and reflexively and examining how ANT can be used to complement other analytical approaches.

Although there are limitations associated with ANT, it provides a useful theoretical lens for understanding complexity within healthcare organisations and how material elements influence social processes (Cresswell et al., 2010). Moreover, ANT provides researchers with an opportunity to examine relationships between human and nonhuman elements without assuming that material objects are passive tools. Additionally, Latour (1999) stressed the importance of considering how objects shape human action. Therefore, ANT provided a useful means of examining how people, documentation, technologies, policies, organisational procedures and other elements became interconnected within transitional-care situations. Unlike conventional causal analysis, ANT enabled me to examine how transitional practices were assembled through associations among heterogeneous elements.

ANT was utilised in conjunction with Situational Analysis (SA) to strengthen the analytical approach of this study. Cresswell et al. (2010) suggested that ANT could provide a theoretically informed approach to sampling and data analysis. Clarke et al. (2018) identified actor-network theory as one of several theoretical approaches that can be used in combination with situational analysis to examine particular facets of a situation. In this study, SA provided the framework for mapping and examining the wider transitional-care situation, while ANT provided a complementary theoretical perspective through which the relationships and effects of human and nonhuman elements could be examined.

Therefore, the combination of ANT and SA provided a coherent approach for investigating the complexity of transitional care. SA allowed me to identify and map human, nonhuman, organisational and discursive elements within the transitional-care situation, while ANT supported my examination of the relationships and effects among these elements. Together, the two approaches enabled me to interpret care home managers' experiences and perceptions of their role in transitional care within the wider relational, organisational and material configurations involved in transitions into long-term care for people living with dementia.

Research design, methodology and key ethical issues

Research questions

The overarching research question addressed by this thesis is:

How do the interactions between human and nonhuman ‘actors’ contribute to social care providers’ roles and create the transitional care path for older people living with dementia transitioning to long-term care?

To answer this, the following research questions were identified:

1. What are the views of social care providers regarding the transitional-care process for older adults living with dementia entering long-term care?
2. What are the perceived barriers and facilitators to providing care for individuals with dementia during transitions into long-term care?
3. How can situational analysis increase understanding of the interactions among human, nonhuman, organisational and discursive elements involved in transitions into long-term care?

I planned to begin interviewing participants in January 2024. However, before contacting prospective participants, it was essential that I developed a set of questions designed to gather care home providers' perspectives on the transitional care process and the barriers and facilitators contained within it (Appendix 1). To achieve this required in-depth engagement with situational analysis (SA), specifically an understanding of the purposes and analytical capabilities of its four mapping strategies. I recognised that if I did not understand how the mapping process functioned and what data it required, my ability to collect interview data that could be used within the analytical framework would be limited.

My primary concern initially was to understand how situational maps were developed. I reviewed the individual headings in Clarke's situational map to determine their applicability to my situation of inquiry. I also discovered that 'memoing', or writing analytical notes, was a vital aspect of the SA process and supported both theoretical clarity and self-reflexivity. Memoing was an important component of my planning because it aided my understanding of the maps, assisted me in anticipating the types of data required, and facilitated critical reflection on my own assumptions. Importantly, memoing allowed my assumptions to be made explicit throughout the research process and supported a reflexive approach to the development of my interpretations.

Situational mapping provided the initial analytical starting point for this study. Its aim is to describe the human and nonhuman elements within the situation of inquiry. Guiding questions for this process include: Who and what comprise the situation? Who and what else may be relevant? What elements may have an effect? As additional data are collected, the situational map can be revisited and refined repeatedly. Under each of Clarke's categories, I brainstormed potential human actors and nonhuman elements relevant to transitional care, producing my initial 'messy' situational map (see Figure 3). After establishing my situational map, I began conducting relational analyses, in which each element was considered in relation to the others. Relational mapping directs attention towards the nature, direction and significance of relationships between the various elements rather than focusing only on the elements themselves. This process influenced the design of the interview guide and generated additional analytical enquiries. For

example, I considered whether presenting a simplified relational map to participants could assist discussion; however, I determined that doing so could potentially influence their responses. I therefore continued to analyse the data as soon as possible after each interview and applied emerging insights from these analyses to the maps, allowing the maps to provide a developing visual representation of the data. Engaging systematically with Clarke's categories also highlighted the importance of discourses within the situation. As Clarke et al. (2018) point out, discourses extend beyond language to include visual, symbolic, material and organisational forms. They produce and express the social worlds that create them.

For this study, the support and needs assessment (SANA) document emerged as an important form of extant discourse material. Atkinson and Coffey (1996) indicate that organisational documents illustrate how organisations elect to present themselves and their practices, making document analysis applicable to understanding how transitional information is developed and disseminated. Prior (1997) similarly suggests that qualitative analysis should focus on the creation and structure of thematic discourses rather than merely their surface-level meanings. This perspective influenced my consideration of the origin, purpose and implications of the SANA documentation.

The study drew on multiple sources of data, including interview data from participants and documentary material. I consequently had to decide whether to adopt an integrated or comparative mapping method. I preferred an integrated mapping method, which analysed the different sources of data together, for two reasons. First, it represented the interconnectedness of transitional care; second, it was consistent with my interpretivist paradigm. This approach allowed me to create maps representing the whole field of data and therefore maintain its complexity rather than separating it into artificial areas.

At this stage, I recognised that situational analysis and actor-network theory were methodologically compatible. Both approaches emphasise relational interactions among heterogeneous elements, including human and nonhuman elements, and move away from simplistic, linear explanations of social events. ANT's emphasis on translation, mediation and distributed agency expanded my analysis of how

documents, policies, technologies and organisational procedures shaped transitional care, whereas SA allowed me to display these relationships graphically and conceptually. During the period of fieldwork, guiding questions such as *Who and what are in the situation? Who and what else may be relevant? What differences do certain elements make?* reinforced the compatibility between SA and ANT.

After piloting my interview guide with a care manager, I discovered that many of the questions I had developed were too open-ended to provide sufficient detail for the types of data I wanted to analyse at the desired level. I specifically found that an open-ended question such as, 'What were some delays or problems you experienced during the transition?' provided little detail about specific system-wide issues that affected the participant's ability to achieve a successful transition, including provider communication issues and organisational barriers to service delivery. Following the pilot interview, I revised the interview guide to meet my analytical goals of examining care providers' perspectives.

The overarching objective of the interviews was to examine care home managers' accounts of transitional care for older individuals living with dementia who were transitioning to long-term care. The study drew on the narratives of workers in residential care settings, which can include professional stories describing the complexities of the assessment process and the social interactions involved in it (Riessman and Quinney, 2005). Through situational analysis, these accounts were analysed in conjunction with documentary material to elucidate how human decision-making and material infrastructures combined to shape transitional outcomes.

The interpretivist orientation of this study recognises that knowledge is jointly constructed through the interaction between the researcher and participant and acknowledges that my own positionality affects the research. Rather than considering researcher subjectivity as a form of bias to be eliminated, the interpretivist paradigm recognises the importance of the researcher's interpretation and reflexivity in developing an understanding of participants' experiences (Creswell, 2013; Lincoln and Guba, 1985). This investigation therefore relied on

my presence, interpretation and analytical decisions in developing and finalising the analytical process.

Finally, the development of the interview questions, the iterative creation of the situational and relational maps, and the incorporation of actor-network theory supported a research approach that was appropriate for examining the complex, layered and material mediation of transitional care. This approach enabled me to investigate not only the perspectives of care home providers but also the wider sociomaterial arrangements involved in transitions for older individuals living with dementia.

Ethical Considerations

This section begins by outlining the ethical considerations, followed by the purposeful sampling strategy. Ethics Research refers to the application of ethical principles to all research activity. It encompasses the research design and its implementation, treatment of others and the use of resources and research outputs. The General University Ethics Panel approved the research project. The research was conducted based upon the principles of the Code of Good Research Practice (University of Stirling, 2009) and the School of Applied Social Science Ethics Handbook (2010). Furthermore, the research followed the guidelines of the Economic and Social Research Council Framework for Research Ethics (Stanley and Wise, 2010). Some key aspects of the code include accuracy, non-maleficence, respect, autonomy, efficiency, beneficence, honesty, objectivity, fairness, and justice. Practising ethically depends upon using reflection as a core component. Care home managers use reflection to keep an ethical focus in their practice. Reflection is the act of thinking about actions before acting. Reflection is, however, also the "process of looking back at decisions and actions, considering the related thoughts and feelings and evaluating the consequences of actions" (Payne, 2002, p.124). All participants in this study were adults who were fully informed of the purpose and scope of the project before agreeing to participate. This investigation relied on my presence, interpretation and analytical decisions in developing and finalising the analytical process. The information sheet provided an

opportunity for each participant to ask questions about the study and included the following information. In addition to providing an explanation of confidentiality, I provided a brief overview of the project, an outline of what they were going to have to do in order to participate in the study, and a statement indicating their involvement was entirely voluntary, and they could withdraw from the study with no consequences at any time. I also listed my name and contact number, as well as the details regarding how participants' personally identifiable information (PII) would be protected, along with who to contact for further information on data protection.

Sampling strategy / access to participants

Since my research questions were centred around transitional care for older adults living with dementia transitioning from an acute hospital setting into long-term care and the perceptions of care home providers involved in this process, the sampling strategy was initially deliberately targeted towards this professional group. I did not initially consider including other stakeholder groups, such as older adults living with dementia, family members or informal carers, since the intent of the study was to gain insight, in care providers' own words, into the experiences, challenges and insights arising from their specific roles in the transitional-care process. A review of previous scholarship supported this focus: while considerable research has examined the views of older adults with dementia, carers and hospital-based professionals, less research has focused specifically on the perceptions of long-term care providers themselves.

I therefore used a purposeful sampling approach to ensure that participants had direct, relevant and practice-based experience of transitional care. The participants came from a variety of local authorities. This was an intentional methodological choice to capture diversity in organisational structures, local policy environments and everyday working practices and thus reflect different experiences of transitional care for older adults with dementia.

As recruitment progressed, however, I became increasingly aware that restricting the sample to care home managers would provide only a partial view of transitional care. Through ongoing reflection on the developing research and consideration of the wider system within which transitions occur, it became apparent that the experiences of professionals involved in assessing, commissioning and arranging placements were also relevant to understanding the relationships and processes that shape transitional care. I therefore broadened the sampling strategy to include participants whose professional roles provided perspectives from elsewhere within the transitional-care system. This development was consistent with the interpretivist and situated approach adopted in the study, in which understanding is considered in relation to the social and organisational context in which practices occur.

The final sample comprised seven participants. Five were care home managers, while the remaining two participants were a Trusted Assessor/care consultant and a commissioning manager for older adults. The inclusion of these additional participants provided perspectives beyond the care home setting and offered insight into the assessment, commissioning and organisational processes that form part of the wider transitional-care system. Their perspectives complemented those of the care home managers and enabled me to consider transitional care from both the care-provider and wider system-level perspectives. There is no established guideline for determining sample size in qualitative research. Qualitative studies commonly involve relatively small samples, with some methodological literature reporting between one and 30 participants (Fridlund and Hildingh, 2000), while smaller studies have suggested using between six and ten interviewees. The qualitative approach to research indicates that researchers are responsible for identifying an appropriate sample size based on the information required for the research project (Patton, 2002). The central consideration was therefore whether the sample was sufficient to enable me to address the research questions in appropriate depth.

For this study, I considered that a minimum of six participants would provide sufficient variation in professional experience while allowing me to engage deeply and reflexively with each participant's account. This decision reflected the

analytical objectives of the study: to examine participants' individual experiences and interpretations while also identifying relationships, similarities and differences across accounts. The eventual recruitment of seven participants provided an additional insight beyond the minimum anticipated sample and incorporated both care home and wider system-level perspectives. The range of professional experience represented within the sample also contributed to a richer understanding of the practices, relationships and decision-making processes involved in transitional care.

The decision regarding sample size was therefore not based solely on achieving a predetermined numerical target. Rather, it reflected the scope of the study, the accessibility of participants, the depth of the interviews and the requirements of the situational analysis. The sample was considered sufficient when it provided a range of relevant professional perspectives from individuals with direct experience of the transitional-care process and enabled the situational analysis to examine the relationships among the different elements involved in the transition.

Participant recruitment

Participant recruitment was more difficult than I anticipated. While I thought I had a promising idea of who the most relevant participants would be, gaining access to them required considerable time and multiple strategies. First, as a member of a local care association, I posted a request for research participants via the association's website, along with a written document detailing the purpose, scope, and ethics of the study. Those interested were encouraged to contact me directly, allowing for a more detailed discussion about their participation. To expand the recruitment options beyond this formal route, I contacted various professional colleagues with connections to care home managers and asked if they would be willing to disseminate my research poster during their training sessions. Additionally, I requested that several well-connected colleagues help circulate information about the study within their professional circles. While these methods were dependent upon personal and professional relationships, they were congruent with the relational and socially situated commitment to interpretivism,

which recognises that knowledge is produced through relations and is situated within social worlds (Braun and Clarke, 2013; Bukamal, 2022). If these methods failed to yield results, I was prepared to personally contact care home managers via email; however, I recognised that contacting them would be time-consuming and was likely to result in minimal response.

As I continued to reflect on the developing shape of the research and through ongoing discussions with supervisors, colleagues, friends, and family, it was increasingly apparent that limiting myself to care home managers would only produce a partial view of transitional care. From an interpretivist perspective, to explore the situated meanings that participants assign to their practices requires consideration of the larger ecological system of agencies involved in transitions. The shift in reflexivity led me to search for perspectives from the local council's capital depletion team, which manages the changeover from private paying to public funding for residents once their income falls below the public funding threshold. The local authority will no longer fund all of the fees that the resident had been receiving, and thus the care home manager may have difficulty providing care at the lower fee rate, potentially resulting in the need to relocate the resident. This process, referred to as brokerage and capital depletion, is commonly completed with little or no input from the residents, families, or social workers.

These issues challenge normative expectations of person-centred practice and illustrate the structural constraints that influence transitional care for older adults with dementia. In response, I modified one of my interview questions to ask more clearly whether participants had seen person-centred approaches during transitions. This adaptation illustrates what Clarke et al. (2018) describe as the iterative and emergent characteristics of qualitative inquiry, where the researcher responds to the 'messy realities' of the field. As an interpretivist researcher, responding to the development of meaning is key, and it was clear that transitional care could not be understood without examining how administrative and financial systems affect the lived experience of individuals. Follow-up attempts were made to recruit both the brokerage team and capital depletion team, whose roles are crucial in determining relocation and facilitating communication among agencies. Participant engagement with these teams was slow, and highly unpredictable, an experience common in qualitative research that involves busy practitioners. I

remained committed to recruiting a minimum of six participants to obtain a sufficiently rich and multi-perspective dataset. The slow-paced, relationally constructed process of recruitment was reflective of the interpretivist emphasis on meaning-making, context, and the co-creation of knowledge. In addition, the challenges faced during the recruitment phase of the study provided valuable analytical insights into structural barriers, agency limitations, and various levels of visibility among agencies providing transitional care for older adults with dementia.

Participant selection

The participants were selected using purposeful sampling, as the study sought insight from professionals with direct knowledge and experience of transitions for people living with dementia into long-term care. Participants were therefore selected according to their professional roles within the transitional care process, including assessment, discharge planning, admission, care coordination and the provision of long-term care. Although this method of recruiting participants was a practical one for identifying them, it reflects the epistemology of the study. Individuals' perceptions of transitional care are contingent upon their positioning within the larger care system.

I therefore sought to include participants occupying different positions across the transitional care process, enabling the study to bring together perspectives from those involved in assessments, coordination, organisation and delivery of care. This shaped the knowledge generated by the study, while also recognising that the findings reflect the experiences and perspectives of professionals directly involved in organising and delivering transitional care.

There were also elements of convenience sampling involved in the study as participants' availability, organisation access and willing participation influenced recruitment. A participant's relevance to the research question and experiences with transitional care practices, however, remained the primary criteria for inclusion. It was not the intent to gain statistically representative data but instead

to gather rich, detailed accounts that would support in-depth qualitative analysis. This approach is consistent with the studies' interpretivist orientation and the use of situational analysis to provide analytic depth rather than breadth.

Reflection and positionality

Recruitment, in itself, allowed me to reflect on my dual positioning as both a care home provider and as an independent researcher. The importance of assuring participants that I would be examining the transition care experiences of older adults with dementia from their own viewpoints and not judging or evaluating the operational practices of organisations was essential in establishing trust and participant perceptions of psychological safety, which are foundational elements of an interpretivist paradigm, whereby the co-construction of meaning is shaped through the relationships between the researcher and participants and the participants' perceptions of the researcher's position. Therefore, creating a safe space for participants to feel comfortable and willing to speak candidly was a major methodological concern.

My professional background allowed me to be what Langellier and Peterson (2004) described as someone able to 'problematise' the situated practices of the participants, to demonstrate the importance of critically assessing context-dependent narrative practices to understand how individuals construct meaning through storytelling. As the researcher, I was able to assume the 'insider position', which would allow me to understand the depth of complexity behind straightforward statements or sector-related terminology. Terms such as 'best value search', 'MCA best interest', 'DoLS assessment' or 'behaviours that challenge' may seem procedural; however, they relate to complex assessment frameworks, legal processes, and behaviour support strategies that require expertise, judgment, and what Hochschild (1983) coined as emotional labour, the management and regulation of emotion to fulfil professional obligations. Emotional labour allowed me to actively listen for nuances, interpret what was implicitly stated, and to encourage participants to think more deeply during interviews. I had to be very self-conscious about the role I was playing. As Braun and Clarke (2013)

discuss, inside researchers have to remain aware of what their professional role and values add to how they make sense of participants' narratives and the types of questions they ask participants. For example, I had to reflect upon all the times I used my past experience in the care home field when interpreting participants' narratives or formulating questions for participants. Additionally, having time to write memos about my thoughts during the analysis phase, I was able to acknowledge my own interpretative enmeshment and make my methodology transparent (Finlay, 2002). I have also demonstrated that the researcher provides their own history, beliefs, and orientations to the knowledge-building process. Bukamal (2022, p.327) states that regardless of whether you are an outside or inside researcher, your position will influence your observations and interpretations. Therefore, according to interpretivism, researcher subjectivity is not necessarily a limitation, however you need to be aware of this and use it as a resource for creating knowledge by acknowledging it, examining it, and using it ethically and critically. My insider role in the care home sector was both a benefit and a burden to my ability to understand the participants' experiences, and therefore, I developed and employed several intentional methods to minimise the impact of my insider role on the data collected. To facilitate access to the study, and reduce potential barriers to participation, I offered the option to complete video interviews in lieu of meeting in person. This was done to allow participants to schedule interviews in a timely manner, accommodate unpredictable scheduling practices common among care home managers, and to create a sense of agency for participants.

Ethical standards were consistently maintained throughout the research, with participants providing written informed consent and being assured of confidentiality, anonymity and their right to withdraw from the study at any time. These measures, aligned with interpretivist ethics, supported the relational trust needed to elicit authentic, experience-based narratives from participants.

Based on my discussions with my academic supervisors, I employed an adaptive sampling approach, which consisted of reviewing the emergent data following each interview to assess whether additional perspectives were required. This iterative strategy is consistent with the principles of interpretivism, specifically,

depth, sufficiency, and meaning-making over verbal representation. This strategy enabled me to collect perspectives from both parties to the relational process of transitioning individuals to long-term care, thus ensuring that I was collecting data that would enable a comprehensive and situational understanding of the factors that contribute to the care of individuals with dementia during transitional periods. Although the study has direct relevance to the care sector, I experienced limited enthusiasm for the study from some care home providers. In addition to the limited body of transition-based research in care homes outlined in my literature review, I believe that the extreme pressure experienced by care home managers was evident in their reaction to my initial request for study participation. The large volume of daily operational demands faced by care home managers, including investigating and responding to allegations of abuse, providing adequate staffing levels, coordinating among several disciplines, responding to emergency situations requiring immediate medical attention, ensuring compliance with environmental regulations, and meeting regulatory standards, can have significant effects on the lives of care home managers. Similarly, the substantial number of daily operational demands limited the opportunities for research in care homes. Understanding the limitations associated with the operational demands faced by care home managers, in relation to the potential for conducting research in care homes, is essential when utilising an interpretive methodology, as these limitations illustrate the larger contextual environment in which practice takes place, limit the voice of those practising in the field, and limit opportunities for reflective engagement in care homes.

Although recruitment was open from January 2024 through to October 2024, I identified a total of seven participants for the study. Of those taking part in this study, five of the seven participants were managers of homes providing residential care across the South West region of England. Although I had hoped to recruit participants from other geographic areas of the region (e.g., Somerset, Wiltshire, Gloucestershire, Devon, and Cornwall), the participants provided a meaningful cross-section of care home providers involved in the transitional care of people with dementia. The remaining two participants, a Commissioning Manager for Older Adults and a Trusted Assessor provided complementary perspectives that offered insight into the organisational, procedural and interagency aspects of

transitional care. Collecting these perspectives was critical to map the relationship between the parties that manage placements and those that receive them, which represents the core relationship in the transitional care system being researched in this thesis.

The characteristics of the participants are described in more detail in Table 3.

Table 3 – List of Participants

List of Participants	Location	Details
Participant 1 (P1)	East Dorset	Registered Manager of small-size care home
Participant 2 (P2)	South Dorset	Registered Manager of small-size care home
Participant 3 (P3)	West Hampshire	Registered Manager of large-size care home
Participant 4 (P4)	West Sussex	Registered Manager of small-size care home
Participant 5 (P5)	East Sussex	Registered Manager of medium-size care home
Participant 6 (P6)	North Dorset	Trusted Assessor / Care Consultant
Participant 7 (P7)	South West	Commissioning Manager – Local Council

Characteristics of the participant sample

This research included a range of professional personnel who directly engaged in admitting individuals with dementia to long-term care. The array of participants included care home managers; health and social care practitioners, and individuals who assess and place individuals with dementia. As such, all participants have significant practical experience of providing support for transitional care, and each has contributed their perspectives at various stages of the transitional care pathway.

All care homes that participated in this research represent a cross-section of long-term care environments. Four care homes offered residential placements, and the CQC rated them all as "Good." A fifth organisation had received an outstanding rating and offered both residential placements and nursing placements. Each of these organisations supports transitions for many people with dementia as part of their usual activities and, as such, has considerable experience in transitional-care practices. The difference in participant selection is relevant, as the type of registered nursing care available may influence how care home managers

determine clinical complexity and respond to risk factors associated with care transitions and communicate resident-related information to health professionals during transitions. This project did not intend to investigate or compare residential and nursing home environments. Thus, my analysis of data from participants working in all of these types of settings together was made deliberately (this was part of taking an organisational and relational process approach to studying transitions). Therefore, I was able to understand transition as a connected process rather than as a series of separate entities. The amount of time participants had been employed in their respective professions varied significantly. Some participants reported only a few years, while others reported employment periods of many decades. The variety in employment periods allowed me to collect a rich array of transitional care practices and decision-making processes across different professional settings.

Influence of participant characteristics on the findings

Firstly, all participants were experienced professionals working in long-term care and related services. This allowed me to gain considerable detail regarding organisational procedures, care coordination, assessment methods and professional decisions made during the transitional process; however, they may have also developed a level of familiarity with their organisation's existing arrangements and viewed the transitional issues in terms of their own professionalism.

Secondly, all of the care homes participating in this study received a "good" or "outstanding" rating from the CQC. These ratings did not determine whether or not each home was selected for this study. Rather, the ratings reflected the organisations from which participants were successfully recruited through the purposeful and relational recruitment strategies described above. Good and outstanding ratings reflect the CQC's assessment of governance, staffing and other aspects of service quality. Therefore, while the findings from this study will provide useful insight into how high-rated providers manage transitional challenges, they may not completely capture the experiences of other providers

who face greater problems in terms of their staff gaps, governance issues or other constraints related to regulatory requirements. Such providers are likely to experience transitional care differently than other providers and also will have more difficulty maintaining continuity of care both within the organisation and across relational boundaries.

Thirdly, the study focused largely on the views and experiences of transitional care professionals rather than on individuals living with dementia and their family members. Although this approach aligned with the aims of the study, it clearly shaped the type of experiences and challenges identified. Professionals frequently spoke about the organisational pressures and complexities surrounding communication processes, accountability, documentation and service coordination that corresponded directly with their role in transitional care systems.

Fourthly, using professional networks and organisational relationships to recruit participants may have resulted in some degree of self-selection bias. Transitional care advocates, service improvers, and dementia specialists are more likely to be interested in improving transitional care, which may have led them to participate in the study. In addition to creating rich data, a wider variety of perspectives may have emerged if a larger number of organisations had been included, particularly organisations experiencing greater operational difficulties. Despite these limitations, there was sufficient variability among participants' professional roles, organisational contexts and transitional care experiences to allow for the achievement of the primary aim of the study. Statistical generalisation was not an objective of the study; rather, the aim was to develop an in-depth appreciation of the relational, organisational and sociomaterial processes involved in transitioning individuals to long-term care. Thus, the breadth and depth of participants' experiences served as an appropriate base upon which to ground the analytical objectives of the research.

Development of interview schedules and consideration of alternative methods

Three semi-structured interview schedules were developed to reflect the differing roles, duties, and experiences of the participants in the transitional care system. Although each interview schedule covered the concept of transitioning to long-term care for individuals living with dementia, the specific questions asked in each interview schedule depended on where the participant was on the continuum of the transitional care system.

A literature review, documents related to transitional care and dementia services, and my own professional experience in long-term care provided direction for developing the interview schedules. Issues related to communication, continuity of care, assessment processes, discharge planning, information sharing, interagency collaboration, and person-centred care identified in the literature formed a common set of overarching topics that were discussed by all participant groups. Recognising that participants represented different professional positions within transitional care networks, separate interview schedules were developed to ensure that the questions were relevant to their professional roles and responsibilities. For example, care home staff had interview schedules focused on referral information, admissions processes, assessment documentation, family engagement, risk management and admission logistics. Staff at the organisational level had an interview schedule that included service coordination, commissioning, policy implementation, organisational relationships and decision-making processes. Each interview schedule contained questions specifically designed to reflect how transitional care is understood and enacted at different levels throughout the wider transitional care network. These schedules reflect the sociomaterial and situational analysis frameworks underlying this study. Developing interview schedules based on the role of the participant allowed diverse perspectives on transitional processes to emerge and acknowledged that different actors encounter different aspects of transitional care. Therefore, using role-specific interview schedules allowed for a deeper understanding of the organisational, relational and sociomaterial factors that influence the transition into long-term care.

My insider perspective as a practitioner working within long-term care also informed the development of the interview schedules. Through professional experience I recognised ongoing barriers to entry into long-term care (the quality of referral information, the role of assessment documentation, differing interpretations of client need and conflicts between organisational priorities and person-centred care). Clinical experience has shaped the areas of content explored in the interviews and ensured their relevance to participants' day-to-day practice. Throughout this research study, I practised reflexive awareness to ensure that clinical experience shaped but did not predetermine analytical results.

The semi-structured interviews generally lasted approximately 45-60 minutes. This provided sufficient time for participants to describe their experiences and perspectives in detail while maintaining a clear focus on the transitional-care process. The duration also allowed relevant issues raised by participants to be explored in greater depth, particularly where participants described organisationally driven limitations and other professional sensitive issues.

Alternatives to collecting data (focus groups) were considered. Focus groups can potentially generate insight into collectively held professional views and viewpoints on inter-professional interactions regarding transitional care practices. However, because participants came from organisations with varying amounts of responsibility and authority, discussion regarding funding, referrals, organisationally driven limitations etc. may have been professionally sensitive. Participants may have felt uncomfortable discussing their experiences openly with their peers in a group environment. Additionally, organising a group meeting across multiple organisations would create logistical problems with regard to scheduling, participation and maintaining confidentiality. Ultimately, individual interviews were chosen over focus groups as they provided a safe environment for participants to discuss their thoughts in detail without peer pressure or concern about being judged. Furthermore, participants chose their preferred site for conducting interviews which helped reduce the inequality in power dynamics between the interviewer and interviewee during the interviews. Observation was also considered as a potential complementary method. Observing referral, assessment, discharge and admission processes in practice might have provided

additional insight into interactions between human and nonhuman actors as they occurred in real time. However, the practical, ethical and access considerations associated with observing potentially sensitive transitional-care activities across different organisations, together with the study's focus on participants' accounts and interpretations, meant that observation was not pursued."

This methodology fits with the study's intent to collect situated accounts of the referral process that can be analysed using situational analysis (Clarke et al., 2018). Additionally, the ability of semi-structured interviews to adapt to participant direction in relation to aspects of the referral system that were meaningful or problematic, facilitated the collection of rich, contextually embedded data. Attempts to obtain perspectives from both the capital depletion and brokerage teams at the local authority failed too. Both teams are central decision-making bodies involved in determining how resources should be allocated to people requiring ongoing support to meet their long-term care needs, but neither team chose to take part in the research. Participation from the two departments may have provided greater insight into the referral and placement process.

The literature highlights a more general problem of a lack of transparency in the systemic processes that operate in transitional care pathways; the fact that the two teams did not choose to participate in the research illustrates this. Information flows between agencies can often be opaque. The failure to obtain successful engagement from both groups has been noted as a procedural limitation; however, their lack of engagement became analytically relevant in demonstrating how organisational silence, information gatekeeping and institutional absence can shape the research methodology. Clarke et al.'s (2018) definitions of silences are considered analytically significant because these silences represent the institutional practices and power dynamics that shape the lives of people who have dementia, carers and care providers.

The work of trusted assessors is reflective of a system-level attempt to address fragmentation, eliminate duplicate assessments, and improve transitions, all of which are commonly cited as obstacles to safe and individualised care for older adults with dementia. The presence of trusted assessors and the constraints affecting their practice influenced the availability of documentary data for this study

and represented part of the broader situational landscape that the analysis sought to map. Interviews with individuals representing different professional roles facilitated the identification of key collective actors involved in the transitional care situation. This finding supports Clarke et al.'s (2018) suggestion that the first step in a situational analysis should involve identifying and mapping the diverse actors (both human and nonhuman), the discourse that informs their actions and perceptions, and the organisations where they operate within the context of the situation being investigated. The external contextual data (i.e., health and social care regulations and publicly available information concerning long-term care resources) remained stable and provided a common reference point from which to interpret participants' descriptions based upon their experiences.

Exemplars of situational analysis research further guided this methodological approach. As Clarke et al. (2018) point out, situational analysis is fundamentally flexible, with the goal of establishing an analytic sensitivity to accommodate and engage 'messy' social worlds. Confidence in adapting the approach to suit the particularities of dementia care transitions was reinforced by an appreciation of the ways in which others had employed situational analysis. Rather than attempting to create order out of a complex system, the method permits complexity to become analytically productive. This is consistent with Clarke's (2018, p. 39) assertion that situational analysis asks, "not only what conditions exist within a situation, but how they appear and assert themselves in practice".

The mapping processes themselves (relational, social worlds/arena, and positional) were iterative and dialogical. Repeated visits to each map were required as additional interview data or documentary evidence arose, prompting reappraisal of previous interpretations. Clarke et al. (2018) emphasise that using an iterative visualisation technique to create the maps from the data allows researchers to reflectively engage with the data and utilise the data to examine the assumptions that have been developed during the research, recognise patterns or themes in the data that may evolve over time, and acknowledge aspects of the data that have not been previously acknowledged. In the current research, the maps were used as a means of representing the data; they also served as a stimulus for theory building and helped to illustrate how the actors interacted with one another, how certain issues were marginalised or ignored by institutions, and

how competing discourses operated in this particular context. The analytical memos developed throughout the research contributed positively to the overall rigour of the methods used. Memos provided spaces for reflection and theory development, acting as 'bridges' between raw data, visual mapping, and final analytical synthesis. In this manner, the mapping and memo-writing processes functioned synergistically to generate a nuanced and multi-dimensional understanding of the transitional care system, as well as the situated complexities experienced by older adults with dementia and those who support them.

Chapter 4: Data Analysis

In this chapter, the study presents the analysis of care provider perspectives of the transitional care process for people living with dementia transitioning out of hospitals or community-based settings to long-term care (LTC) homes.

In the context of this study, the LTC providers have a critical role within the larger organisational dynamics that shape the transitional care process. The situational analysis used participant interviews, analytical mapping, and memo writing to identify the elements (both human and nonhuman) that shape the transitional care process. Using these methodologies allowed the study to develop a comprehensive understanding of subjective experiences and shared realities of the transitional care process. Additionally, the methodology allowed the study to capture the patterned practices that constitute "the informants as collective actors in webs of social processes" (Öhman et al., 2023, p. 996), defining it as both a social world and a social arena (Clarke, 2005). The social world refers to the organisational arrangement of the LTC homes, the relational interactions between LTC providers, healthcare professionals, older adults living with dementia, and their families. The social arena encompasses those organisational forces and constraints that influence the transitional care experience of people living with dementia. The actors in this environment function in constantly changing and evolving social worlds and arenas (Clarke, 2005). Therefore, the social world and the arena in which these actors function can be viewed and analysed through the lens of situational analysis (Clarke, 2005) and will be discussed further on in this chapter. Data from the situational analysis showed that the transitional care process was affected at two levels: meso-level (organisationally) and macro-level (the broader healthcare and social care systems). In addition to providing additional context for the situational analysis, all data collected in this study were analysed via a common methodological approach; in other words, the interview data collected were analysed alongside documentary evidence that included policy documents, organisational protocols and guidelines, regulatory requirements, and patient admission processes. The approach used in the present study was based on a comparative and iterative evaluation of participants' reflections about their experiences and organisational documentation. This reflects Clarke et al. (2018),

who suggested that researchers could employ different forms and sources of data, including nonhuman data such as assessments, referral templates, and regulatory and legislative frameworks. While participants' accounts from interviews evolved iteratively as part of the process of developing the methodology, the external contextual data (i.e., legislation, regulation and public-facing LTC information) remained relatively stable, providing a structural framework through which to evaluate participants' accounts. Memo writing formed the initial stage of the analysis permitting the identification of emerging external conditions, structures, and social groupings influencing LTC providers' understandings of the transitional care process. Memo writing facilitated the organisation of perspectives, the formulation of questions regarding who, what, and how, and supported the identification of positions and discourses shaping LTC providers' perceptions of transitional care. Memos were a 'note to self', enabling observations and reflective moments to be recorded throughout the interviews.

The study will now turn to participant accounts to investigate how these contextual elements are lived, interpreted, and practised by participants. This chapter will include the interview data to determine how participants describe their experiences of transitional care and how their language, metaphors and framing demonstrate the social worlds and restrictions illustrated by the mapping of the situation. It should be noted that this shift does not signify a move away from situational analysis; rather, it represents a continuation of the approach, investigating the situated meanings, interactions and sense-making practices of participants within the transitional care process, while illustrating the abstract relations and positions represented in the maps that follow. The grounded-theory origins of situational analysis informed the use of constant comparison, supporting concurrent coding, interpretation and refinement of the analysis (Clarke, 2005).

The purposeful sampling strategy resulted in the participation of five registered care home managers (two of whom had a nursing background), one commissioner of adult social care, and one trusted assessor/care consultant. This sampled population represented those most deeply entrenched in the LTC referral and placement process. Fifteen open-ended interview questions assessed aspects of interagency working, the quality and quantity of referral information, organisational

decision-making, and the adaptability of care providers to meet the care needs of older adults living with dementia.

Participants described having significant levels of responsibility for business management, supervising staff and coordinating care for older adults living with dementia,

“We can’t afford to be more than a few beds down at any one time... for the business to remain financially viable” (P1).

“For instance, he was more complex than documented, but at that point, I didn’t have enough staff to take another person with those needs... there has to be a fine balance” (P3).

“Very few documents actually say what type of dementia someone has... you have to know the type of dementia to understand the complexities” (P4).

The above narratives provide a rich description of both the relational and organisational challenges of the transitional care process. Several participants acknowledged these challenges. Participant 2 illustrates the tension between adaptability and structural constraint by stating,

“Knowing the level of mental capacity would help us to gauge how we are going to approach the person and the assessment and whether we can meet their needs or not” (P2).

The initial open coding of participant accounts remained proximate to participants' language and captured the broadest range of issues they articulated. Through continuous comparison, the analysis advanced the elaboration of the key properties and dimensions of the most durable themes. Situational analysis (Clarke, 2005) was used to build upon the grounded-theory tradition through the integration of visual mapping techniques.

Although there were reservations about the necessity of using all four mapping techniques (situational maps, relational maps, social worlds/arena maps, and positional maps), further exploration of the methodology provided evidence that each map provided distinct analytic utility. Therefore, the study systematically used all four mapping strategies; this process proved analytically productive. Iterative work between maps and the data (interview transcripts, policies, procedures, and regulatory documentation) allowed the identification of relational patterns, tensions, contradictions, and influences that would not be captured through the analysis of participant accounts alone. The iterative mapping process continued until additional interviews were no longer generating substantially new insights relevant to the developing maps and analytical interpretation.

Analytical process

The analytical process utilised for this study involved a sequential, iterative and concurrent approach to data analysis, which is in line with Clarke's (2005) situational analysis approach. The analysis occurred simultaneously with data collection, with the first round of analysis taking place after each interview was conducted. This simultaneous data collection and analysis process allowed ideas, relationships, and interesting areas to emerge from the data, which then influenced the next round of interviews and the approach to the subsequent analyses.

Familiarisation with the data

After conducting each interview, I transcribed the audio recordings and reread them multiple times to help me gain an understanding of the themes that emerged from the interviews. After reviewing the transcriptions, I created reflexive field notes and analytic memos which included initial impressions of participant responses, aspects of their responses that seemed significant, areas where there appeared to be tension and contradiction, and my own assumptions from both a research and practice perspective. During this time, I focused on how participants

described transitioning to long-term care, the terminology used by them when discussing difficulties/responsibilities associated with care for individuals in transition, and their references to organisational processes, documentation, communication systems, and interpersonal relationships. Reading the transcriptions over and over again allowed me to identify themes and patterns that were emerging throughout the data, but also to focus on other, less identifiable issues, gaps, and contradictions that may have been present in the data.

Early coding

The first stage of manual coding took place. The coding was done on a segment-by-segment basis with each participant's words and descriptions used for labelling. The initial codes were very close to the participants' own language and experience. Early examples of these codes included communication delay, incomplete assessment, unclear responsibility, missing information, pressure to discharge, family participation, developing relationships, a considerable amount of paperwork, and managing risk. Codes were kept very broad to avoid narrowing down interpretations too quickly. As new interviews occurred, new codes emerged; previous codes were revisited before and after new codes developed into emerging concepts. This provided a continued cross-comparison of all interviews and helped identify repeating themes or variations from participants' experiences.

Development of analytic categories

During the process of coding, groups of related codes evolved into broader analytic categories. The decisions made about category construction were based on continual comparisons among participant interview responses, policy documents, field notes and developing situational maps. As an example, codes associated with documentation, information sharing, assessments, referral forms and patient care records became connected as it was observed that the

documentation itself influenced decision-making and action during transitional care. In addition, codes which were concerned with emotional support, negotiating, reassuring patients/families, facilitating open family communications and maintaining continuity evolved to form the foundation for what would be described as 'relational labour'. Categories were developed by repeatedly reviewing patterns found among various participants and multiple data sources rather than being developed from one individual's interview.

The role of memoing

Memoing was a key part of every stage of the analytic process. It provided a way to connect the different parts of the project (coding, mapping, and theory) and facilitated the use of analytic memos to note new ideas as they emerged, make records of the decisions made during analysis, examine how some concepts could be related, and evaluate alternative ways to interpret findings.

For instance, earlier memos indicated that many participants experienced difficulties with communication. As analysis continued, however, memo writing assisted in taking the discussion of those issues out of the context of simple communication failure. Memoing assisted in documenting the observation that communication problems are often associated with documentation systems, organisational pressures, assessment processes, and conflicting institutional priorities. This moved the focus from seeing communication as an independent issue toward seeing transitional situations as social-material networks where information, documents, technology and professional practice interact.

Memoing also assisted in identifying recurring references to relationship-building work carried out by care providers. Early memos viewed this type of activity as providing emotional support or maintaining relationships. Memoing supported the comparison of data collected through interviews and mapping. These comparisons aided in developing the idea that relational labour is one method that care providers use to stabilise transitions when other formal systems fail.

Beginning with situational mapping as an iterative analytic approach

The situational maps were initially created to provide an overview of the number of human and nonhuman participants in transitional care settings. The maps were revisited on several occasions during the course of the data analysis. Each time, they were updated based upon additional information that was derived from code-based analysis, memo writing, and document review.

These mappings were useful for visually representing and analysing the relationships among various individuals, organisations, documents, policies, technologies, and discursive practices. By using these mappings, it became possible to analyse the collective actions of many actors and systems which resulted in the creation of transitional care. Afterward, social world/arena mapping techniques were used to analyse organisational relationships and institutional structures. Positional mapping techniques were then employed to identify points of convergence, conflict, silence, and contradiction in the data set. In combination, all four mapping methods provided insight into the dominant discourses and relational patterns identified in the results.

Refining and testing interpretations

Initial situational maps showed all of the various types of human and nonhuman entities that exist in transitional care. The maps were continually revised as I gained additional information through memo writing, document analysis, and coding. The situational maps allowed for visualisation and study of the interrelations among actors, organisations, documents, policies, technology, and discourse. In this manner, the situational maps assisted in moving the research focus away from individual experiences to an understanding of how all of the different social worlds and institutional systems interacted with each other to create transitional care. Relational mapping was then used to examine the relationships and connections between the identified elements, highlighting how they interacted, influenced one another, or remained disconnected within the transitional care situation. The social worlds/arena maps subsequently examined

organisational relations and institutional frameworks, while the positional maps enabled me to identify areas of agreement, conflict and silence within the dataset.

In addition to the iterative comparison of interview data, documents, memos and situational maps, emerging interpretations were discussed with my academic supervisors during the research process. These discussions provided opportunities to question developing interpretations, consider alternative explanations and reflect critically on whether emerging concepts remained grounded in the data. Supervisor discussions therefore formed part of the reflexive process through which interpretations were reviewed and refined, rather than being used to determine or impose particular findings. This process was particularly important when considering the developing concept of relational labour and the relationship between individual experiences and wider organisational and system-level processes.

Combined findings from Situational Analysis and Actor-Network Theory reveal the complex sociomaterial institutional relations

Building upon the cartographic foundations developed through the four situational maps of the study through the analysis of interview data, the study explored through ANT how care providers make sense of and negotiate the dynamics of their daily practice, including their experiences, challenges, and strategies within a complex and system-driven environment. The qualitative methodology used in this study allowed an examination of the experiences of care providers who were willing to share their insight into the referral and transitional care process. The experiences of care providers are reflective of the different stresses they face, including organisational stressors and emotional and ethical demands of providing support to people living with dementia and their families. By framing the interpretation of the interviews using situational analysis within this study, the analytical scope of the chapter will be enhanced, providing a greater understanding of *how* care providers' narratives can be seen as situated within broader social, organisational, and structural contexts.

Direct quotes added an additional level of analytical detail, allowing the voices of the care providers to highlight the relational, emotional, and practical complexities associated with their work. An additional interpretative level focused on the way in which care providers interpreted the stories they had narrated and gave meaning to them. This interpretation recognises that the performance of participants' narratives is socially constructed. Narratives are shaped by the context in which they are performed and their target audience, as well as the institutional structures through which care is provided. They also provide insight into how care providers assemble concepts of responsibility, professional identity, burden, and moral obligation in interpreting the provision of everyday care for individuals with dementia.

Through these narratives, systemic issues, such as fragmentation of services, inconsistencies in the flow of information, and the pressure generated by funding and regulatory frameworks, were illustrated in a manner that relates the individual experiences of the care providers to the broader institutional realities of transitional care. The overall analytical strategy used for this portion of the study is based on Nicolini's (2009) notion of 'zooming in and zooming out', whereby the researcher moves back and forth between the detailed analysis of specific narratives and a broader situational understanding. This iterative methodology is critical for demonstrating the complex interplay between human and nonhuman elements, such as policies, assessment tools, documentation systems and organisational logics that contribute to the delivery of transitional care. By continually moving back and forth between the analysis of interview data and situational maps, the study illustrates how localised experiences are situated within, and shaped by, larger structural contexts, and thus demonstrates the benefits of applying a combination of narrative grounded insights and situational and relational analysis.

The findings of the study demonstrate that the transitional care process is an extraordinarily complex social, material, and institutional process. Transitions into long-term care are shaped by multiple layers of interdependency rather than following linear pathways.

Care providers must continue to mediate between structural constraints and the lived experience of individuals living with dementia. These findings establish a

critical foundation for understanding the broader dynamics of transitional care that are explored in subsequent chapters.

Mapping through situational analysis

Situational analysis employs mapping to depict the relationship among the numerous elements that contribute to the complexity of a given situation (Clarke, 2005). The healthcare system is itself a complex adaptive system (Plsek and Greenhalgh, 2001) and care within long-term care (LTC) homes is subject to the organisational dynamics and the pressures of the larger system level. Therefore, the maps serve as analytic tools to illustrate the relational and structural influences of the larger system and the effect of those influences on decision-making, communication, and the ability of older adults living with dementia to express preferences and maintain autonomy during the transition to long-term care.

Situational maps

As previously discussed, the results of the situational analysis via participant narratives are depicted in the maps central to Clarke's (2005) methodology: the situational map, relational map, the social worlds/arena map, and the positional map. Clarke et al. (2018, p. 180) state "Situational maps allow for the initial collection and organisation of all elements of the situation thereby illustrating the complexity of transitional care and the multiple perspectives of the actors facilitating transitional care". For the purposes of protecting anonymity, the situational maps do not reference specific referral documents; however, the situational maps were informed by the critical analysis and integration of the referral documents into the understanding of the situation.

Situational maps are manually created and typically represent the first step in the situational analysis process to elicit analytic consideration and examine the complex relationships between human and nonhuman elements contained within the situation (Clarke et al., 2018). They form the basis of the situational analysis and are used to re-gather and organise the elements of the situation of inquiry. The maps serve as a visual aid to help clarify the complexity of the situation of

inquiry, and to illustrate the relationships between the elements of the situation. In this study, the situational mapping process was developed as an iterative analytical tool, providing a means to move back and forth between the emergent insights derived from interviews and the broader theoretical considerations. As the contextual conditions emerged from the data, multiple situational maps were produced and updated to remain deliberately disorganised and de-centred to promote analytic breadth rather than premature closure.

Situational mapping involves examining the representative characteristics of the discourses embedded within the social phenomenon under investigation, utilising the interview data and relevant organisational documents. At this stage, the researcher begins to gather new data and to identify the similarities and differences within the data gathered up until now. All elements were placed onto the initial situational maps without assigning hierarchical or weighted status, producing a deliberately unstructured and de-focused representation of the situation. This openness promoted the visibility of unexpected configurations and influences and invited a critical examination of the question "what is occurring here?" from the perspective of care providers navigating the complex social processes of transitional care for older adults with dementia entering long-term care (Clarke et al., 2018). After the preliminary brainstorming phase, the situational map elements were reorganised according to the analytic categories proposed by Clarke (2005, p. 90), including human and nonhuman elements, discourses, contested issues, political and economic influences, organisational and institutional forces, spatial and temporal dimensions, and discursive constructions of human actors and nonhuman actants (Figure 3).

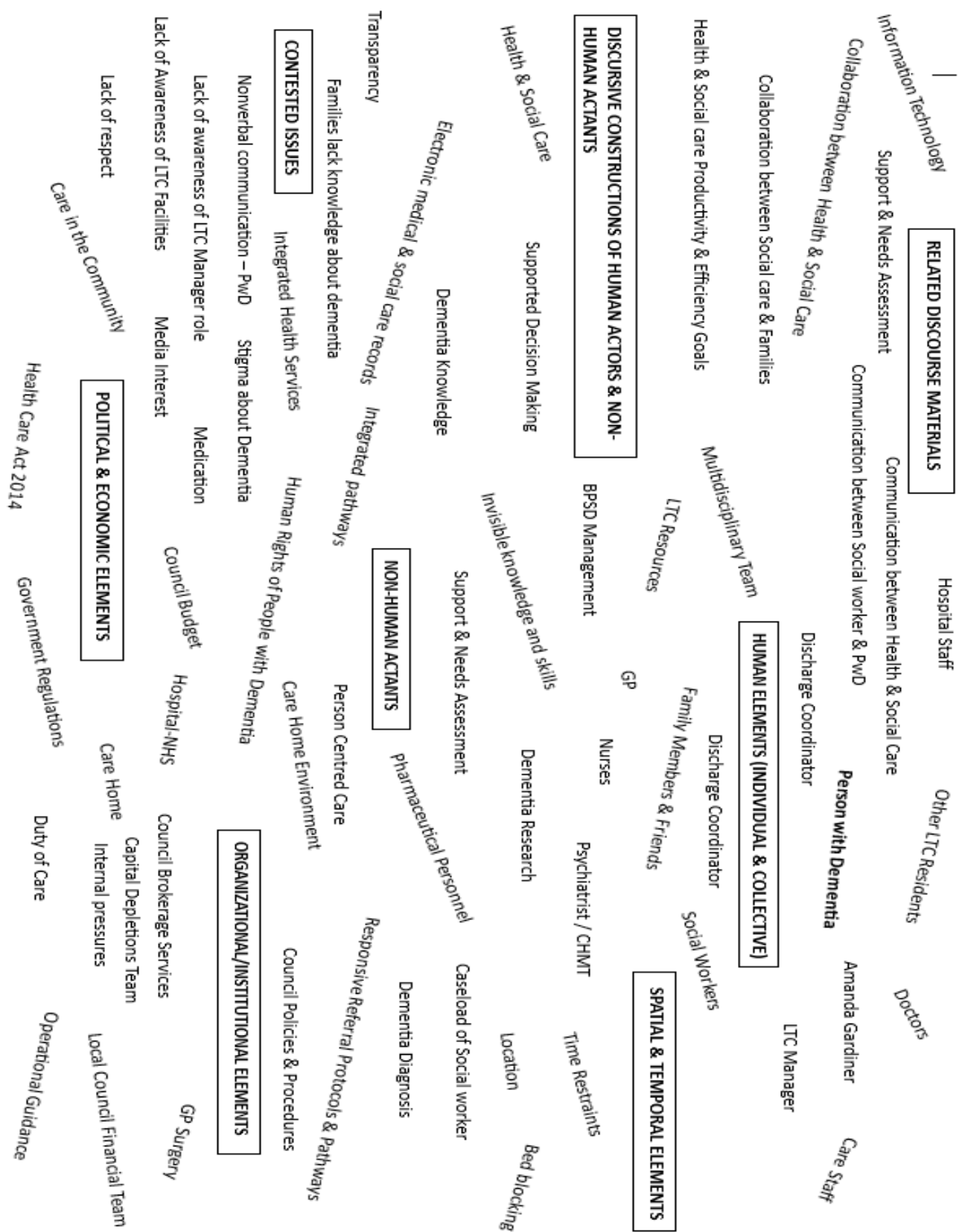
The early maps included a number of generic elements representing my prior field knowledge, and some speculative elements that were found to be empirically irrelevant. Subsequent iterations became increasingly grounded in the data, and as my understanding of the institutional and organisational dynamics became more defined, elements that were not empirically evident in the data were eliminated, narrowing the analytic parameters of the situation under investigation.

The situational maps illustrated the density and complexity of the structural and system-level influences shaping transitional care and the movement of people with

dementia into long-term care settings. This research explored an assessment of the support and needs assessment (SANA), one of the most important factors in determining how individuals with dementia are moved from where they currently live and what kind of care they will eventually receive. The inclusion of the interaction between human and nonhuman elements, such as care managers, assessment tools, referral documents, and organisational structures, highlighted the importance of these relationships in informing decision-making and outcomes. The inclusive approach to mapping was a deliberate methodological decision to ensure that the analysis did not prematurely limit its scope and allowed for unexpected dynamics to arise throughout the progression of the study. Multiple iterations of the situational maps expanded and evolved. The initial map had fifty-seven elements that related to the study.

Five additional elements, 'quality of care' (P1), 'social worker caseload' (P7), 'the local council's brokering team' (P5), 'there is no person-centred focus' (P4), and 'lack of knowledge about LTC facilities' (P2) were identified as needing inclusion in the next version of the map, and thus, a total of 62 elements were mapped. Six more elements, 'disjointed services' (P2), 'a lack of professional respect/acknowledgement' (P4), 'reform of systems' (P1), 'empowerment and choice are being denied' (P3), 'processes are driven by the system' (P6, P2), and 'pressures from finances' (P5, P1) were also identified as requiring inclusion in the final version of the map. Collectively, the additional components of this study demonstrated the variety of ways in which the transitional care environment is influenced by all of the above variables. Although the individual elements are not discussed separately here, their relevance is clarified when examined in relation to the relational map and its domains, which were directly generated as an extension of the situational mapping process. Therefore, the situational maps served as an analytic starting point as well as a foundational scaffolding for the construction of deeper relational and structural analyses.

Figure 3: Situational map



Relational mapping - an extension of situational mapping

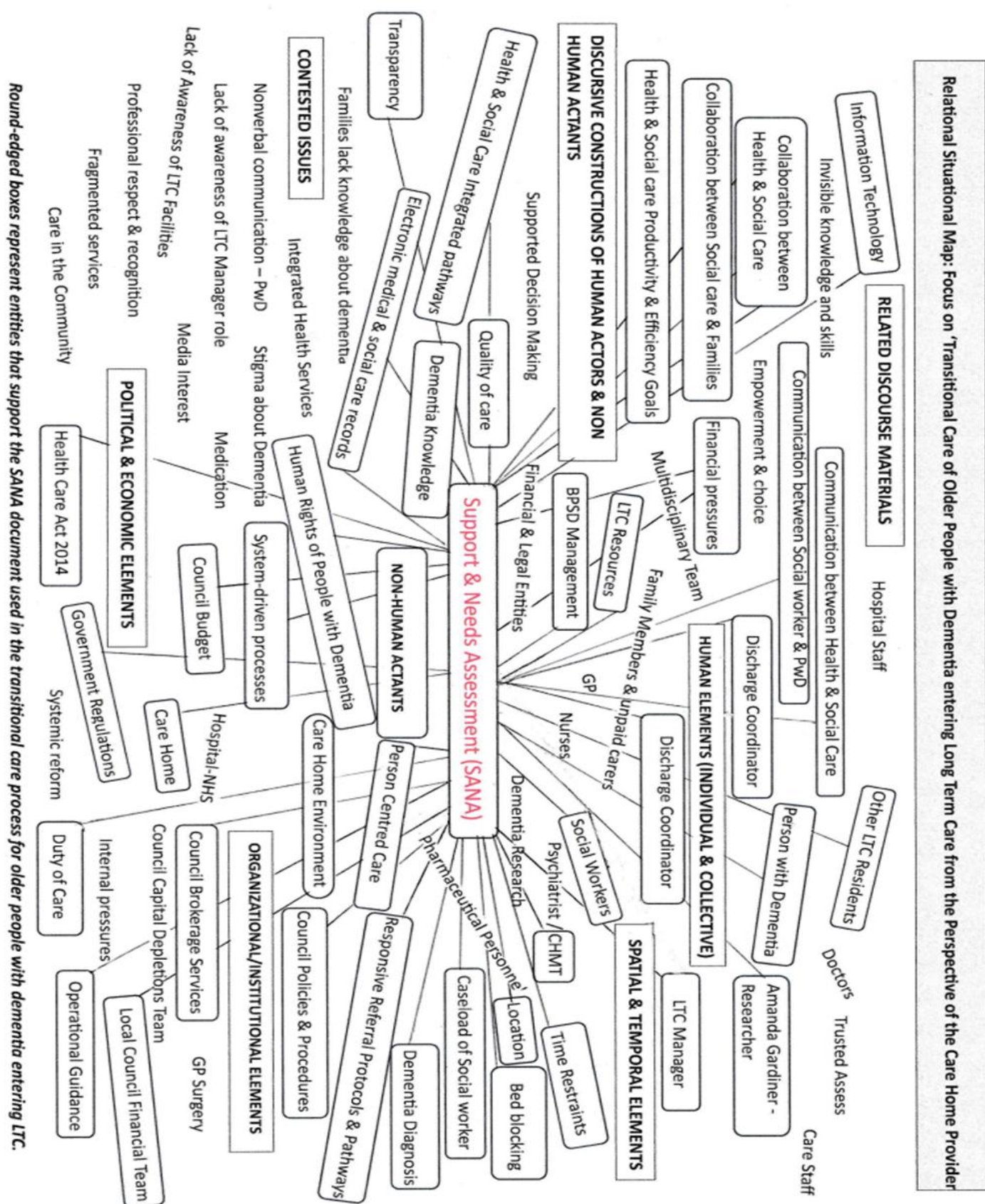
Following on from the insights generated via the situational maps, relational mapping extends the situational mapping process, allowing further exploration of the transitional care environment by identifying and exploring the patterns and interconnections of the identified elements, and how they mutually inform each other and create new dynamics. While the situational maps identify the breadth and complexity of the situation, relational mapping establishes a more defined lens through which to understand the structured relationships (collaborative, conflicting, hierarchical, or contingent), that facilitate the care provision and transition of older people living with dementia into long-term care. Relational mapping illustrates the extent to which organisational structures, professional roles, assessment tools, regulatory frameworks, and discursive practices collaborate to produce the transitional care process, and, in doing so, create tensions or contradictions for those involved. Relational mapping demonstrates how the dynamic interactions between human and nonhuman agents, together with systemic, organisational and practice-level factors, combine to produce care trajectories.

To produce relational maps, the researcher makes a copy of the most complete situational map available at a specific point in the research and then examines the relationship, or lack thereof, between the chosen element to all other elements present on the map. Clarke et al. (2018) suggest that while relational analyses using situational maps can be organised, logical and potentially useful, they rarely are exceptional; however, they do provide an alternative method for examining the complex situations represented by situational maps and for developing memos.

As such, I have found my relational and situational maps to be remarkably similar to begin with; in fact, my initial relational mapping was heavily influenced by my assumption of the significance of human relationships and tended to exclude or devalue the potential of nonhuman relationships. However, my approach to relational mapping changed significantly as my paradigm evolved throughout my research and with increased data collection. The example shown in figure 4 is illustrative of this. The resultant relational map developed based upon the SANA document, was selected due to its perceived importance to the situation under investigation; however, numerous other relational maps could be created.

Figure 4 illustrates a selection of human and nonhuman entities that were felt to support the use of the SANA document as a valuable tool in the referral process for older people living with dementia transitioning to long-term care (solid lines connect the SANA document). The relational map was found to be highly revealing, particularly when compared to the forty entities included in the map, where only nine were human and thirty-one comprised nonhuman actors and discourses. The number of nonhuman entities was also higher than expected indicating that the SANA document had become an important and integral part of the situation under investigation. The variety of data collected during the research enabled the identification of the relationships between the elements of the situation, thereby enabling additional relational maps to be produced to further investigate and explore the interconnected relationships. This enabled me to discover and categorise the primary relational components of each entity within the situation of enquiry.

Figure 4: Relational map



Social worlds / arena mapping

This section describes the use of social worlds and arena mapping to take the inquiry beyond the individual's experiences, to look at the organisational and relational structures that underlie the transitional care process. Building upon the earlier coding, categorising, and relational analyses described in this chapter, this section expands the analysis by using social world mapping and actor-network theory (ANT) to analyse the transitional care process. At this point of the analysis, the focus moves from the individual's views to the organisational, relational, and structural contexts that form the situation of inquiry. Through the social world, arena, and actor-actant relationships that form the dementia care ecosystem, this analysis identifies the collective commitments, tensions, and interactions that arrange transitional care for older adults with dementia. These social world maps were used to visually represent social and symbolic interactions and to identify the multiple social worlds of collective actors with a common perspective or identity (subworlds) that share collective commitment and a shared identity for collective action within the situation of inquiry. Collective actors exist within an arena focused on a single issue, in this case, the transitional care process for older adults living with dementia. Using this framework allowed me to synthesise sociological knowledge with empirical data, raising questions about the nature of collective commitment and the social worlds at work in this arena.

Collective commitment in transitional care

Analysing the collective commitments to transitional care illustrates how stakeholders engage with each other throughout the transitional care process. An overarching theme identified through this analysis was the collaborative commitment among the social worlds of the local authority, the long-term care home, and healthcare professionals. The motivation behind this collaboration is the shared goal of improving care quality and the transitional experience for older adults living with dementia. While there are a number of different elements that contribute to tension between the commitment to delivering individualised care, the need to ensure cost-efficiency, and the limitations of funding, it is also clear that an organisation's ability to work together effectively will be significantly impacted by

competing commitments to different groups, for example, meeting the needs of everyone. A few participants stated

“But if the NHS don’t have enough bed capacity, then brokerage is under pressure to place people wherever... consequently, they will go for the cheapest option” (P3).

“You want your bed filled... but you have to put the work in to get the patient safely out of hospital, so they don’t end up going back due to misplacement” (P4).

Seven social worlds were found to be salient within the transitional care process arena: local authority, dementia community, primary care sector, secondary care sector, technology and information systems, regulatory framework, and the long-term care facility (LTC). Each social world had distinct roles and responsibilities yet are connected to one another through their collective commitment to the transitional care process.

The construction of the social world map was analytically significant in itself. The purpose of creating this map was to place the analysis at the collective organisational level to provide a meso (within the long-term care home) or macro (local council and health system) perspective of the social world. By doing so, the 'social' is brought to the fore, and the 'conditions of possibility' (Foucault, 1988) are made visible. A key component of analysing social world maps is distinguishing the social world from an arena. A social world is a collection of common knowledge, actions, and relations; a 'world' that is defined by a particular group or community (Clarke et al., 2018). A place to do business in is an arena; it can be a space (or context) where people interact socially with each other, and in many cases, there will be competition and negotiations going on amongst the individuals/actors involved (Clarke, 2005).

The findings of this study demonstrated that seven social worlds, each consisting of several subworlds, were present within the transitional care process arena, as illustrated in Figure 5. Using prior relational analysis mapping (see Figure 4) and interview analysis, I was able to uncover the complexities of relationships among the primary social world arenas of the dementia care ecosystem.

The local authority social world consists of subworlds including social workers, commissioners, and the brokerage team. The long-term care facility collaborates extensively with the local authority. These bodies make funding decisions and implement policies, as well as the overall management of dementia care services. They provide the LTC home with funding and policy guidance, as well as input about the needs and challenges that exist for the residents. However, budgetary limitations and system-wide planning initiatives partially limit their scope of practice. Social workers play a vital role in assessing and recommending placements, working with complex service systems, managing large caseloads, and linking fragmented service systems together. Social workers frequently act as the coordinator for dementia care placements, engaging closely with primary and secondary care sectors, as well as long-term care (LTC) providers. In terms of the brokerage team, they are accountable for looking after the financial aspects of placements and also position themselves as the intermediary between the care provider, the social worker, and the commissioner. The brokerage team manages placements and funding arrangements, although it appears they decide on placements; many care providers I interviewed stated that their interactions with brokerage teams were consistently difficult due to budget constraints and the need to prioritise costs over individual care needs. Participant 3 stated that

“When brokerage contact me regarding a referral, the first thing they ask is about costs and how much are we going to charge them per week for this person and they’ll keep chipping away at us to lower the price” (P3).

Other social worlds present within the transitional care process arena included the dementia community (people living with dementia and their families). LTC homes are a principal place of interaction for the dementia community. Staff and management at LTC homes are seeking to create an atmosphere that will respond to the needs of the residents and assist in creating a feeling of community and support for the residents and their families. Participants demonstrated this by saying,

“We always advocate for our residents. Because that is the absolute correct thing to do” (P1).

“The family... are essential in us giving the best care to that person” (P7).

LTC homes work with the primary care sector, which consists of general practitioners (GPs), nurses, and community health services. GPs and other health professionals within the primary care sector are involved in providing clinical evaluations and the ongoing medical care of the residents of LTC homes. In addition to working with primary care services, LTC homes also interact with secondary care services (e.g., hospitals). In order to avoid unnecessary misplacement of an individual to their new care environment or providing gaps in care when they leave the hospital, as well as to avoid difficulties in arranging their discharge from the hospital, it is essential to plan and coordinate the transition of care at the time of hospital discharge between the hospital and the LTC home. Collectively, the primary and secondary care sectors include medical professionals who encounter dementia patients in hospital settings. Primary care facilitates in the initial diagnosis and ongoing care of individuals with dementia, yet a gap often exists between primary care and other sectors resulting in poor coordination of information sharing and care planning (Eika and Hvalvik, 2022). Secondary care (particularly hospitals) is significantly involved in the transitional care process where issues can develop with transitions from hospitals. Participant 1 acknowledged this by saying

“Poor communication and inadequate assessments can lead to the placement of individuals inappropriately or with insufficient support” (P1).

The ‘technology and information systems’ world is representative of the data and processes associated with technology and information systems. Through the use of technology and health information systems, LTC homes are able to collect and monitor data related to the care provided to residents (i.e., medical records and assessments, etc.). As data is collected and monitored in such a way, LTC homes can provide quality care through enhanced efficiencies and ensure that all parties have access to the same data. Although participants felt that information systems were not always helpful, stating that

“Systems don’t unfortunately talk to each other” (P7).

“Records are frequently fragmented and there is often a lack of shared care plans” (P4).

“Different professionals (such as GPs, physiotherapists, OTs) use different measures, often forcing us to record the same information multiple times, wasting our time and reducing time for direct care” (P5).

The ‘regulatory framework’ represents the policies and procedures developed and enforced by governing bodies, such as the Care Quality Commission (CQC), that govern all placements. The purpose of these recommendations is to assist in providing high-quality patient/resident care while also maintaining accountability and compliance. The regulatory framework provides a link to all the social worlds as it contains policies and regulations as a sub-group. Thus, the regulatory framework demonstrates that while they are neither people nor organisations, they have a significant impact on the interactions of stakeholders in the social world arena. The regulatory framework influences how the social worlds interact through setting and enforcing standards for care quality. Participants spoke widely about regulation and system governance, with one stating,

“I kind of feel that CQC have a bit of a remit, and they don’t like the older smaller care homes very much, maybe they think we are antiquated and therefore are not up to date regarding regulations etc” (P1).

The long-term care facility (LTC) resides in the centre of the social world maps and represents all the social worlds surrounding it. The LTC world includes care home managers, staff, and owners who provide direct care to individuals with dementia. Their function is to collaborate with health and social care professionals throughout the transitional care process for individuals entering their LTC facility. The LTC world enables interactions among the various social worlds, thereby impacting the overall care experience. Several participants expressed less favourable interactions from some of the social worlds by saying,

“They sit in an office with a budget... they don’t see the person’s face; they don’t see their individual needs” (P3).

“I’ve had social workers here that have been nothing short of confrontational and challenging” (P2).

"If you can track the right broker down, they might have some knowledge on the case" (P4).

"They expect a lot from us, but we get nothing in return" (P5).

The map in Figure 5, below allowed me to see individuals acting both as members of social worlds and as individual actors, providing insight into the social worlds, arenas, social formations, regimes of practice, and discourses produced and circulating within them. The maps demonstrate how fluid and interactive the various agencies and structures are, which supports theorising and memoing. Clarke et al. (2018) used oval shapes with perforations to illustrate that the social world is dynamic and constantly in motion.

Figure 5 employed circular shapes with dotted lines to illustrate that most social worlds have permeable boundaries, permitting analysis of change and multiple perspectives. The majority of the elements are located in areas where multiple circles overlap, indicating the interdependence of the elements and the overlap among elements, denoting influence. For example, individuals with dementia in the 'dementia community' domain are influenced by or are a member of the social arenas of collective groups, as indicated by their positionality between the local authority and primary care sector. Following creation of several maps filled with social worlds I knew to be significant to the situation, I realised that they were analytically unhelpful. As I continued to explore the literature and engaged more with it, my maps became much more complex. I found myself trying to create the 'big picture,' undoubtedly more than was warranted. I then decided to take a different stance and when I was no longer spending a lot of time trying to get the maps looking like maps, I was able to use them as analytical tools much more effectively than before.

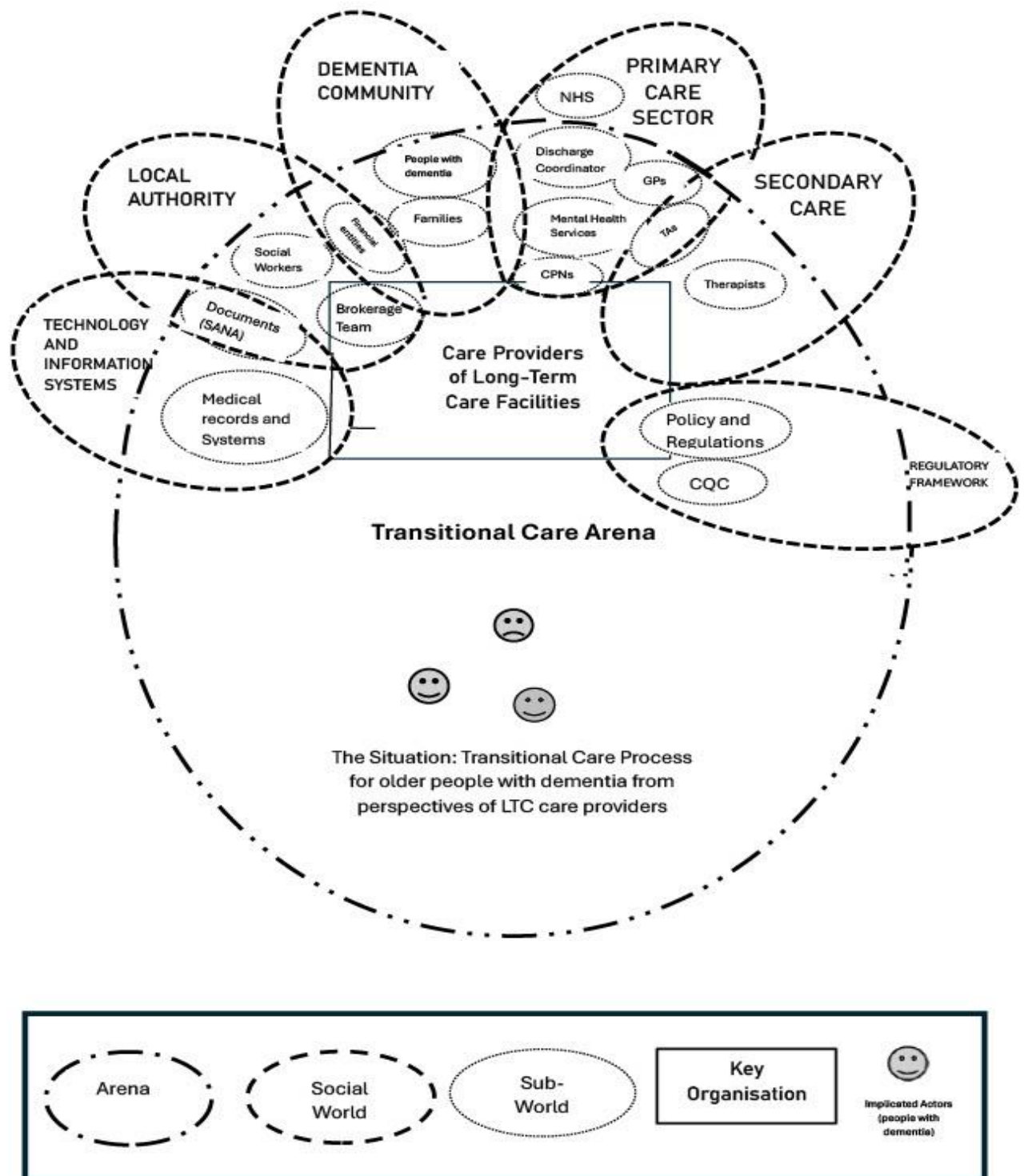
Whilst analysing the social world/arena map, the use of ANT helped me to ask, "what is going on here?" and to show *how* decisions, practices and results were created collaboratively through networks of people, technology, documents, policy, and other organisational processes. This relational focus also made apparent that no single actor could control the transitional care process. Instead, the action was distributed among the many interconnected actants, including the assessment

tool, the referral document, the electronic system, the funding criteria, the organisational roles, and the professional expectations. These elements functioned to determine what information was available, how the decision was made, and what options were seen as feasible or acceptable at given times. ANT allowed the tracing of how these actants influenced one another and how the often-routine activities, including preparing documentation or transferring information from service to service, contributed to directing the paths of care. Thus, the analysis went beyond superficial explanations of practice to explain how action was formed by the convergence and divergence of the relationships in the network. As the relationships were analysed iteratively, the analysis involved a filtering process that eliminated complexity without losing relational detail. Through comparison of the maps, memos and the coded data, patterns of clustered action and a higher number of contradictions began to emerge. This iterative process permitted the identification of the most significant situational arenas where social, political, and economic forces converged. These arenas defined places where decisions regarding risk, responsibility, resources, and care were debated and implemented. They did not pre-exist but were developed during the course of the analysis as the locations where conflicting priorities and logic were observable. Therefore, the combination of situational analysis and ANT allowed the development of a thorough analytical explanation of how transitional care was created by interconnected relationships and provided a situated knowledge of the structuring of action within the situation of inquiry.

After determining how the action is structured throughout the situation through the mapping of social worlds, arenas, actor-actant relationships, the analysis proceeded to the positional maps. The positional maps expand upon the analysis based upon the social worlds and arenas maps in that they provide an examination of the variety of viewpoints, suppositions, and disagreements in relation to the transitional care for people living with dementia. The positional maps allow the analysis to go beyond the organisational roles and relationships to explore how the competing logic, value and discourse are allocated throughout the area. Furthermore, the positional maps illustrate the prevailing, marginalised, and silent views that describe how transitional care for people living with dementia is perceived, negotiated, and performed within the situation of inquiry.

Fig. 5 – below, ‘situational analysis using Social worlds/arena map’, focuses on identifying the primary collective groups (organisations, social worlds) and the arenas of commitment in which they are engaged (Clarke, 2019).

Figure 5: Social worlds / arena map



Social Worlds/Arena map for older people with dementia transitioning to LTC: Care providers perspectives.

Positional maps

The positional map was created to illustrate the positioning of different actors within the situation of inquiry. Positioning is an important aspect of situational analysis, as it helps to identify power dynamics, conflicts, and other types of relational tension. The positional map provides a visual representation of the positioning of different actors within the situation.

Positional maps are a primary discourse-analytic tool within situational analysis. Positional, in this sense, refers to discrete positions or vantage points taken on particular issues that can be observed within the situation itself. Participant observation, interviewing, and fieldwork are methods for collecting the discursive materials. The horizontal and vertical axes allow the positional maps to be analysed in relation to one another, identifying the theoretical possibilities of position in the situation, despite the lack of empirical evidence. The maps demonstrate the diversity of positions (Clarke et al., 2018). Finally, I developed the last positional map through the comparison of the main discourses of the situation to each other and used my lack of knowledge as an advantage in the development of the map. Choosing the two axes for plotting the major discourses was new, time-consuming, and accomplished through trial and error. However, the most important aspect was to simply begin somewhere and continue with the process. There were countless iterations of revisiting, contesting, and collapsing various positional maps before arriving at the positional map represented in figure 6. The final positional map is an abstract positional map that includes two major axes that are arranged in terms of "less versus more." Having developed a broad structural, relational, and positional context of the situation via situational/relational and positional mapping, I found multiple important discourses that exemplify the complexity of care delivery and would have been acceptable alternatives in the final map. These discourses capture the fundamental conflicts that stakeholders face and affect the quality and effectiveness of care provided. A closer look at the discourses follows:

Discourses identified

Discourse 1: Quality of care versus cost-effectiveness.

Quality of care emphasises offering services that meet the unique needs of people living with dementia, providing a personalised, empathic, and evidence-based experience. It establishes an essential foundation that encompasses professional communication, comprehensive evaluation, and a basic understanding of what people living with dementia require. Cost-effectiveness as a discourse establishes a basis for financial sustainability within the service delivery of care. Frequently, pressure to reduce costs arises from budgetary constraints, and subsequently, the quality of care is compromised. The conflict between these two discourses demonstrates the problem of maintaining an elevated level of care quality while working within budget constraints. Implementation of cost-cutting plans would lead to either a reduction in the number of staff available to provide services or less time provided to individuals with dementia to receive one-on-one care. Thus, a cost-cutting plan could negatively impact the outcome of the treatment of people living with dementia as well.

Discourse 2. Family participation versus professional decisions regarding dementia care.

Supporting a loved one who has dementia by the people around them (family) is significant, as many family units provide support and care to each other and provide healthcare professionals with information about their feelings and experiences. Family involvement allows for the creation of more effective care plans and ensures that the individual with dementia remains true to themselves. Healthcare providers make decisions regarding the care of an individual with dementia based on clinical guidelines and assessments. On occasion, the healthcare provider's assessment may differ from the wishes of the family regarding the care of their relative. Thus, it is essential to create collaborative decision-making models that incorporate the participation of both family members and healthcare professionals. Healthcare professionals have the responsibility to

work collaboratively with families to empower them, and through this collaboration, families will have a positive influence on the overall care of their relative.

Discourse 3. Complete evaluations versus rapid placement decisions.

Complete evaluations are a detailed examination of an individual's needs prior to determining the type of care they will receive. Since the needs of individuals diagnosed with dementia can differ significantly from person to person, complete evaluations are extremely beneficial in creating customised care plans. Quick placements, however, are often made in response to pressure to expedite the admission process, at the expense of thorough assessments. Rapid placements often resulted in a mismatch of the provided care and the actual needs of the individual, resulting in insufficiencies of support and adverse consequences. Therefore, these differing views highlight the importance of achieving a balance of timely access to care and the need for a comprehensive assessment of the individual to ensure they have received the most suitable care.

Discourse 4. Privacy issues versus communication transparency.

Communication transparency refers to the value placed on the importance of communication (open dialogue) with care providers, family members of people with dementia and people living with dementia themselves. Open communication fosters trust increases understanding and enables collaborative care planning. Privacy concerns, however, often arise in the context of sensitive health information. A second source of tension is the requirement for transparency in disclosure versus the necessity of protecting the private nature of the relationship between a healthcare provider and patient. For example, families may desire detailed information regarding the status of a family member; however, healthcare providers are obligated to protect the confidentiality of this information. Additionally, this model indicates the necessity of healthcare providers developing communication strategies to encourage open dialogue with families while maintaining the rights of patients to have privacy within their therapeutic relationship.

Discourse 5. Specialisation in dementia care versus general care provision.

Specialisation in dementia care involves focusing on developing expertise and specialised approaches that are directed toward individuals with dementia. The professionalisation of care provides the potential for improving the quality of care because it is based upon a belief that trained carers are capable of recognising and responding to the unique challenges of caring for individuals who have dementia. On the other hand, general care provision may not consider or address the unique needs of those living with dementia. Therefore, 'one-size-fits-all' approaches can provide inadequate support to individuals with complex needs. The conflicts between the two discourses highlight the necessity to recognise and address the complex aspects of providing care to individuals with dementia as well as the need to include and provide access to all individuals with dementia in mainstream healthcare services.

Discourse 6. Continuity of care versus fragmented services.

Continuity of care is particularly important for individuals with dementia as it ensures that care services are well-coordinated and continuous across multiple care environments and providers. Throughout a patient's life span, care continuity plays a crucial role in properly addressing their complex issues. Fragmented care occurs when there is no coordination between the many services or aspects of a patient's care. Fragmented care services can lead to confusion among patients and their families, thereby lowering the quality of care they receive. The fragmentation of care demonstrates the need for a continuum of care delivery models that promote collaboration among all of the parties involved to provide care continuously.

Discourse 7. Professionalism of care versus devaluation of roles.

The advocacy for the professionalisation of care is about recognising the role of caregiving within the healthcare system and formalising caregiving roles, as well as providing carers with education, support, and compensation for their work. This

discourse aims to raise the standing of care work and ensure that caregivers have the knowledge and skills needed to provide high-quality support. Undervaluation of roles highlights societal views that may undervalue the role of caregiving, resulting in inadequate compensation and acknowledgment of care workers. The conflict between the two discourses has led to a high rate of caregiver turnover and instability in the workforce and, therefore, will negatively affect the quality of care being provided. Therefore, it is essential to address this discourse in order to stabilise the workforce and provide individuals with the care they deserve.

Discourse 8. Individualised approaches versus frameworks.

The term "structured (or standardised) framework" is used to describe a predetermined process or procedure for the delivery of consistent levels of quality support by using established methods and protocols to help create safety while caring for individuals diagnosed with dementia. In addition to the benefits of increased efficiency and accountability associated with standardised frameworks, there is no assurance that they will be able to address the needs of individuals with dementia or other complex conditions. An individually customised method of providing support to people with dementia recognises that they are all different from one another and, therefore, will require varying levels of support tailored to meet their individualised needs. Therefore, an individually tailored method of providing support to people with dementia will provide a more personal and responsive form of care than a standardised framework. This distinction highlights the ongoing quest for developing a balance between the need to develop and implement standardised frameworks to govern how support is delivered to people with dementia while also creating an opportunity to deliver a level of flexibility that allows the carer to provide the necessary support to meet the unique needs of the person being cared for.

Discourse 9. The Medical model versus the social model of dementia care.

The medical model of dementia care emphasises the biological characteristics of dementia and focuses on diagnosis, treatment, and symptom management. The medical model of dementia care may create a limited view of the individual who has developed dementia by limiting the individual to their medical condition. The social model of dementia care acknowledges that social, environmental, and psychological factors play a role in shaping the experiences of people who live with dementia. The social model of dementia care provides a broader framework of reference for considering how dementia affects individuals with dementia and what needs to be considered by care providers when developing care plans for those who live with dementia. The social model encourages a holistic approach that takes into consideration the broader context of an individual's life, enabling individuals to live with dignity and quality of life. This discourse represents a transition towards more holistic ways of providing support that are focused more on an individual's experience of living with dementia than just their medical condition.

Analysis of these key discourses provides insight into the numerous challenges and opportunities that are inherent in the transitional care process for individuals with dementia. Each of the discourses identifies essential contradictions that stakeholders must address to deliver effective and compassionate care. It is necessary to understand and address these contradictions to develop an appropriate care environment that addresses the needs of individuals living with dementia while attempting to reconcile the structural constraints associated with the care system. These findings could be useful when developing policies and practices. Integrating these findings into practice and policy development can assist stakeholders in creating a more equitable and inclusive landscape of dementia care.

Overall dominant discourses.

The two most influential discursive positions to emerge from the positional map-making were considered overall to represent 'person-centred focus versus system-

driven processes'. These were not predetermined categories for the larger situation of concern but were evident through the iterative analytic work of mapping, memoing, and intense engagement with participant accounts. Through the development of the maps, I was able to see how practices within transitional care were organised around opposing logics that continued to redirect practice in opposite directions. On the one hand, there was the moral and professional obligation to provide relationship-building support for individuals living with dementia as well as support to family members who are experiencing acute emotional challenges. On the other hand, the opposing position represented a greater rationality at an organisational level that was primarily concerned with performance measures, time limits, entry standards, funding models, and technology-based systems; all of these are used to produce efficient output and manage risks. Although participants did not explicitly name these discourses, they were representative of the way participants described their work, including the constraints they experienced and how these influenced their decision-making. Participant 5 described these expectations, stating, "They expect a lot from us, but we get nothing in return" (P5). Participant 4 described the constraints associated with limited information and time: "You're suddenly now having to go, 'I've got no data, and I've got to go find the time to go and find it'" (P4). Participant 1 described how these constraints influenced their decision-making: "The document therefore... is asking a lot from you, yes, as a manager, so now you must turn detective" (P1).

Language patterns were identified through an interpretation of the data collected. Relational aspects of care were described by participants using personalised language, first-person pronouns, and emotional language to highlight responsibility, empathy, and ethics. The shift in language also indicated a transition from human-centred meaning-making to system-centred accountability, demonstrating how two diverse types of power and agency interact and influence the same context. Actor-network theory was useful in demonstrating that these discourses are not solely ideological stances but were developed through the interaction of humans and nonhumans in the form of assessment tools, referral forms, funding panels, online systems, and discharge timelines. In addition, actor-network theory illustrated how these human and nonhuman actors work together

to develop systemic processes which sometimes limit professional capacity to deliver person-centred outcomes. Situational analysis also supported this interpretation by demonstrating that these competing discourses occupied distinct positions within the maps and frequently intersected and conflicted with one another, especially in the areas where decisions about placement, timing, and appropriateness occurred. Therefore, the selection of person-centred focus versus system-driven processes as the key discourses was grounded in their repeated presence throughout the various data sources and analytical phases. Person-centred focus and system-driven processes cut across the individual interviews, social worlds, and arenas, and they structured how actions were justified, contested, or normalised in transitional care. Moreover, these discourses were mutually influential and re-influenced one another within the broader situation of concern. The analysis showed that transitional care pathways are generated through the continued negotiation between these two discursive forces and therefore, these are central to understanding "what is happening here" in the transition of people living with dementia into long-term care.

Analysing 'silences' in positional analysis

Positional analysis provides a further layer of insight into the dynamics of transitional care for older individuals diagnosed with dementia, since analysing the relationship between the initial coding of the data and the mapping of the social world/arena(s) creates the context for positional analysis. The positional map shows the array of positions, tensions and controversies existing in the inquiry situation, as illustrated in Figure 6 below. Furthermore, the positional map identifies and focuses on "silences," or absences, as defined in situational analysis (Clarke et al., 2018), and not the presence of the data. In this case, "silences" refer to the voids or gaps in the data created by the absence of perspectives, experiences, or types of knowledge (Clarke et al., 2022).

Silences do not suggest there is no data but rather demonstrate the constraints placed upon participants' ability to articulate their experiences due to the dominant structures of transitional care (Bengtsson and Fynbo, 2018). Patterns in language were identified through an interpretive lens (Rehman and Alharthi, 2016).

Participants spoke about care in relational terms, using personalised language, first-person pronouns, and emotive language that described responsibility, empathy, and ethical practice. Participant stated,

“We couldn’t take him... and that was a direct conflict with what was on paper” (P3).

“That was not possible. It was actually not possible” (P5).

The use of repetition and emphasis by participant 5 illustrates the ethical constraints, recognising what would have been a good relational approach but being unable to take the action because of the system (in contrast, when participants spoke about system processes, they switched to dehumanising language, passively stated items, and referenced abstract constructs (e.g., ‘the system’, ‘the process’ and ‘the portal’) the following examples demonstrate this, with participants stating,

“That’s how the process works” (P4).

“The system doesn’t allow for that” (P1).

In addition to offering information about the role of silence in the transitional care process, it is also important to understand why this silence occurs. For example, although the positional map illustrates conflicts between person-centred care and system-driven processes, the space between these positions points out experiences that are not aligned with the policy ideals and cannot be reduced to procedural requirements. Thus, many of the emotional, ethical, and relational aspects of care are contained in these spaces. Furthermore, the concept of ‘silences’ indicates how certain voices are restricted in terms of structure and not necessarily in terms of the individual voice (Bengtsson and Fynbo, 2018). Providers may recognise unmet needs, ethical distress, and/or risks associated with the transitional process, but they have limited opportunities to formally articulate their concerns through the documentation provided during referrals, assessments, and decision-making processes. As a result, these experiences do not always manifest themselves in the positions identified on the map; however,

they significantly impact the provision of care. Therefore, the positional analysis illustrates not only what has been articulated but also what is systematically difficult to articulate such as concerns regarding the suitability of placements, the rapidity of transitions, and the emotional toll of managing system pressures. Positional maps are not meant to provide a comprehensive account of experiences; rather, they provide an abstract illustration of the social positions present within the situation (Clarke et al., 2018). Abstract representations of the positions allow a reflective consideration of the factors that have resulted in some being prioritised over others, the ways in which some perspectives exist indirectly or can be inferred from the data, and the role of the gaps (or silences) between the positions in encouraging reflexive thought about whose knowledge is valued, whose responsibilities are emphasised and whose experiences are obscured within the transitional care context.

In addition to illustrating the positioning of care providers as being placed in the middle of competing expectations and limited choices, the placement of the care providers in the map demonstrates the distance between their professional values and organisational expectations. Therefore, the distances shown represent the conflict between differing professional values, expectations, and organisational requirements; they also represent the difficulties associated with reconciliation. Thus, the spatial relationships facilitate additional analytical exploration into how care providers negotiate transitional care in practice, as well as how they manage the tension between providing what they intend to provide and what the system allows them to provide. By examining the silences through this methodology, the analytical rigour of the positional analysis is enhanced. The study moves beyond simply explaining the positions and controversies present within the situation and begins to examine the underlying conditions that create them. Therefore, the analysis captures the complexity of transitional care as a socially organised situation that is shaped equally by what is constrained, deferred, or left unspoken as by what is formally expressed. Using the combination of grounded-theory coding and the creation of situational/relational and social worlds/arenas maps provides the framework for positional analysis that facilitates the examination of the dynamics of the transitional care process for older adults diagnosed with dementia. The positional map (Figure 6) illustrates the various positions and

controversy present within the situation of inquiry. Additionally, the positional map draws attention to what is absent, specifically the "silences" (Clarke et al., 2018) between positions. Examining these silences is an essential component of situational analysis and not an oversight or deficiency in the data.

Analysing the positions on the map

Figure 6 places the long-term care (LTC) provider at the centre and diagonally between the person-centred focus axis and systems-driven processes axis. This placement is analytically significant because it captures the lived experience of tension as described in the data. Specifically, LTC providers are not fully aligned with system requirements and are not entirely free to implement person-centred care. Instead, the practice of LTC providers occurs in the space between these opposing forces. Their position at the centre demonstrates that LTC providers are exposed to the competing demands of multiple stakeholders and actors and must mediate the transitional process despite having limited control over the decisions made prior to the referral and the timeframes established. From the actor-network theory (ANT) perspective, the LTC providers placement at the centre also indicates the LTC provider is enrolled as a critical intermediary within the network responsible for supporting the stabilisation of the transitional process despite the limited capacity for influence over the decisions and actions taken prior to the referral and the timing of the referral. The diagonal placement of the LTC provider indicates both the dynamic and changing nature of the provider's role in the transitional process and the way the provider is constantly torn between relational commitment to the individual with dementia and procedural obligations to support the referral processes, commissioning criteria, and the discharge pressures. This is an important part of analytic silence because participants do not always recognise conflict when they describe their experiences. Instead, they report experiencing frustration, emotional labour, and a moral obligation to reconcile person-centred values with system constraints as described by several participant below,

“Those with little capacity generally are not involved in any way and become victims of the system” (P5).

“If somebody has got a representative that can fight on their behalf, they are the ones that get what they need” (P6).

“We’re not really given the true picture, nor are the families” (P3).

This reconciliation is illustrated in the map as the typical assumption about how person-centred values and system constraints are addressed in practice, which is expected to occur at the LTC provider level.

The position in the lower left quadrant of the map illustrates the start of the referral process and indicates the commencement of the transitional pathway. The inference of the location of the left-bottom side of the map relates to how transitions occur based on a lack of information, rather than clarity. The "silence" of the left-bottom space is deliberate, establishing the context of the referral process and the documentation of referrals and emphasising expediency and eligibility decisions, as opposed to creating an inclusive and comprehensive account of the individual's previous relationships, behaviours and other aspects of the individual's biography. With regard to situational analysis, the 'silence' of the left-bottom space illustrates that the individual's biography, relationship history, behavioural history, etc., was unavailable at the time of critical decision-making. The absence of this biographical information will negatively affect all subsequent interactions involving the individual within the system. Extensions of the map subsequently demonstrate various spaces where multiple actor positions intersect, illustrating stagnant or conflicted stages of the referral process. The intersection of multiple actor positions illustrates instances of missing information, conflicting views regarding allocation of funds, and unclear roles preventing progress within the transitional care process. The intersections of multiple actor positions on the map are analytically significant since they demonstrate that delays in transitional care processes are not single-event occurrences but rather the culmination of misaligned actors and actants. In addition to the intersections of actor positions on the map, the "silence" in those spaces illustrates the lack of commonality among organisations, indicating that no single participating organisation can be identified

as solely responsible for the delays experienced during the transitional care process; however, each organisation does experience the effects of these delays.

Actor-network theory (ANT) offers a way of conceptualising the manner in which nonhuman actors (e.g., funding panels, assessment thresholds, and digital portals) create pause/stagnant conditions in transitional care processes and impact the outcomes of the transitional care process. Conversely, the upper-right space of the map represents an idealised situation in which the long-term care provider (LTC) is perceived as being acknowledged, supported, and valued as part of the transitional care process. Examples of characteristics of the upper-right space of the map include effective communication, timely provision of information, and cooperative relations between local government agencies, healthcare providers and care home providers. In total, the upper-right portion of the map represents an exceptional experience and is used as a point of comparison to better understand the experiences of other LTC providers. The distance between the upper-right space of the map and the intersection of actors' positions illustrates the extent of emotional, relational, and operational labour required to transition from diverse to unifying care. The situational analysis also demonstrated that the space between positions reveals more than the positions alone. This gap is an indicator of a structural discontinuity within the system from which it was generated, not a gap in professional collaboration.

The area where the two positions are separated shows that, for collaborative action to occur among professionals, similarly constructed support systems must be present across multiple areas. Creating these types of supports for people working cooperatively is a difficult endeavour. Therefore, the positional map illustrates how systemic design, rather than the intentions of professionals alone, often shapes whether transitions proceed in a more procedural manner.

In summary, the positional map does not represent a continuum of the transitional care process; rather, it represents a field of tensions, absences, and partial alignments. The positional map illustrates that LTC providers operate in a precarious position within the transitional care assemblage and must continuously mediate between ideals and constraints. The analytical value of the positional map lies in its ability to identify what is often not obvious in narrative accounts alone;

specifically, the structural locations of silences, the concentration of responsibility, and the silent work of maintaining the system intact.

Examining emotions and experiences during transitional care

Care providers experience a changing emotional landscape throughout the transitional care process from the initial referral to the time of admission. The emotions that care providers experience include anxiety, frustration, and moral concern, as well as relief, reassurance, and cautious optimism. Although the situational and positional maps illustrate the structural positions and relational connections that exist between the care providers, the maps do not illustrate the full emotional labour of care providers to occupy those positions. Therefore, the emotional experiences of care providers represent another type of silence within the analytical process. Although the emotional experiences of care providers are represented in the data and influence their actions and decisions, they are only partially visible when the primary focus is on structural relationships and discursively constructed positions.

The degree to which emotional responses occur for those providing care indicates the amount of strain care providers endure because of the current structure of the system versus the relational and ethical responsibilities that exist beyond the boundaries of the system. Due to the repetitive nature of the experiences of uncertainty, limited information and conflicting expectations, care providers have emotional reactions to the ambiguity they experience repeatedly. At the time of referral, care providers report experiencing apprehension and concern due to the lack of clarity regarding the referral and the individual with dementia. The emotional distress that care providers report is closely related to the lack of clarity regarding the referral and the individual with dementia illustrated in the positional maps and the early referral positions that are characterised by a lack of knowledge and low levels of informational density. Statements by several participants commented

“You get very little information... and then you would go and do the assessment and go, wow, they are very opposite” (P1).

“That’s the only information I’ve got” (P2).

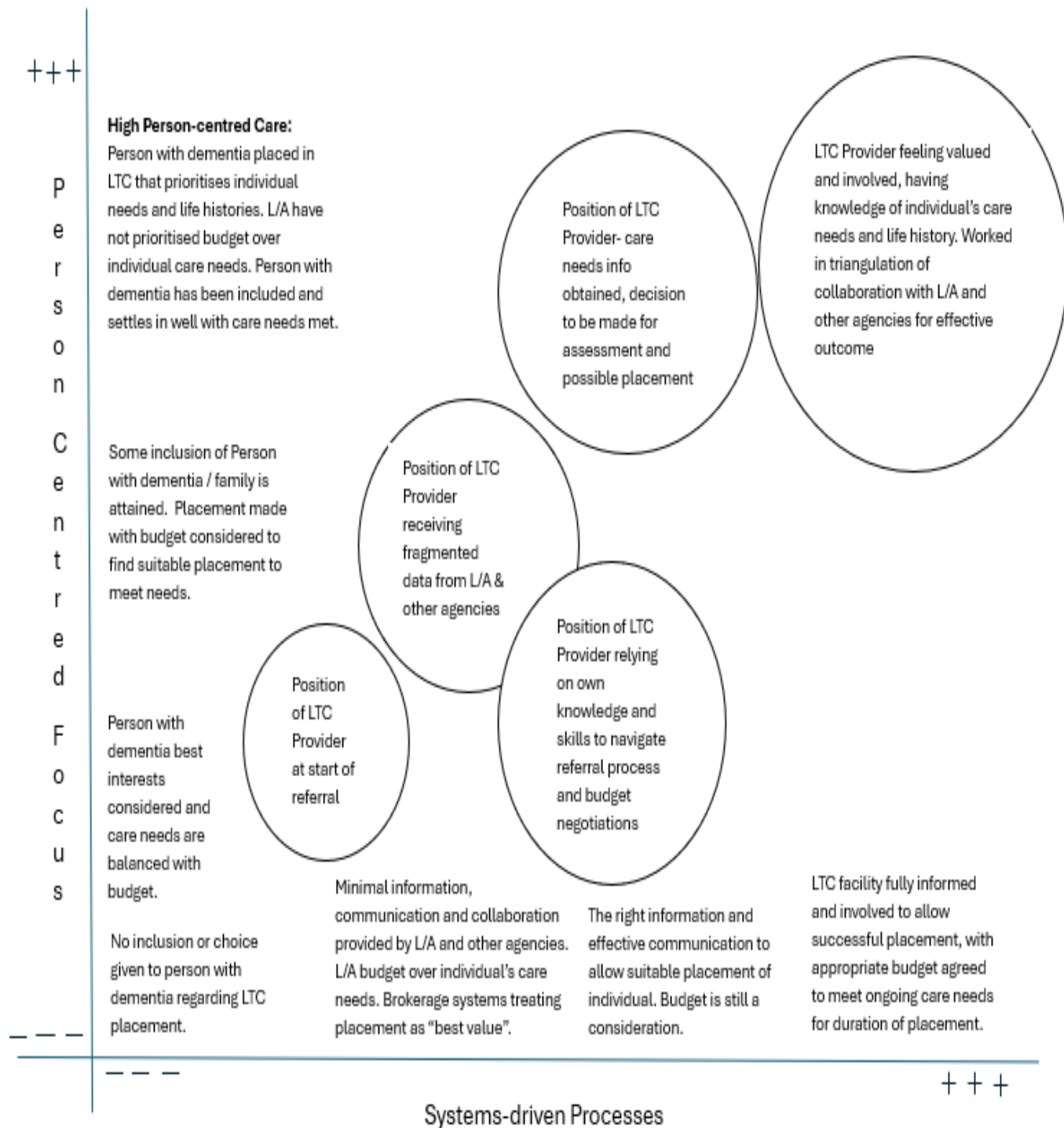
“Very few documents actually say what type of dementia someone has... it just says ‘dementia’, which doesn’t have any real meaning” (P6).

Care provider silence is not just informational; it also adds emotional stress to care providers who must make decisions about risk and suitability and collaborate with other stakeholders in the network using limited training and support. The emotional responses of care providers change during the transitional care process based on their experiences with both human and nonhuman agents. Care providers can be exhausted and frustrated, as evidenced by the language used to describe their emotional burdens resulting from delays, budgeting discussions, and the need to continually clarify issues. From an ANT perspective, the sociomaterial configuration of the system can be understood as contributing to the emotional responses of care providers (Latour, 2005; Clarke et al., 2018) which arise from their interactions with documents, digital systems, temporal demands, and organisational protocols and cannot be attributed solely to interpersonal relationships. For example, referral forms that minimise complexity and/or digital systems that limit the expression of narrative detail do not only reduce the availability of information; they also produce feelings of helplessness and moral distress among care providers as they are able to recognise the difference between what is documented and what is experienced. When care providers’ experience successful collaboration and improved communication, they report feeling relieved or reassured. These are typically times when there is alignment between the person-centred aspect of the position and the system-based aspect of the position on the map. However, even in these situations, the emotional experiences reported by care providers are conditional rather than definitive. Care providers continue to recognise that the stability of the transitional care process is fragile and conditional and depends on continued cooperation and the absence of future disruptions. The emotional vigilance reported by care providers is indicative of their awareness that transitions are rarely completed or stable, but rather, transitions are subject to potential disruptions. Emotional responses to care indicate how much care providers are being strained within the system, or how far beyond the capabilities of the system are the relational and ethical obligations to

care. The synthesis of learning about the emotional dimensions of care from both emotional narratives and positional mapping provides deeper analytical insights into transitional care as a lived experience rather than simply a procedural experience. Transitions in care are not just physical movement through systems, but are also emotional negotiations based upon an assessment of responsibility, uncertainty, and moral judgment. Although these emotional aspects were largely absent from the official policy documentation and performance metrics examined in this study, it is clear that they affect how care providers interpret information, act, take risks and make decisions. The findings of this study show that transitional care for older adults with dementia is made possible through continuous emotional labour as a means of filling systemic gaps in care. As such, this study expands our understanding of transitional care and specifically demonstrates that the success of transitional care is dependent upon many factors including not only structural alignment and procedural efficiency but also the capacity of care providers to manage uncertainty, absorb emotional stress and maintain a relationship in the midst of fragmentation. Therefore, emotional expressions are not ancillary to the analysis; they are central to understanding the transitional care process as enacted and sustained in practice.

To conclude, the synthesis of learning from the two analyses (silences and positional mapping) has expanded our knowledge of the complexity involved in the transitional care process for older adults diagnosed with dementia. This analysis explains the systemic obstacles, emotional journeys, and relational dynamics that influence the care providers' experiences during the transitional care process. Stakeholders can work toward creating a more effective and caring environment for individuals living with dementia. Furthermore, this synthesis not only informs individual practice but also contributes to broader policy dialogue in order to improve the systems of care for individuals diagnosed with dementia.

Figure 6: Positional map



Positional Map: Long-term Care Providers position throughout the transitional care process for older people with dementia transitioning to LTC.

Chapter Summary

This chapter has provided an overview of the findings and major themes of this thesis as well as how transitional care functions in an organisational context and how the daily activities of care providers occur. This chapter investigated a central theme, person-centred focus versus system driven processes, from both the organisational perspective and the care providers' perspective. This analysis reveals how the barriers experienced by the care providers when attempting to offer personalised, person-centred care are shaped by the need for a system focused on efficiency, standardisation, and risk reduction. This study employed an analytic strategy combining iterative coding and thematic identification as part of situational analysis and situational map processes in order to provide greater detail on how care providers interact with, react to, or resist institutional structure(s) that shape their work. The key themes that emerged throughout this chapter by iteratively coding participant accounts, documentary materials, and situational maps were further analysed using the situational analysis mapping process. Care providers attempted to provide personalised care; however, the referral system they operate in usually provides a structure for delivering care that is driven by limited resources, risk management, and administrative obligations.

The integration of participant accounts with documentary material and the situational mapping process was essential in identifying the complexity and structural conditions influencing the transitional care environment. Mapping facilitated the identification of the meso-level organisational arrangements and macro-level structural influences organising the transitional care environment and demonstrated how LTC providers engage with regulatory frameworks, pressures from the health system, and challenges of interagency communication.

The findings presented in this chapter add to existing knowledge of care for individuals diagnosed with dementia and provide research results that support the development of transitional care systems that are inclusive, equitable, and responsive to the needs of each patient. This chapter has shown how situational analysis, supported by iterative coding and interpretive attention to participants' accounts, can provide a valuable methodology for researching the experiences of care providers during the transitional-care process.

The study highlights the intricacy of care work and the impact of various structural factors on care provision. In addition to enriching the data collected in this research, the methodology used contributes to the wider academic discourse regarding dementia care, highlighting the importance of ongoing research into the relationship between lived experience, organisational practice, and structural conditions. Additionally, as care providers navigate the continuum of the referral and admissions process, they experience a range of negative and positive emotional responses and practices. These emotional changes constitute another layer of silence. While the mapping provides a visual representation of positions, it may not fully capture the emotional landscape experienced by care providers. Chapter 5 provides further detail on care providers' reflections on their experiences and what they learned during the transitional care process.

Chapter 5: Discussion Part 1 - Interpreting the findings.

Understanding transitions through systems, relationships, and time

This interpretive section builds on the descriptive analyses presented in previous sections by exploring how the patterns discussed in the thematic analyses are interpreted within the context of the research study's integrated analytical framework. Where the prior section documented what care home managers encounter regularly and repeatedly (i.e., conflicting organisational demands, documentation gaps, fast-paced timelines, emotional strain, and disparate flows of knowledge), this section examines the mechanisms through which these challenges are created and maintained. Using narrative-discursive analysis, actor-network theory and situational analysis, this section demonstrates that transitional care challenges are the result of much broader configurations of institutional power, knowledge systems, and sociomaterial arrangements that shape what care home managers can know and do. Therefore, through this lens, transitional care for older adults with dementia is viewed not as a direct process, but as an emergent and frequently contradictory system where the demands of time, documentation systems, organisational logics, and relational practices continuously interact.

How do distinct parts of the system push against each other?

The themes that emerged from the analysis of participant responses regarding transitional care for older adults with dementia reflect the interrelated factors that define the transitional care experience. The data from the study clearly demonstrate that transitional care exists at the intersection of competing institutional logics, which include multiple interpretations of how health services operate; consequently, many operational logics of health care organisations contain elements that directly contradict each other. The policy and professional cultures of the public sector and the performance measurement of both the private and public sectors drive the rationales of all types of organisations involved in transitional care, which include hospitals, local authorities, and residential care

facilities. As a result of the competitive nature of the operation of the organisations listed above, the organisational rationalities that govern the actions of the respective organisations do not align. Practitioners engaged in transitional care will, therefore, experience the conflicting logics of the organisations involved in transitional care as conflict, confusion, and contradiction in practice. Rather than describing transitional care as a singular process between service providers, the emergent themes of this study describe transitional care as a transitional experience defined by multiple, interacting dimensions, including organisational inconsistency and irregularity, time pressure, incomplete knowledge flows, document inefficiencies, and the continuous emotional and relational labour of practitioners as they attempt to stabilise an inherently unstable process.

Research into transitional care using situational analysis has indicated that the friction experienced through conflicting organisational logics is a fundamental feature of transitional care systems rather than an unplanned outcome. As a result, transitional care creates inevitable and systematic tensions because it involves multiple institutions with differing missions, knowledge structures, and resources. Care providers' reports of becoming "stuck in the middle" demonstrate the relational and emotional burdens of being mediating agents in organisational logic that cannot be resolved.

Research using an interpretivist perspective indicates that the repeated difficulties experienced within transitional care can be understood in relation to the lack of alignment among the organisational logics involved. These misalignments were evident across participants' accounts and appeared to contribute to fragmentation, pressure, and the moral burden of mediating between systems. Similarly, neither the standardisation of care nor the documentation of care could fully address the differences in the time horizons of the organisations involved in transitional care. This interpretation frames transitional care as a multi-logical assemblage and, therefore, requires care home managers to continually adapt, negotiate, and perform relational repairs to facilitate interaction between systems that are based on fundamentally different assumptions regarding what constitutes care.

In common among all participants, transitional care was portrayed as a highly restrictive practice environment defined by competing institutional logics and infrastructural constraints that frequently create tensions between relational, ethical, and clinical expectations and organisational realities. The participants' descriptions of transitional care reflect both the commitment of care home managers to provide high-quality care and the fragility of the systems in which they work. The findings do not merely catalogue problems; they demonstrate how problems emerge within sociomaterial arrangements and how practitioners struggle, negotiate, repair, and adapt within those restrictions. The themes presented below are organised according to the primary themes and patterns that defined transitional care. Those primary patterns include fragmented institutional landscapes, documentation as a restrictive representational technology, risk trajectories defined by previous decisions, asymmetric communication pathways, misaligned temporal regimes, and the emotional and relational labour that defines continuity. Collectively, these themes identify the mechanisms that care home managers have described as defining their work, their experiences, and the results of transitions.

Paperwork does not provide a complete picture

Throughout the study, participants consistently showed that transitional care was an environment defined by competing institutional logics that do not converge across institutions. In hospitals, output is the driving logic, and the emphasis is on rapid discharge to ensure the maintenance of patient flow and bed availability. For local authorities, output is the driving logic, and the emphasis is on statutory requirements and financial constraints. For brokerage teams, output is the driving logic, and the emphasis is on affordability, compliance with contracts, and availability. For care homes, output is replaced by relational understanding, behavioural compatibility, and the long-term well-being of residents. The competing institutional logics and outputs generate resistance at points of transition. Throughout the study, care home managers have repeatedly articulated conflicts arising from conflicting priorities: hospitals need to 'clear beds', social workers need to complete statutory assessments, brokerage needs to "move

cases through", and care homes need time, information, and relational preparation to safely accept a new resident into their facility. The non-convergence of the institutional worlds has often led to hasty decision-making that creates unrealistic expectations for care homes to mitigate the challenges of a particular transition.

Additionally, participants have documented how organisational boundaries influence the flow of information, access to information, and the allocation of authority. Often, care home providers find themselves excluded from discharge planning conversations, receive referrals too late to prepare adequately, or are told about decisions that have already been made prior to consulting care home managers. Exclusion from the discharge planning conversation and decision-making process reinforces a downstream position where care homes are responsible for absorbing risk and responsibility yet have no voice in decisions that affect their capacity to provide safe transitional care. Furthermore, the thematic analysis revealed a pattern in which transitional care is not guided by a shared framework of values or goals but by a combination of institutional objectives that exist in parallel to, and occasionally in opposition to, one another.

Participants described this fragmentation succinctly: "systems not communicating with each other" (P4), "everybody working towards their own targets" (P2), and "nobody has the whole picture" (P6).

This fragmentation of institutional objectives generates care trajectories that are discontinuous and frequently insecure and leaves care home managers with the responsibility of addressing the consequences of decisions that have been made upstream.

Information becomes unclear between services

Documentation was one of the most prominent factors influencing transitional care throughout the study. Instead of serving as an objective representation of a person's needs, documentation was portrayed as a restrictive, sanitised, and often inaccurate artefact that governs what can be known and anticipated at the point of

transition. Throughout the study, care home managers have frequently stated that they received referrals that omitted important aspects of the individual's behaviour (e.g., behavioural history), minimised the level of complexity, or provided only a limited description of the individual's functional and clinical needs. Participants have articulated that documents typically offered "*only half of the picture*" (P1), a "*sanitised version*" (P4), or "*just the essentials*" (P6), but nothing that assists with the planning and development of care for the individual. Behavioural triggers, emotional vulnerabilities, relational patterns, and traumatic histories are often missing, although they are critical to successful dementia care. The use of hospital templates, electronic referral portals, and assessment tools limits the ability to capture a person's narrative, prioritise biomedically relevant data, and encourage brevity to facilitate rapid discharge. Additionally, employees working in a time-sensitive environment such as hospitals may only provide the minimum amount of information required to progress the process. Documentation, therefore, functions as a product of institutional pressures and limits what is recorded, and what is rendered invisible. Care providers often receive individuals whose needs differ from those documented. The participants stated that these omissions in the documentation reflect an overall hospital strategy to speed up the discharge process rather than being an intentional act to deceive. Participants demonstrated that they have received many residents who were more distressed, behaviourally complex, and medically fragile than what was documented in the referral. Participant 4 stated

"I don't blame the hospital staff, not really... when someone is fit for discharge then they need to be moved on... they need the beds, they have a lot of pressure on them to move people through the system quickly; you can see why they end up omitting information. The hold ups mainly occur with the social workers and the funding teams trying to find care home placements" (P4).

This difference in the types of individuals' needs has made transitions between hospitals and long-term care facilities predictable and has increased the chances of immediate crisis situations occurring when transitioning an individual into their care. When hospitals under-report, omit, or downplay risky or challenging behaviours, even during face-to-face assessments with LTC providers,

responsibility for identifying and responding to those behaviours is placed on the care home that will accept the level of care needs as described in the referral document and in practice. Consequently, this places additional stress and liability on the care home manager. The participants have presented the documentation as both a structural limitation on behaviour and a manifestation of institutional power. Documentation reflects the priorities established higher up, defines the expectations for downstream actors, and facilitates inter-organisational relations. Documentation is also a formal record that legitimates decisions and renders the relational knowledge necessary for providing safe transitional care invisible. Documentation as a sociomaterial construct has been shown to produce the conditions for transitions rather than solely documenting transitions.

This finding raises an important question regarding how transitions continue to function when documentation, assessments, and formal information systems fail to provide a sufficiently complete account of an individual's needs. In these circumstances, care home providers were required to move beyond the information available within referral systems and engage in additional forms of work to 'bridge' informational gaps, reduce uncertainty, and support continuity of care. This work frequently involved developing relationships with family members, seeking informal sources of knowledge, negotiating with professionals across organisational boundaries, and using professional judgement to interpret incomplete information. Consequently, the findings suggest that transitions are not sustained solely through formal systems, documentation, and organisational procedures, but also through the ongoing relational efforts of those responsible for receiving and supporting individuals entering long-term care. It is this often-overlooked work that can be understood as relational labour.

Relational labour

The concept of relational labour builds on earlier scholarship concerning emotional labour and relationship-centred care. Baym (2015) introduced the term 'relational labour' to describe the regular, ongoing communication involved in building social relationships over time. Baym developed the concept in the context of musicians'

relationships with their audiences, where relational labour involved maintaining connections that could foster paid work. Although this differs from the context of the present study, the concept provides a useful starting point for understanding the ongoing relational work undertaken by care home providers during transitions into long-term care.

Emotional labour, by contrast, concerns the management and regulation of emotions during social interactions (Hochschild, 1983), whereas relational labour emphasises the development and maintenance of relationships over time. Relational labour should also be distinguished from relationship-centred care, which emphasises the importance of relationships between older people, their families and care workers as fundamental to care practice (Nolan et al., 2004). Similarly, Kitwood's (1997) work highlights the importance of relationships in maintaining personhood and understanding the individual beyond the tasks associated with daily care. In this study, relational labour refers specifically to the work undertaken by care home providers to develop, maintain and mobilise relationships in order to support continuity of care and navigate organisational fragmentation.

Transitional care research has identified the importance of many of the activities associated with relational labour, including communication, coordination, discharge planning, continuity of care and service integration. The literature reviewed for this study provided limited evidence about how care providers use relational labour to manage fragmented systems, incomplete information and organisational uncertainty during transitions into long-term care for people living with dementia.

The empirical data demonstrate that relational labour was enacted through several interconnected activities. Participants described developing relationships with families to obtain information that was absent from formal assessments. P3 explained that families would often provide information about behavioural triggers and management techniques during admission that had not been included in either the support and needs assessment or hospital assessment.

Relational labour was also evident in the mobilisation of established professional relationships to overcome gaps in formal communication. P5 described having developed “good relationships” with individuals across local authority and NHS departments, which enabled them to obtain clarification when further information was required.

Care home managers also described acting as a ‘bridge’ between hospitals and families, providing clarification, reassurance and emotional support when families arrived uncertain or insufficiently informed about the planned admission.

Taken together, these accounts demonstrate that relational labour was not simply an interpersonal feature of care. Relationships were actively mobilised as a resource through which care home providers accessed person-specific knowledge, clarified incomplete information, negotiated across organisational boundaries and supported families during periods of uncertainty. Relational labour therefore functioned as a practical mechanism through which care providers compensated for limitations within formal information systems and organisational processes, contributing to continuity and stability when formal systems and processes were insufficient.

The contribution of this study is not that relational labour represents a new form of interaction, but that it demonstrates how relational labour functions in the specific context of transitioning people with dementia into long-term care and how it forms part of the wider network of sociomaterial interactions involved in creating and sustaining transitions. By examining relational labour through the experiences of long-term care providers, this study provides insight into the interplay among relationships, documentation, organisational processes, professional judgement and practice, and how these elements collectively shape the transitional experience.

The concept of relational labour also demonstrates coherence between the empirical findings and the methodological approach adopted in this study. Situational analysis conceptualises situations as relationally produced through interactions among heterogeneous human and nonhuman elements (Clarke et al., 2018). The relational labour identified in this study similarly demonstrates that transitional care was produced through relationships among care providers,

families, professionals, documentation, assessment tools, organisational procedures and technologies. Relational labour therefore provides an empirical illustration of the relational ontology underpinning the study: stability was not inherent within the transitional system but was continually produced through interactions among its constituent elements.

How documentation affects what practitioners know and do

Care providers have to mediate the different burdens (temporal and material) associated with each environment, where the burdens compete with one another. Documentation (assessments, safeguarding documents, behavioural charts) is a mediator in the social matrix of transitional care. Documentation does not just transport information from one location to another but creates meanings regarding the individual and the risks they pose to others. Participants reported that documentation makes complicated things simple, produces standard behavioural histories, and develops overly basic profiles that remove many of the relational and emotional components of the individuals' needs. Omission of such details can have real effects: care homes receive unclear information; staff are not fully prepared for the transition and people living with dementia experience anxiety/distress when their needs are not represented. Documentation, thus, plays a role in the social and material infrastructure of transitional care. Documentation is used to allocate responsibilities and redistribute risks across organisational units.

Documentation is a key 'actor' in transitional care; therefore, it was necessary to consider documents using actor-network theory (ANT), which recognises the capacity of nonhuman entities to participate in and shape networks (Latour, 2005). These descriptions reveal an epistemological hierarchy within documentation systems, prioritising functional descriptions, emphasising biomedical categories, and marginalising or removing relational knowledge. As such, documentation of an individual moving from one organisational boundary to another is a product of the institutional logic of the organisation and does not represent the individual's experience. Documentation therefore defines perceptions of risk, responsibility,

and appropriate behaviour for both the individual and the care home. When templates limit the narrative detail included in documentation, practitioners surrender their epistemic authority. Additionally, documentation is not a passive repository of information; it is an active agent of institutional power, determining what is made visible, what is invisible, and how care homes organise their work relative to the information contained in the documentation produced during admission. Using sociomaterial theory, documentation represents and supports the institutional priorities of efficiency, standardisation, and defensibility over relational knowledge. Therefore, improved communication alone has not solved long-standing problems because the way information is presented must also fit the rules of the institution. Consequently, documentation functions as both the epistemic structure and a constraint on practitioner knowledge, redistributes risk, and mediates the relational components of transitional care.

Risk and responsibility shape people's actions.

Risk was a consistent concern among participants' accounts; however, the findings suggest that risk is not solely assessed and addressed, but constructed, transmitted, and redistributed through the transitional process. Participants emphasised how hospitals sometimes underestimate behavioural risks to allow for discharge, and how care homes are accountable for assessing and addressing risk prior to the individual being admitted and thereafter. Participants have repeatedly illustrated examples of receiving people living with dementia who were not accurately represented in terms of behavioural needs. Omission of behavioural needs inevitably relocates risk further down the line and places care homes in the position of having to rapidly address unexpected distress, aggression, or complex presentations.

Participants characterised this as being "*set up to fail*" (P1), not due to individual failures, but due to the way the system distributes risk, favouring institutional expediency over relational safety.

Risk was also magnified by the absence of relational knowledge. Without the detailed behavioural histories of the individuals, practitioners were forced to make

interpretations of behaviours without context, creating a greater possibility of misinterpretation, distress, or escalation of behaviours. Participants have emphasised that knowledge of the routines, communication styles, and trauma histories of individuals can diminish risk. When this type of knowledge is not conveyed regarding the individual, risk increases. The themes demonstrate how risk can travel along paths created by documentation systems, organisational hierarchies, and institutional priorities. Risk is not neutral; it is formed by what is visible, what is obscured, and what is prioritised at different junctures in the network. Therefore, transitional care exists as a setting where responsibility is both delegated and avoided, and where each organisation negotiates the extent of accountability in a context of restricted options.

Relational insight is critical but frequently lost

Participants have portrayed communication as a structural barrier to relational knowledge transfer. Participants have described receiving partial or incomplete information about people living with dementia through the discharge communication chain. Participants have articulated instances of receiving information from families prior to receiving the same information from hospital ward staff or receiving verbal information that was later contradicted by written documentation. Participant 3 stated,

“Often families will inform us of behavioural triggers and management techniques upon admission of their loved one - it’s not a surprise anymore that this isn’t mentioned in the support and needs assessment during the referral period, or during the hospital assessment, behaviours that challenge are often under reported by hospital staff” (P3).

Families who were involved in transitional care provided considerable help to the care home manager in helping to ensure continuity of care for the person admitted to the care home. However, families' level of engagement varied greatly. Some families were supportive and provided comprehensive histories of the individual's medical history, medication lists, previous placements, and previous experiences of hospital stays and community services. Other families were unengaged and

were either overwhelmed by the stress of caring for someone with dementia or were unclear about the transition and the care home's role in supporting them.

Care home managers often found themselves acting as a 'bridge' to support communication between hospitals and families. Many families arrived at the care home during the transition period (e.g., after hospital admission) feeling anxious, uncertain, and uninformed about the planned admission. In response to this, many care home managers reported taking on additional responsibilities to provide clarification about the care plan and the reassurance given to families that the care home would support their relative with the transition. Furthermore, the care home staff would often assist with providing emotional support and managing the negative emotions caused by the failure of the health care system to provide adequate support and communication. This theme demonstrates that families are critical components in transitional care, and their knowledge and engagement is important to support continuity of care for individuals with dementia. However, due to systemic failures, families may not receive timely, clear, accurate and consistent information, making it difficult for families to contribute effectively to the transition process. Therefore, many care home managers' relational work supports the inclusion of structured family involvement in transitional care planning.

These structural communication barriers arise from the organisational hierarchy and systems of information exchange that position care homes on the periphery rather than at the core of the transitional planning process. Participants have articulated frustration at being consulted after decisions have been made and being unable to influence suitability assessments, risk assessments, and transition timetables. Personal relationships, informal communication networks, direct contact, and historical professional relationships have often facilitated communication between care home staff and other professional stakeholders and have assisted in bridging the gaps in the formal communication pathway. Participants have valued these relationships as dependable means of compensating for the structural separation of the formal communication pathway.

Participant 5 said

“ Over the years I have built up good relationships with people in different departments of the local authority and within the NHS, so if I need to find out any further information, I tend to go to them for clarification” (P5).

Additionally, the use of informal communication paths demonstrates the vulnerability of formal communication pathways and the unfair manner in which relational knowledge flows between organisations.

The hidden emotional labour that aids transitional care

Emotional labour was identified as a central, highly embodied element of transitional care. Participants illustrated the ways in which they provided emotional support to families experiencing anxiety related to the transition, managed the emotional implications of uncertain or misleading information regarding a patient's needs, and absorbed the consequences of prior decisions made within the transitional care process. The work associated with managing emotions transcends individual interactions; instead, it serves as a repair mechanism to ensure the transitional care process remains intact, even when systems fail. Participants provided numerous examples of remaining after hours to communicate with anxious families, alleviating distress experienced by individuals during the admissions process, and emotionally supporting staff members who were overwhelmed by behavioural issues.

Participant 4 stated,

“When a new resident is admitted, we usually know it is going to be a long day. We often find ourselves having to assist staff in managing distressed behaviours from new residents as they settle, contact pharmacies to chase up prescriptions and communicate with anxious families”(P4).

As such, participants defined emotional labour as a fundamental aspect of their roles, not an exception. Without emotional labour, transitional care would be less sustainable. Participants viewed the need to perform this type of work as essential to continuing the care of people living with dementia with inadequate documentation, who were being discharged quickly, or whose behaviour was identified during the admissions process as a "behavioural complexity".

Sociomaterial theorising highlights the ‘felt quality’ of sociomaterial relations and recognises emotions as part of these relations (Stein et al., 2014). In the present study, participants’ accounts illustrate how emotional labour can operate as a form of relational repair between organisational silos, particularly when formal systems fail to provide adequate information or support. The accounts provided by participants illustrate the ways in which practitioners explain how they attempt to safeguard their residents and their families while at the same time remaining faithful to an ethic of care but are forced to do so within the walls of their organisations. Thus, emotional labour can be understood as both a resource and a burden; relational resilience defines the reliance on human efforts to compensate for the systemic shortcomings of healthcare systems.

There is a strong association between emotional labour and moral distress. Emotional labour served as both a practical tool and a moral practice, through which care providers navigated the ethical aspects of their work. The practice of emotional labour demonstrates how care work can conflict with the ethical principles of care and how there is a structural compensation mechanism (an unseen support system) for the transition in providing care services when the institutional framework fails or collapses. Participants described feeling guilty when prior decisions compromised the well-being of individuals; anger when documentation concealed risky behaviours; and sadness when people living with dementia and their families were misrepresented or marginalised. Care providers experience moral distress when they must comply with directives that violate their commitment to their residents. Care providers’ emotional investment in the individual’s well-being is both their greatest asset and liability.

The findings of this research indicate that emotional labour is not simply a resource for care providers, but an infrastructural element that corrects for structural weaknesses. Emotional labour provides a solution for the gaps created by inadequate documentation, insufficient time for transition, and the structural separation of communication pathways. However, emotional labour is also a precarious foundation: emotional labour is finite, emotionally exhausting, and will not endure if structural failures persist.

Relational repair and what this means

Consistently across the narratives, participants have emphasised the importance of relational knowledge, understanding a person's background, routines, preferences, and patterns of distress. Relational knowledge allows for the accurate interpretation of behaviours, minimises risk, and facilitates trust. However, relational knowledge is rarely conveyed from one transition to the next. Hospital staff often do not have the time or relational proximity to acquire this type of knowledge, documentation systems restrict the ability to record relational knowledge, and family involvement is variable. Relational knowledge can be acquired and reconstructed through the relational repair undertaken by care home managers to address shortcomings within the transitional care system. Relational repair refers to the work undertaken by care home managers to fill gaps in knowledge created by fragmentation within the transitional care system and can therefore be understood as a context-specific enactment of relational labour.

Examples include gathering missing information, negotiating with commissioning teams, seeking additional information from hospital staff and GPs and supporting families experiencing uncertainty. Relational repair is often described as routine, not extraordinary. In addition, participants acknowledged that transitions typically occurred with significant gaps in the information that was available to them (gaps, errors, omissions) with unrealistic timescales, and that relational repair is required to make the transition viable. Therefore, relational repair is a labour-intensive, high-skilled, emotionally demanding task that is typically invisible to those working formally in the system. The relational repair theme reveals the fundamental idea that continuity is not inherent in transitional care; it is produced through the work of care home managers to address the system-wide contradictions. Additionally, the relational repair theme demonstrates the fragility of transitions, which rely on the discretionary efforts of individuals attempting to navigate an environment that is hostile to the successful completion of transitions. Practitioners consistently stated that they had to "*start from scratch*" (P4) whenever a new individual was admitted to the care home, and that they had to relearn basic relational information through trial and error. Not only did this delay the development of a stable therapeutic relationship, but it also increased the possibility of distress or behavioural escalation. When relational knowledge was transmitted as part of the transition

process (i.e., through informal family communication), it enhanced continuity of care. This theme demonstrates a major structural problem: relational knowledge is essential to providing safe and person-centred transitional care, but the systems used to convey relational knowledge systematically discount and exclude this form of knowledge.

Overall, the themes developed from the data collected during this research demonstrate that transitional care is a complex and structurally constrained practice that is shaped by multiple factors including institutional fragmentation, epistemic limitations in documentation systems, temporal misalignment, fragmented communication pathways, and the emotional and relational labour of practitioners. The themes collectively illustrate that the frequent challenges faced by care providers during transitional care are not solely the product of individual communication failures or organisational inefficiencies; they are the outcome of the sociomaterial infrastructure and institutional logics that structure transitions. This section therefore provides a bridge to the interpretative segment of the thesis, where the mechanisms through which the problems experienced by care home managers during transitions arise and persist are considered.

How care providers describe the limits of their ability to act

Close attention to participants' accounts made it possible to identify the ways in which participants described their actions using a number of common linguistic forms that reflected constraints (i.e., modals (e.g., "we have to", "we can't"), the use of the passive (e.g., "we're told", "it has to be"), and references to the abstract organisational/structural entities that influence them). Beyond simply being common speech patterns, the form of discourse used by the care home managers reflects the ways in which care home managers conceptualise their own agency in transitional care. Care home managers most often represent the locus of control of their work as being outside of themselves (e.g., discharge teams, funding rules, and systems); therefore, they demonstrate an understanding of themselves as actors who are influenced, constrained, or excluded by organisational and structural entities. In addition, care home managers take ownership of outcomes that may extend beyond their ability to exercise control over those outcomes,

resulting in significant amounts of moral conflict in this dataset. When examining the relational elements of care, practitioners would use stories to reveal how they might assist people living with dementia and family members in acquiring further information and fostering relational stability. When comparing relational agency to institutional constraint, the findings can be interpreted as revealing two overlapping roles for care home managers: as moral agents seeking to preserve personhood and as institutional actors whose practice is constrained by organisational processes (Pettersen, 2011).

Finally, examining these accounts as participants' situated narratives, the examples above show how practitioners establish their moral identities in environments in which they have little influence over the outcome, while also illustrating how the dialogue between the constrained and active narrative worlds represents an understanding of the competing duties of care home managers, i.e., honouring their professional ethics while recognising the limitations of the institutional constraints on their practice. The establishment of this identity is critical in understanding how practitioners are able to navigate the conflicting nature of institutional boundaries, and continue to provide a relational approach to care, despite the presence of structural barriers.

Temporality creates a deeper structural strain

Temporal misalignment has been found to be much more than just a theme; it is a major structural factor influencing the transitions. Temporal theory provides a theoretical lens through which to examine transitional care, revealing two competing temporal regimes that govern transitional care: the hospital's goal of timely discharge and the relational time needed to provide safe transitional care for people living with dementia (Poulin et al., 2023). Participants acknowledged this, saying they felt that they worked in two distinct temporal domains: '*system time*' (P7), a temporal domain governed by efficiency, input, and timely decision-making; and '*care time*' (P1), a temporal domain governed by observation, relational understanding and step-by- step adaptation. The temporal domains of hospital discharge decisions and the care needs of people living with dementia have been

portrayed as mutually exclusive. The hospital's temporal domain emphasises timely discharges to facilitate patient flow and bed deployment. Conversely, care homes require time for planning and preparing for the arrival of a new person living with dementia by preparing the physical environment, facilitating communication with the family, and developing an understanding of the new individual's behavioural patterns and care needs. At times when these time-based domains intersect, the care home faces the requirement to quickly admit the individual, causing stress for the new person living with dementia, their family, and the care home. Temporal variability has exacerbated these pressures. Participants have described frequent last-minute changes to discharge plans, impromptu requests for placements, and inconsistent communication about the timing of these events.

"The pressure they can put on you ... we need this done by tomorrow, as you need to take him on Wednesday" (P4).

Participant 1 ...*"Why have you waited until today to call me about this. Or typically on a Friday... we really need this done before the weekend" (P1).*

"The hospital will say ... can you take him today? So, in response I'll say ...what today? Then they'll say, Yes, like now in the next 30 minutes, he's on his way" (P2).

"The biggest excuse they seem to use, for example is the husband has been admitted to hospital... he was the main caregiver....so can you take the wife today as there's no one to care for her tonight, until we get a care package arranged" (P5).

These temporal uncertainties disrupt the routine of care home operations, the duty rota, and the relational preparatory activities of care home staff. The temporal inconsistency between hospital discharges and the relational time needed for safe transitional care has been depicted as a fundamental structural contradiction that influences the stability and quality of transitional care.

While system time dictates the temporalities of the hospital discharge process, and the organisation's functioning relies heavily upon speed, the transitional care of

individuals with dementia, however, relies upon care time that includes slow observation, developing trust, interpreting behaviours and being responsive to relational changes. While the two temporalities may differ in terms of speed, they represent fundamentally conflicting sets of values. Further up the system's hierarchy, care providers will experience crises as the two temporalities collide as they do at every transition. Fast discharges result in incomplete documentation; the compressing of timelines makes it challenging to develop relationships; and the unpredictability of timelines results in difficulties in planning and preparing emotionally for the care home. As such, the strain experienced by care home managers, as they attempt to reconcile the conflicting temporal demands of the system, can be understood as closely associated with this temporal misalignment.

The analysis of the temporal misalignment points toward a broader ethical implication: that the acceleration of system time prioritises the institutional interest (i.e., efficiency) over the relational safety of the individual. Care time is not only slower, but also more humane, person-centred, and responsive to the lived experience of the individual living with dementia. When system time dominates, the individual becomes secondary to the interests of the organisation. In this way, time is a technology of power, directing decision-making, limiting relational practice, and defining what types of care are possible. Thus, temporal misalignment is not accidental but rather a structurally produced phenomenon as a function of the values that exist within organisations. Furthermore, it represents one of the core mechanisms contributing to the instability of transitions. The effects of such temporal misalignment continue through the network, creating an additional labour burden on professionals to restore order within it, referred to herein as relational repair.

The complex sociomaterial web of transitional care

This study's findings show that the care transitions for older adults with dementia take place within a highly complex network of social relationships involving professional actors, institutional logics such as rules and organisational culture, technological systems such as computer software, and documentary artefacts.

The findings of this study demonstrate that care transitions are not simple transactions between organisations but rather an interdependent system of people, processes, technologies, and environments that collectively shape decision-making, communication, and accountability among all stakeholders. Thus, it is inappropriate to characterise the transitional care sociomaterial structure solely through the opinions of the professionals or the policies of the organisations involved in the care process. Rather, transitional care is the product of multiple interactions and influences that are often unseen, uneven, and unpredictable. For example, in the participants' accounts, we see the effect that technology-based tools have on transitional care. Technology-based tools (for example, portal systems, electronic health records, and commissioning systems) directly influence the exchange of information during transitional care. They not only capture and convey information but also define how much information can be included in a record, what mandatory fields exist in a record, and how the information will be formatted for presentation to the next actor in the process. Participants gave many examples of how the narrative details included in a patient's record would be limited, and how predetermined templates used in documentation would limit the complexity of behaviours related to dementia.

Participant 3 stated: *“during the commissioning process, we are reliant on the information provided to us in order to make a decision regarding whether we are able to meet a person’s needs or not, and whether we should assess that person, We would often find discrepancies in their care needs when we do go and assess.” (P3).*

As a result, technology defines both what a person ‘knows’ and what the person’s circumstances are at the time of transition, and what ‘knowledge’ is ‘available’ and what is not available. Therefore, technology establishes and limits the epistemological landscape of transitional care. Transitional care practitioners must be able to navigate the environmental and organisational constraints of both the patient/family and themselves. Most of the time these are not compatible as hospitals want to quickly and efficiently discharge patients, minimising the risks associated with the provision of patient care, seeing discharge as operational. Care providers, by nature of how they admit and relate to people living with

dementia, take time to prepare for the arrival of a new individual, preparing the environment, staffing, and systems of the care home as well as providing relational security for their residents and long-term viability for the facility. Local authority teams have to operate and meet their statutory obligations at the lowest cost possible and brokerage teams have to operate within the financial and contractual frameworks set up by funding agencies. These examples illustrate how the sociomaterial arrangement of transitional care exercises agency that intersects with the intentions of human practitioners, at times facilitating action and at other times constraining or diverting it. Thus, the agency of care providers is achieved through negotiation, rather than assumed.

Embedded power relations within sociomaterial configurations of transitional care

The sociomaterial configurations of transitional care, and specifically the configuration of transitional care as a network of care homes, hospitals and local authorities, contain power relations. Specifically, the fact that the care home sits at the base of the network means that it receives individuals with potentially incomplete/limited knowledge of their individual risk factors due to either non-completion of required documentation or due to the omission of detail. Further, the inability for care homes to have access to hospital-based systems and assessment tools contributes to the epistemological imbalance between the two settings. On the other hand, the documentation created by hospitals and local authorities provides the foundation for all subsequent decision-making, regardless of its completeness or the presence of institutional pressures. Thus, the sociomaterial network contains an existing hierarchical structure as a result of policy and the design of systems, forms, and processes.

Part 2: Interpretivist research design

In Part 1 of this thesis, I described the content of the results of the study based upon the participants' accounts of how social care providers perceive transitional

care. In this section, I shall describe how the study has brought together an interpretivist paradigm, situational analysis as the primary analytical methodology, and actor-network theory as a complementary theoretical lens to develop an understanding of transitional care and specifically the relational, discursive and sociomaterial aspects of transitional care that may not be recognised via more positivist or procedural methods. From an interpretivist viewpoint, the study regarded transitional care as a social construct that exists due to meanings generated, relations and context. The study placed itself within this interpretive paradigm through chapters 1 and 2, highlighting that knowledge of transitions to dementia care arises from participants' accounts rather than merely objective measurement. The interpretivist approach permitted recognition that social care providers not only report transitional care but also interpret it, assign responsibilities, express moral concerns, and make sense of the uncertainty that arises through language. The examples in chapters 3 and 4 show that the participants' accounts of transitional care include metaphors of transition, breakdown and repair and are characterised as fragile, pressured, and emotionally charged. The interpretivist framework allowed a way to treat these accounts as meaningful data to illustrate how transitional care is interpreted and practised.

Participants' discourse shows that transitions were rarely reported as linear or planned. Participants' accounts showed that transitions were reported as reactive, rapid, and affected by conflicting demands. Participants frequently referred to *"firefighting"*, *"scrambling"*, *"chasing information"*, and *"keeping everything together"*. These terms were frequently used and demonstrate that participants regard the transitional process as something that requires active management and stabilisation, rather than progressing along a pre-determined course. Hence, the interpretivist framework allowed the identification of participants' interpretations of their role as mediating agents between systems, families, and people living with dementia and therefore the emotional labour, ethical concerns and identity work associated with transitional care. If the study had adopted another methodological position, then the emotional labour, ethical concerns and identity work associated with transitional care would have been ignored.

Actor-network theory (ANT) offered me an opportunity to explore whether transitional care is an activity that occurs solely due to the actions of humans. According to ANT, transitional care is developed through interactions between human and nonhuman actors including assessment tools, funding thresholds, referral forms, discharge goals, electronic portals, etc., that form transitional care pathways. Since ANT views transitional care as characterised by distributed agency between human and nonhuman actors, participants constantly referred to 'the system', 'paperwork' and 'the portal' when explaining the obstacles to their actions. Although participants' references to these barriers could be viewed as sources of frustration, ANT enables the researcher to see them as indicative of sociomaterial agency. Sociomaterial agency is shaped through documentation and technology and, in turn, influences the dissemination of information, the communication of risk and the options available to the individual.

Several participant accounts identified the transfer of agency from the individual to the networks of structures. When participants stated, "*the system moves people through*" or "*the paperwork does not tell the whole story*", they were identifying that agency had been passed to the network of structures rather than to the individual. ANT provided me with a model to understand how responsibility for transitional care is distributed throughout the network and how the adverse consequences of the decisions made throughout the network are normally attributed to the care home. Care home managers acknowledged in detail how they handled the consequences of decisions made outside of their control, such as behavioural escalation or inadequately communicated unmet needs. Network misalignment, where information, authority and accountability do not correspond, permits viewing these experiences through an ANT lens.

Situational analysis complemented the ANT perspective by providing a structured methodology to assess the complexity of the participants' accounts of their experiences. Chapters 3 and 4 utilised situational analysis, social arenas, and positional mapping to illustrate how the participants' multiple worlds of work, organisational priorities and values impacted transitional care. I used situational analysis to identify the discrepancies between the theoretical concept of person-centred care and the structured transitional care process, a theme that emerged

throughout all participants' accounts. The positional maps illustrated that speed and efficiency are typically prioritised over relational continuity; however, the participants' accounts demonstrated the risks of prioritising speed and efficiency for individuals living with dementia. Across the participants' accounts, the hectic nature of transitions was repeatedly described, particularly the insufficient time available to obtain information, prepare staff and involve families. Situational analysis allowed a way of considering these concerns as more than merely individual frustrations, but as structurally produced contradictions located within the situation. As previously noted, the combination of ANT and situational analysis further enhanced the study's treatment of participants' discourse. By examining both what participants stated and how they expressed themselves, the study identified the underlying assumptions regarding responsibility, care, and risk. The participants' frequent use of passive voice, for example "*the information was not transferred*" or "*decisions were made*", demonstrates a belief in limited agency and ambiguous accountability. Conversely, the participants' use of collective pronouns ('we') when referring to home care practice resulted in a shared moral identity centred on protection and responsibility. The patterns of discourse are comparable to the methodological obligation to understand transitional care as a socially and relationally produced phenomenon.

Together, interpretivism, ANT and situational analysis formed a cohesive methodology that allowed me to explore transitional care as a complex phenomenon that cannot be explored through more direct or outcome-focused methodologies. Interpretivism emphasised lived experience and the process of meaning-making; ANT highlighted the sociomaterial influences on actions, and situational analysis provided the context for exploring the relationships and power dynamics inherent in transitional care. The rationale behind choosing this methodology is illustrated in chapters 1 and 2, whereas chapters 3 and 4 demonstrate its analytical capability by providing results that take into consideration the structure and agency, stability and breakdown, and care and constraint characteristics of transitional care. Transitional care for individuals living with dementia, as the results of this study suggest, is not only a technical procedure but also a negotiated and precarious undertaking. The methodologies employed in this study enable a comprehensive and nuanced representation of

how transitions occur through the interaction of individuals, systems, and artifacts, as well as how social care providers interact with these developments through relational practices, emotional labour, and ethical judgment. Therefore, the methodological interpretation above supports the study's principal contribution by illustrating how the ways in which we undertake transitional care studies impact what we can perceive, understand, and alter.

Part 3: From Methodological interpretation to engagement with literature

Part 3 will present a layer-by-layer discussion of the literature on transitional care as it relates to the study's use of actor-network theory (ANT) and situational analysis. Additionally, this section will provide an overview of the literature at the national and international levels and will then go on to compare the study's empirical evidence to prior research and policy discussions regarding the transition from formal health services to informal community-based care for individuals living with dementia, as well as prior research and policy discussions on person-centred care and system integration. Part 3 will provide a comparative analysis to identify whether the study's results support, expand upon, or refute prior understandings of dementia transitions, person-centred care, and system integration. This comparative analysis will also highlight the contributions of this study and how its methodology has provided new perspectives on long-standing issues in transitional care and why these long-standing issues continue to exist, despite many years of interest in policy.

Where these findings fit with previous research

The study encompasses previous transitional care studies focused on older adults living with dementia. While numerous studies have documented that transitional care is typically fractured, unanticipated, and may fail (Allen et al., 2013; Kable et al., 2015; King et al., 2013) the study adds depth to previous studies by employing a sociomaterial and narrative-based approach to understand how transitional care breaks down and how those involved in the process (care providers) experience

transitional care failures. This section discusses the relationship between the study's results and prior literature by highlighting areas where the study supported past research, challenged former beliefs, and added to the theoretical, policy, and practical contexts of transitional care.

The comparative review is structured around the nine main thematic categories that were derived from the study's findings: fragmented institutional logics; documentation; knowledge flows; the creation and management of risk; time misalignment; communication disparities; emotional labour and moral distress; relational knowledge as a foundation for continuity; and the complexities of transitional care networks as sociomaterial systems. The comparative review demonstrates that prior literature successfully identified the indicators of transitional instability but typically failed to describe the structural, epistemological, and relational processes that generate such unpredictability. As such, while the study validated the concerns previously identified in the literature, it provided a more inclusive and theoretically coherent conceptualisation of the mechanisms that create discontinuities in transitional care than earlier literature. The remaining portion of this chapter will provide an overview of the major themes represented in the study's findings and the relevant previous literature. The section also demonstrates how the study's findings and analyses add to our understanding of both the theoretical and practical dimensions of transitional care for individuals living with dementia.

How do other studies define "system pressures" in transition?

Previous research has demonstrated significant fragmentation among health and social care organisations due to their varying priorities, cultures, and mandates. Hospital discharge research has described how pressure to increase throughput can conflict with holistic assessments. Statutory decision-making within local authorities has created pressure related to budgetary constraints when providing support for an individual. The literature on long-term care has described many of the relational, personal, and behavioural aspects of supporting individuals with dementia. Much of the literature reviewed in this study describes these conflicts in

terms of coordination, communication and service pressures, rather than explicitly examining the institutional logics that underpin them. This study makes an additional contribution by showing that fragmentation is a result of competition between organisational rationalities and is not just a result of poor coordination. Hospitals operate on the basis of performance metrics that measure speed. Local authorities operate under cost and defensibility frameworks. Brokerage teams operate under commissioning rules. Care home operators prioritise relational and behavioural safety in their operations. This multi-logic framework builds upon existing research and provides an integrative theoretical framework for explaining why many transitional care interventions (e.g., improving communication, streamlining procedures) often fail: they do not address the underlying incompatibility of institutional mandates. Therefore, this study supports the sociological literature on complex adaptive systems by identifying how transitional care occurs at the intersection of organisational worlds whose values are difficult to reconcile.

Previous studies have demonstrated the existence of paperwork and information gaps during transitions.

A considerable number of studies identify longstanding problems associated with transitional care, including the quality and completeness of discharge documentation (Kable et al., 2015; King et al., 2013; Allen et al., 2013), the quality of behavioural history documentation, and variability in the documentation of transitions. This research also demonstrates that many studies have found significant gaps in the collected data about patients' functional status, their comorbid conditions, their medications, and potential behavioural risk factors. Many researchers acknowledge that gaps in documentation lead to a series of dangers, as well as poorly coordinated transitions. This study expands the literature on documentation in transitional care by recognising it as an epistemological artefact shaped by institutional priorities, rather than merely categorising it as 'incomplete' documentation. As opposed to viewing documentation problems as errors, omissions, or failures of communication, this study illustrates that documentation is structurally limited by the tools (forms) and

portals through which it occurs; therefore, the limitations of documentation will remain an issue regardless of the many policy interventions implemented to address them. The issue is not staff diligence or skill, but the representational logic of documentation systems.

This study utilises the theoretical framework of sociomaterial research and, as such, aligns with an increasing number of researchers who are challenging the assumption that information is neutral. In support of the existing research demonstrating that templates, digital portals, and other bureaucratic systems impact what types of knowledge can be documented and how individuals are portrayed in institutional processes, this study contributes to the literature on dementia care by demonstrating how biomedical or functional descriptions of patients are prioritised over relational, emotional, or behavioural knowledge, thereby shaping what forms of knowledge are recognised and used within transitional decision-making.

Temporal misalignment between system time and care time in dementia care transitions

There is broad consensus in the literature about the presence of timing pressures in hospital discharge transitions for older adults with dementia. The literature reports that older adults with dementia are discharged from the hospital more rapidly than other populations and that they are provided with little or no time for preparation for their post-hospital care arrangements. The temporal dimensions of relational care have been examined in other studies, and it has been found that slow, deliberate, and empathetic approaches are key to engaging with people who live with dementia. Building on this literature, this study considers the temporal dimensions of relational care through a theoretical model that identifies a conceptual disparity between two regimes with different temporal priorities: 'system time' and 'care time'. 'System time' refers to a focus on processes, service delivery, and productivity, whereas 'care time' refers to a focus on relationships, understanding behaviour, and achieving emotional harmony. As such, the literature on person-centred dementia care rarely examines the structural conflicts

that arise when person-centred temporalities intersect with industrialised, hospital-based logic. This study characterises temporal misalignment as a fundamental mechanism generating discontinuity and instability in transitional care and presents a more theoretically informed account of this phenomenon than the existing literature provides.

The definition of communication breakdowns in transitional care varies across studies.

Communication breakdowns are commonly cited as a primary source of poor coordination in transitional care (Allen et al., 2013; King et al., 2013). Studies have documented the presence of incomplete handovers, inconsistent communication with family members, and fragmented interprofessional communication. Most transitional care literature addresses communication issues as a matter of interpersonal or procedural relations.

This study finds that communication failures are not only relational but also shaped by organisational hierarchies and information systems that favour one actor over another. For example, care homes which are located at the end of the transition sequence are often denied access to conversations, documents, or decision-making processes that other actors assume exist. In addition to confirming prior research that demonstrated communication asymmetry as a mechanism of exclusion that constrains care providers' knowledge and action, this study further clarifies how communication irregularity is not only a symptom of communication failure but a key factor in producing communication failure.

Furthermore, this study explains the compensatory role of informal relational networks (e.g., direct calls, personal relationships, historical interorganisational connections) in helping to mitigate structural communication biases. Although previous literature acknowledges the existence of informal communication, it does not characterise it as an adaptive response to institutional inequities. This study presents informal communication as a relational solution to partially stabilise a structurally unequal communication environment. Temporal misalignment therefore provides an important condition within which relational labour and, more specifically, relational repair become necessary: the compression of transitions by

system time limits opportunities for the relational work associated with care time, requiring care providers to compensate for these temporal differences through additional relational work.

How previous studies frame emotional labour but leave it unexplored.

Previous research has generally identified that carers take on certain obligations in relation to others and that those obligations may create high amounts of emotional labour for carers (Hochschild, 1983; Bolton, 2005; Theodosius, 2008). (i.e., high amounts of exhaustion and stress created by conflicting expectations, poor quality of care observed by the carer, and the resolution of ethically difficult situations.)

This study expands upon previous research by demonstrating that emotional labour is not simply a by-product of the work completed by care providers but rather a core part of transitional care systems. Care providers use emotional labour to reduce distress experienced by people living with dementia, improve communication among family members who are confused and frustrated with them, clarify organisational misunderstandings, and provide the tools to deal with the ethical challenges involved in their role. Furthermore, this study expands previous research by demonstrating that emotional labour is a structural component of transitional care and not an additional variable. Prior literature has conceptualised moral distress in relation to moral constraint and conflict (Jameton, 1984; Corley, 2002; Fourie, 2015). The findings from this study indicate that moral distress is produced by the structural elements of transitional care (temporal acceleration, risk reallocation, and knowledge deficits) that position care providers as responsible for the outcomes of events and processes over which they have no direct control. Therefore, the results of this study provide evidence to support and expand the body of literature related to moral distress (Jameton, 1984; Corley, 2002; Fourie, 2015) by placing it in the context of sociomaterial constructions rather than solely within ethics and psychology.

The marginalisation and non-transfer of relational knowledge in transitional care

A substantial body of dementia-care literature focuses on the role of relational knowledge, for example, the history of a client, their behaviours, non-verbal communication signs, and emotional needs (Kitwood, 1997; Nolan et al., 2004; McCormack, 2004; Dewing, 2008). Transitional care research has given little attention to how relational knowledge is used to help provide care and why it is seldom communicated to other organisations involved with providing transitional care (Allen et al., 2013; Kuluski et al., 2017). This study advances the literature by demonstrating how relational knowledge is consistently omitted from both documentation systems and cross-organisational information exchanges. It further explains why such knowledge is not routinely exchanged between organisations, highlighting how organisational priorities fail to recognise relational knowledge as valuable (Allen et al., 2013; Brown Wilson et al., 2009). In doing so, the study extends existing literature by conceptualising relational knowledge not as informal, but rather as formalised and marginalised.

To the author's knowledge, limited research has examined the development of relational knowledge from the perspective of long-term care providers during the post-admission transitional care process (Allen et al., 2013). This study's results indicate that relational knowledge develops through the day-to-day interactions of care providers, and it is dynamic, not static. If systems do not provide for the sharing of relational knowledge, care providers will have to continually revisit and reinterpret their relational knowledge to maintain continuity of care.

Transitional care as a sociomaterial network of human and material actors

Although a sizeable number of sociomaterial scholars have studied healthcare infrastructure, technologies, and professional practices (Latour, 2005; Fenwick and Edwards, 2010; Mol, 2002; Greenhalgh and Stones, 2010) relatively few studies using these frameworks have focused specifically on transitional care for older adults living with dementia. Transitional care research has focused on

communication, procedures, protocols, and human behaviour (Naylor et al., 2011; Coleman and Boulton, 2003; Allen et al., 2013). This study offers a fresh perspective by depicting transitional care as a distributed sociomaterial system, where humans and nonhumans jointly construct agency. The various actors in the transitional care process, such as portals, templates, discharge targets, funding rules, assessment tools, staffing levels, and physical environments, interact with care providers and family members to shape transitional care. This study extends the literature by showing that systemic difficulties in transitional care can be understood not only in relation to human actions but also through the co-construction of transitional care through interactions among human and material actors (Latour, 2005; Mol, 2002; Clarke et al., 2018). This study therefore provides a more comprehensive interpretation of why transitional care continues to be difficult to achieve, regardless of the level of training, policy guidance and communication-based interventions. By portraying transitional care as the emergent outcome of sociomaterial networks, this study adds depth to the ANT and situational analysis (Latour, 2005; Clarke, 2005; Clarke et al., 2018). This portrayal of transitional care as sociomaterial networks shows how systemic changes in transitional care will require changing the relationships between humans and materials, not simply changing human behaviour or procedures.

From fragmentation to a multi-layered model of transitional care

The evidence-based findings from this study, along with those from multiple other studies, indicate that transitional care failures are related to factors such as fragmentation of care, poor documentation, communication failures, and systemic barriers; all of these share the common theme that various complex factors contribute to transitional care failures, making them difficult to identify and resolve. This study contributes to the understanding of transitional care failures through the integrated use of situational analysis and actor-network theory, supported by close interpretive attention to participants' narratives and accounts. In addition, the study demonstrates how transitional-care difficulties can emerge through interactions among a number of structural, temporal, epistemological and relational mechanisms that contribute to instability in care as reported in the many

other studies documenting transitional care failures. Thus, the study adds further to the existing body of research concerning transitional care failures in dementia care by providing a more inclusive and integrated theoretical model of how the relationships among the sociomaterial factors and the relational and ethical complexities of the transitional care experience are linked. The study also offers a comprehensive, multi-layered and theoretically informed model of the transition into long-term care that brings together the sociomaterial, relational and organisational dimensions identified through the analysis.

Using an interpretivist approach to knowledge development (in combination with the lenses provided by actor-network theory and situational analysis) enables the provision of a detailed and nuanced description of the events that occur in transitions to long-term care for individuals with dementia and how the transitions are created, negotiated and given meaning by the individuals and organisations involved in the transitions. The participants' accounts demonstrate that transitional care is a process characterised by elevated levels of both relationality and materialisation and is shaped by professional judgements, organisational pressures, documentation practices, digital systems, and emotional labour. Interpretivism focuses on how care providers and other professionals make sense of the uncertainties they face in caring. Actor-network theory highlights the role of both human and nonhuman actors in shaping the course of care. Collectively, these analyses suggest that transitional care is best conceptualised as occurring within multiple domains (the social, organisational and policy) and that each of these domains potentially creates many linkages when studied as a process. Collectively, these analyses indicate that transitional care is inherently unstable and contingent and must be continuously stabilised by practitioners due to its unpredictability and lack of a universal process.

Part 4 - Providing answers to the research questions

In this part, the study provides the response to the research questions. The study was designed to investigate how care home providers conceptualise and implement transitional care for older adults with dementia as they transition to

long-term care. Semi-structured interviews were conducted with care home providers and other professionals, and the resulting accounts were analysed through situational analysis, informed by the complementary theoretical lens of actor-network theory (ANT). The findings demonstrated that transitional care does not occur as a singular event but rather as a process created by interaction between people, systems, documentation, policies, and organisational constraints. Each research question is examined separately using a continuing narrative to show how the study's findings respond to each of the study's research questions.

Research Question 1: Social care providers' views of the transition process

The first research question was: "What are the views of social care providers regarding the transitional care process for older adults living with dementia who enter long-term care?" The findings of this study were that, unlike what would be expected based on literature regarding transitional experiences, social care providers do not see the transition as a discrete, identifiable stage of care. In fact, they report that the transition experience is emotionally charged, relationally complex, and uncertain, which is part of the overall care experience (prior to and after admission to a care home). Social care providers identified the transition experience as precarious, characterised by uncertainty about roles or responsibilities and increased levels of risk. They believed that transitions are less about following a recognised process and more about managing uncertainty during admissions. There is doubt regarding the individual's cognitive functioning, physical needs, behavioural presentations, and family expectations. Providers repeatedly stated that they were "keeping things together" during the transition period. Providers are able to compensate for missing information, delayed assessments, and unclear discharge plans. This positioning places care home staff not as passive receivers of referrals, but as active coordinators and negotiators within the confines of the current systems. Using ANT, the findings of the study indicate that providers see themselves as primary actors within the larger transitional network. The work of providers involves translating information from hospital documents, negotiating with families, interpreting risk assessments, and ensuring adequate staffing. Importantly, nonhuman actors (e.g., discharge

summaries, referral forms, risk assessment tools) play a pivotal role in how transitions evolve. Although these documents are often incomplete or inaccurate, they have a significant impact on decision-making. Therefore, the transition is created through interactions between humans and paperwork, not solely through professional judgment. This situational analysis expanded my understanding of the care provider's perspective by locating the transition within its organisational and structural context. The transition is influenced by a number of pressures, including bed availability, commissioning agreements, staffing levels, and regulatory requirements. This approach also enabled me to reflect on the broad range of societal and environmental forces within health and social care that may create time constraints and accountabilities that limit the provider's ability to adopt a person-centred approach to planning. As a whole, the findings of this study demonstrate that care providers conceptualise transition as an ongoing relational process that requires constant adjustments, vigilance, and emotional labour. This conceptualisation contradicts policy discourses that characterise transitions as linear and/or procedurally controlled events.

Research Question 2: Barriers and facilitators to transitional care.

The second research question was: 'What are the perceived barriers and facilitators to providing care for individuals with dementia during transitions into long-term care?'. The findings of the study demonstrate that barriers and facilitators to transitional care are not static categories but rather emerge as a product of the interaction of numerous human and nonhuman actors in the transition network. One of the most significant barriers mentioned by participants was poor communication across organisational boundaries. Providers frequently reported receiving incomplete or delayed information from hospitals or community agencies, especially regarding the cognitive status, behaviour, or medications of the person with dementia. The lack of dependable information increased staff anxiety placed additional burdens on them and increased the risk for the person with dementia during the initial stages of admission to the care home. From an ANT perspective, this illustrates the failure of the network where important nonhuman actors (i.e., assessment documents, electronic medical records) failed

to function properly as intermediaries of information. An additional significant barrier was time pressure. Participants described transitions happening rapidly and usually as a result of the need for the hospital to meet discharge targets rather than because of readiness or suitability of the person with dementia for the care home. The rapid nature of the transition provided little opportunity for building relationships with staff, preparing for the transition, or engaging with family members. Situational analysis highlighted how time pressures are located in policy and organisational structures rather than being the fault of individual practitioner incompetence. In addition to barriers to transitioning, several facilitators were identified. The strong informal relationships that exist between practitioners, such as when a care home provider has previously worked with the hospital discharge team or social worker, are viewed as crucial to creating smooth transitions in care. These informal relationships allow staff to ask for clarification, work together to create an acceptable timeline and fill gaps in systems. Using the terms from actor-network theory (ANT), these interpersonal connections can be seen as 'stabilising' ties within the network, therefore allowing transitions to occur regardless of the limitations of the structure. Professionals' experience and tacit knowledge also served as facilitators. Care providers rely heavily on their collective knowledge of dementia care to interpret limited information and anticipate potential problems. This knowledge enables them to adapt care practices quickly after the person has arrived. However, reliance on individual competence also reveals structural vulnerability since many successful transitions rely on the resilience of individual practitioners rather than the robustness of the systems.

In summary, the findings of the study suggest that barriers and facilitators are dynamically produced in the transitional situation. They are developed through interactions between people, documents, policies, time constraints, and organisational cultures, rather than as separate factors.

Research Question 3: The contribution of situational analysis to understanding transitional care.

Question 3 within the study asked, How can situational analysis increase understanding of the interactions among human, nonhuman, organisational and discursive elements involved in transitions into long-term care? The use of situational analysis, supported by actor-network theory (ANT) as a complementary theoretical lens, provides the most direct response to this question. Findings show that actors are continually negotiating and developing transitional care pathways as opposed to the pathways being predetermined or standardised. Human actors include care home managers, nurses, hospital staff, social workers, families, and the person with dementia, while nonhuman actors include assessment documents, referral forms, risk tools, medication charts, policies, bed availability, and regulatory requirements. Each of these actors affects the manner in which the transition develops. ANT is useful in demonstrating that nonhuman actors are not passive. For example, discharge summaries and assessment forms often shape whether a care home accepts a referral, how staff prepare for admission, and what resources are mobilised to provide care. When these documents are incomplete or incorrect, they can disrupt the network and lead to reactive rather than planned care. Therefore, nonhuman actors influence practice, risk management, and decision-making. Situational analysis provides additional context to these interactions by illustrating the broader influences on the transition.

These influences include the imperative to promote hospital flow, the pressure to contain costs, the shortage of available staff, and the expectation of society to promote quality dementia care. The transitional pathway is therefore the product of intersecting social worlds where conflicting priorities must be aligned. At the intersection of these social worlds, care providers strive to strike a balance between person-centred values and system-based expectations. Within the transitional-care networks examined in this study, people with dementia emerged as marginalised actors. Family member accounts, documentation, and professional interpretations are used to capture the voice of an individual with dementia. Therefore, transitional pathways are shaped more by organisational and material elements than the expressed wishes of the individual, which raises ethical and practical concerns regarding the personhood and autonomy of individuals with dementia in transitional care.

Synthesis of the three research questions

The three research questions do not represent separate aspects of transitional care but rather explain distinct levels of the same complex situation. Read collectively, they demonstrate that transitional care for older adults living with dementia is generated by the interactions of professional perspectives, systemic constraints and the sociomaterial networks that shape how transitions occur in practice.

Chapter 5 has interpreted the findings of the study through an interpretivist paradigm, using situational analysis as the primary analytical methodology and actor-network theory as a complementary theoretical lens, to demonstrate that transitions into long-term care for people living with dementia are not smooth, continuous, rational pathways, but are relational products of the social world that are systemically constrained and emotionally maintained. This discussion has shown how long-term care providers make sense of transitional care as a fragile process shaped by conflicting institutional logics, sociomaterial arrangements, temporal pressures, and uneven distributions of responsibility. The analysis has demonstrated how care home providers and nonhuman actors interact to produce transitional pathways, how barriers and facilitators emerge within fragmented systems, and how long-term care providers perform substantial amounts of relational and emotional labour to stabilise transitions in the absence of systemic coherence. Having located the findings of the study in the existing literature and articulated the theoretical and practical implications of the findings, the discussion has illustrated what this study adds to our understanding of dementia care transitions and why the challenges associated with these transitions persist regardless of the amount of policy attention they receive. Chapter 6 will consider the strengths and overall contribution of the study, its limitations and outline implications for future research, policy, and practice.

Chapter 6 - Conclusion

The study presents empirical evidence of transitional care experiences from the viewpoint of care providers who work with people living with dementia, presenting a grounded representation of how transitional care is experienced at the point of service delivery. The study also presents a theoretical contribution. Transitional care has historically been viewed as a linear process and, therefore, as a sequence of transitions between several types of care environments. The study, however, views transitional care as a sociomaterial assemblage (a term taken from actor-network theory) which consists of human agents (care providers), nonhuman material objects (such as documentation, technology, etc.), institutional logic (commissioning, performance metrics, etc.) and emotional labour (the emotional demands placed upon care home providers when supporting individuals who are transitioning from community settings into care homes).

The study therefore proposes a conceptual approach to understanding transitional care that places responsibility for problems associated with transitional care within the wider system rather than attributing them solely to individuals within the system, thereby providing a foundation for identifying potential solutions.

Limitations of the Study

In evaluating this study, it is necessary to take into account the constraints and limitations imposed by its design. The number of participants in this study was relatively small, and nearly all of the participants in this study were based in the south and south west of England. Although I made attempts to engage respondents from a broader geographic base and from various professional backgrounds, recruitment constraints resulted in the sample ultimately consisting of long-term care service providers and a small number of system-level service providers. Consequently, the transferability of the findings is necessarily shaped by the specific geographic region and professional contexts which the sample was recruited, and the findings do not represent a nationally representative view. However, as previously discussed, I designed this study within an interpretivist

paradigm, using situational analysis as the primary analytical methodology and actor-network theory as a complementary theoretical lens. In accordance with this, the primary intention of this study was to develop theoretically informed interpretations rather than statistical generalisations. Secondly, this study has placed significant emphasis on the perceptions and experiences of long-term care service providers. The views of other stakeholders involved in transitional care (i.e., people experiencing dementia, family carers, hospital discharge staff, and social workers) were not included in this study. Including their views may have provided a clearer understanding of the ways in which transitional care is constructed across different organisational and relational boundaries. Thirdly, this study has focused on transitions into long-term care and has not investigated alternative forms of transition (e.g., reintegration into the community; transitions between different care settings). In addition, the research project was conducted in the context of the English health and social care system. Therefore, the applicability of the findings to other countries would need to be considered in relation to differing structures and policies. Finally, the methodological and theoretical approaches used in this study emphasise meaning, relationships and system interactions rather than measurable outcomes or cost-effectiveness. Although this study provides a wide-ranging overview of the mechanisms and processes at work, it does not allow for conclusions to be drawn regarding the quantitative effects of the problems identified.

Strengths and contributions of the study

Despite these limitations, the study makes several important contributions. The study provides an in-depth analysis of transitional care from the viewpoint of long-term care providers, whose expertise and experiences have historically been under-represented. In addition to making an empirical and conceptual contribution, the study also makes a methodological contribution by demonstrating how situational analysis, informed by an interpretivist paradigm and complemented by actor-network theory, can be used to examine transitional care as a relational and sociomaterial process.

Situational mapping was used to identify the broader arenas and social worlds that shape transitional care. Actor-network theory was employed to identify the agency of documents, technology, and policy in creating obstacles to transitional care. The combination of actor-network theory and situational analysis therefore provides a richly textured and complex understanding of transitional care, enabling both the wider situation and the relationships among human and nonhuman actors to be examined. Additionally, the study identifies the significance of relational and emotional labour in providing continuity of care, while at the same time demonstrating how relational knowledge is frequently marginalised through formal systems of documentation and decision-making.

Relational labour has also been informed by earlier research on emotional labour (Hochschild, 1983; Theodosius, 2008) and relationship-centred care (Nolan et al., 2004). This research is distinctive because, although relational labour has been recognised as important within care and relationship-centred practice, its operation within transitional care, particularly in the context of organisational uncertainty, fragmented systems and limited information, has received less attention. Therefore, the primary contribution of this research lies not in identifying relational labour as a new entity, but in demonstrating how relational labour functions throughout the transitional care process and how long-term care providers utilise relational labour to compensate for systemic fragmentation, lack of information and organisational ambiguity. Through examination of relational labour from care providers' perspectives, this research expands the understanding of transitional care and offers fresh perspectives on the interaction among relationships, professional judgement, organisational processes and documentation to stabilise transitions.

Furthermore, by developing a dynamic and continually stabilised understanding of transitional care, the study proposes a conceptual framework that brings together temporal misalignment between system time and care time, relational labour and relational repair, human and nonhuman actors, organisational processes, documentation and professional judgement to explain how transitions are produced and stabilised. This framework has implications for policy, practice and future research.

Lastly, the study offers a theoretical interpretation of person-centred care by demonstrating how the delivery of person-centred transitional care is shaped not only by professionals' intentions and relationships with individuals, but also by the organisational, material and procedural conditions within which care is provided. The study therefore offers a theoretical interpretation of how the relational, organisational and sociomaterial configuration of transitional care contributes to the difficulties encountered during transitions.

Recommendations for future research

Future research could extend this work in several important ways. For example, research that includes participants from a wide variety of backgrounds, including people living with dementia, family members, health professionals, social workers, and commissioners, would enhance our understanding of how transitional care occurs within differing organisational contexts. Comparative research examining different parts of the UK and internationally would allow researchers to assess the degree to which structural and policy contexts affect the transitional care of an individual. In addition to assessing the effectiveness of new assessment tools and improved communication systems and collaboration among professionals, further research is needed to determine whether these strategies are effective in addressing the problems identified in this study. The use of longitudinal studies to follow the same individual through the entire transitional care process may provide insight into changing needs of individuals during their transitions.

Research comparing different methodological approaches, such as qualitative and quantitative methods, and examining the frequency and effects of the issues identified in this study may help researchers develop evidence-based recommendations to improve services on a larger scale.

Implications for policy and practice

A key implication for policy is that transitional care reform cannot be achieved simply through procedural changes (such as developing guidelines for care providers). For example, the study found that care providers are unable to provide the best possible care to people who are transitioning into care homes because of the lack of information, flexibility in commissioning processes and the lack of incentives for healthcare professionals and care providers to develop relationship-based services. These structural conditions produce fragmentation and inefficiency in transitional care.

This study's second policy implication is that decision-making often overlooks the critical relational and experiential knowledge that care providers possess. For example, care providers possess important relational and experiential knowledge about what can support smoother transitions from community to long-term care. Therefore, transitional care reform requires policymakers to recognise and value the knowledge of care providers and involve them in decision-making at an earlier stage than is typically the case.

A third implication of this study for policy is that care providers require support and resources to deliver high-quality transitional care. For example, health and social care providers require training and education to understand the complexities of transitional care and to develop the relational and technical skills required to deliver this care. Similarly, care providers need the resources necessary to deliver relationship-based services, including sufficient staffing and funding to employ staff with the required skills.

A fourth implication of this research for policy is that the changes needed for transitional care need to be accompanied by an overall cultural transformation in how transitional care is viewed. In order to achieve such a cultural transformation, there needs to be a culture that supports and values relational work (i.e., the work involved in building and maintaining relationships), as well as acknowledges the emotional labour involved in supporting individuals through transitions in care. A

culture that supports and recognises the work of care providers will allow for a more comprehensive approach to transitional care rather than focusing solely on reducing costs and increasing administrative efficiency. In addition to producing implications for policy, the study also produces implications for practice. For example, the study argues that transitional care reform requires a fundamental redesign of assessment and referral processes. These processes should incorporate narrative and relational knowledge rather than solely relying on medical knowledge. The study asserts that care providers should be supported to use digital systems that facilitate rather than constrain their work. Care homes collect a large amount of data regarding individuals, but it is held in different formats, and the systems do not connect with NHS or local authority records, making it harder to see individuals' health and care needs clearly. The highest priority arising from the implications of the above research findings is the early recognition and incorporation of the relational/experiential knowledge of long-term care providers into the transitional-care process. These findings show that care providers in this study used relational labour, professional judgement and relational repair to offset incomplete information, time compression and fragmentation of communication. Early inclusion of care providers in assessment, referral and discharge planning will allow a number of the structural barriers illustrated throughout this study to be mitigated. Shared responsibility among the health and social care systems, including hospital discharge teams, local authorities, commissioners and providers, is required to make this change rather than placing the burden on individual practitioners. In practice, this will include care providers participating at an earlier stage in discharge and placement discussions; relational and behavioural knowledge being incorporated into assessments and referrals alongside clinical information; and communication systems being put in place to facilitate the timely exchange of information across organisational boundaries.

Through the voices of the care providers, this study demonstrates that, despite the significant amount of focus that has been given to transitional care through government regulations and policies, it remains an emotionally demanding and structurally constrained process. By describing the hidden labour that supports transitional care, this study contributes to a deeper understanding of the transition

from home and community care to long-term care for individuals living with dementia.

The study lays the groundwork for re-evaluating the organisation of transitions, the valuation of knowledge within care systems, and the provision of suitable support for both individuals living with dementia and care providers involved in transitional care. The study describes how the transition from hospital to long-term care for older adults living with dementia is not a straightforward administrative task but rather a negotiated accomplishment. Through the accounts of care providers, the study reveals a system of transitional care in which continuity is sustained through additional pre- and post-transition work, relational repair, and emotional labour, despite the presence of significant structural barriers to practice. The study was informed by an interpretivist paradigm, with situational analysis used as the primary analytical methodology and actor-network theory as a complementary theoretical lens, providing a comprehensive understanding of the development and sustainability of transitional care processes and the factors contributing to ongoing challenges in transitional care despite increasing policy attention. Although improving transitional care may involve better communication, clearer guidelines, and improved coordination, the study demonstrates that these will not be sufficient without recognition of the sociomaterial infrastructure, temporal regime, and power relations that shape practice. The study lays foundations for examining the 'invisible' labour which underpins transitional care and provides a framework for understanding how transitions are organised, how care providers' knowledge, expertise and contributions should be valued within health care systems, and how effectively these systems support both the individuals living within them and the professionals working within them. Ultimately, transitional care is not simply a process of moving an individual from one setting to another; it is a negotiated, relational and sociomaterial process sustained through the often-invisible work of those who provide and coordinate care.

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Appendix 1



Care home providers experiences of ‘transitional care’ for people living with dementia entering long-term care.

Introduction

Questions – Care Home Provider

1. Could you describe your current role within the care home and your involvement in supporting people living with dementia who are transitioning into long-term care?

Probe:

- How long have you worked within long-term care?
- What responsibilities do you have during admissions and transitions?
- How frequently do you support admissions from hospitals or community settings?

2. From your experience, could you describe the current process of receiving people living with dementia into your care home?

Probe:

- What usually happens from receiving a referral to admission?
- Which organisations and professionals are involved?
- How do you work alongside hospitals, social workers, brokerage teams, Trusted Assessors, families, and other services?

3. What information do you usually receive during the referral and admission process, and how useful do you find this information?

Probe:

- Which documents are commonly provided?
- Is information regarding dementia diagnoses, mental health history, behaviours that challenge, communication needs, preferences, and life histories routinely available?
- What information is frequently missing?
- Is there any additional information that would assist you in planning care?

4. How do you determine whether a prospective resident's needs can be safely and appropriately met within your home?

Probe:

- Staffing levels?
- Environment?
- Staff knowledge and skills?
- Resources?
- Risks associated with accepting admissions?
- Have there been occasions where you felt a referral was not an appropriate match?

5. How important is understanding a person's life history, routines, preferences, relationships, and behaviours when planning care following admission?

Probe:

- How do you obtain this information?
- Who provides it?
- Is this information routinely documented?
- How is this information shared among staff and with other organisations?
- Does this information influence continuity of care?

6. Are there occasions where you undertake additional work to support transitions when formal information or referral systems are incomplete?

Probe:

- Liaising with families?
- Contacting professionals?
- Clarifying misunderstandings?
- Seeking additional information?
- Providing reassurance?
- Negotiating expectations?
- Supporting continuity following admission?

7. Can you describe your experiences of communication and information sharing during transitions into long-term care?

Probe:

- What works well?
- What challenges arise?
- Are there differences between organisations?
- How transparent do you perceive the process to be?

8. From your experience, what factors contribute to delays or difficulties during transitions into long-term care?

Probe:

- Communication issues?
- Funding arrangements?
- Availability of placements?
- Staffing pressures?
- Hospital discharge targets?

- Waiting for assessments or decisions?

9. How do you seek to provide person-centred care when someone living with dementia is admitted to your care home?

Probe:

- Family involvement?
- Understanding preferences?
- Supporting routines?
- Preparing staff?
- Managing transitions sensitively?

10. Can you describe your experiences of working collaboratively with hospitals, social workers, brokerage teams, Trusted Assessors, and other professionals during transitions?

Probe:

- Positive examples?
- Challenges?
- Building relationships?
- Trust between organisations?
- Opportunities for improvement?

11. What roles do services such as Trusted Assessors, Transfer Care Hubs, or discharge teams play in supporting transitions into long-term care?

Probe:

- Improved communication?
- Better matching of placements?
- Reduced delays?

- Support for families?
- Any limitations?

12. Have you observed any differences in how self-funded and Local Authority-funded individuals experience transitions into long-term care?

Probe:

- Opportunities to visit homes?
- Family involvement?
- Timing of decisions?
- Choice and control?
- Access to information?

13. Reflecting on your experiences, how influential do you think referral documents, assessments, digital systems, and organisational procedures are in shaping transitions into long-term care?

Probe:

- Do they facilitate practice?
- Do they constrain practice?
- Do they influence decisions independently of professional judgement?
- How significant are they in supporting safe and effective transitions?

14. If you could improve any aspect of the referral, admission, or transitional care process for people living with dementia entering long-term care, what would you change and why?

15. Is there anything else you would like to add regarding your experiences of supporting people living with dementia during transitions into long-term care?

Appendix 2



Trusted Assessors' experiences of 'transitional Care' for people living with dementia entering long-term care.

Questions – Trusted Assessor

1. Could you describe your current role as a Trusted Assessor and your involvement in supporting people living with dementia who are transitioning into long-term care?

Probe:

- How long have you worked in this role?
- What are your main responsibilities during the transition process?

2. From your experience, could you describe the current process of supporting people living with dementia who are entering long-term care?

Probe:

- At what stage do you become involved?
- Who are the key professionals and organisations involved?
- How do you work alongside hospitals, social workers, brokerage teams, families and care home providers?

3. In your experience, does the information available during assessments provide a sufficiently comprehensive understanding of the person living with dementia?

Probe:

- Is information regarding dementia diagnosis, behaviours that challenge, mental health history, communication needs, preferences and life history routinely available?
- Are there any important types of information that are frequently missing?

4. How do you obtain information that is not captured within formal assessment documentation?

Probe:

- Do you speak with families, ward staff, care home providers or other

professionals?

- How important is informal or relational knowledge in informing your assessment?

5. What factors facilitate or hinder effective transitions into long-term care for people living with dementia?

Probe:

- Communication between organisations?
- Availability of placements?
- Time pressures associated with hospital discharge?
- Funding arrangements?
- Access to specialist services?

6. To what extent do you believe current assessment and referral systems support person-centred transitions?

Probe:

- How are the views and preferences of the person and their family considered?
- Are there situations where organisational priorities can make person-centred approaches difficult to achieve?

7. What do you perceive to be the benefits and challenges of the Trusted Assessor model in supporting transitions into long-term care?

Probe:

- Does the role improve continuity?
- Does it improve information sharing?
- Does it reduce unnecessary delays?
- Are there limitations associated with the role?

8. In your experience, are people living with dementia generally placed in care settings that appropriately meet their assessed needs?

Probe:

- What factors influence these decisions?
- How are concerns addressed when a proposed placement may not be suitable?

9. Have assessment and referral processes changed during your time working within transitional care?

Probe:

- Have these changes improved transitions?
- Are there aspects of previous systems that worked better?

10. Reflecting on your role, do you think assessment documents, referral systems and digital technologies significantly shape transitional care processes?

Probe:

- How do these systems support practice?
- How might they constrain decision-making or communication?

11. Is there anything else you would like to add regarding your experiences of supporting people living with dementia during transitions into long-term care?

Appendix 3



Local Authority Care Commissioner experiences of ‘transitional care’ for people living with dementia entering long-term care.

Questions – Local Authority Care Commissioner

1. Could you describe your current role and responsibilities within commissioning older adult services?

Probe:

- How long have you worked within commissioning?
- What aspects of transitional care fall within your remit?
- How do you engage with long-term care providers, health services and other stakeholders?

2. From your experience, could you describe the current process for supporting people living with dementia who are transitioning into long-term care?

Probe:

- Which organisations and professionals are involved?
- How are commissioning decisions made?
- How do commissioning arrangements influence transitions?

3. How do commissioning teams seek to ensure that transitions into long-term care for people living with dementia are person-centred?

Probe:

- How are people living with dementia and families involved?
- How is choice promoted?
- What challenges arise in maintaining person-centred approaches?

4. How do current referral, assessment and placement systems support transitions into long-term care?

Probe:

- What systems work well?
- What aspects require improvement?
- How do commissioners monitor system performance?

5. How important is information sharing between organisations in supporting effective transitions?

Probe:

- What information is commonly exchanged?
- What information is frequently unavailable?
- How do commissioners seek to improve information sharing?

6. In your experience, what factors contribute to delays or difficulties during transitions into long-term care?

Probe:

- Availability of placements?
- Workforce pressures?
- Funding arrangements?
- Communication between agencies?
- Hospital discharge targets?
- Assessment processes?

7. How do commissioners work collaboratively with care providers, social workers, hospitals, Trusted Assessors and brokerage teams to support transitions?

Probe:

- Examples of good practice?
- Challenges?
- Opportunities to strengthen partnerships?

8. What roles do services such as Trusted Assessors, Transfer Care Hubs or discharge teams play in supporting transitions into long-term care?

Probe:

- Improved continuity?
- Reduced delays?
- Improved placement matching?
- Support for providers and families?
- Limitations?

9. From a commissioning perspective, how are decisions made regarding matching individuals to appropriate long-term care settings?

Probe:

- Needs assessment?
- Service availability?
- Specialist dementia provision?
- Environmental suitability?
- Managing risk?

10. To what extent do funding arrangements, commissioning priorities and market pressures influence transitions into long-term care?

Probe:

- Balancing individual needs with resource constraints?
- Market sufficiency?
- Sustainability of services?
- Challenges associated with increasing complexity of need?

11. Have referral and placement processes changed during your time working within commissioning?

Probe:

- What improvements have occurred?
- Have any changes created unintended consequences?
- What aspects of previous systems were beneficial?

12. How do commissioners understand and respond to concerns raised by care providers regarding information quality, placement suitability, or system pressures?

Probe:

- How is provider feedback obtained?
- How is feedback used to inform service development?
- Have changes been implemented as a result?

13. Reflecting on your experience, how influential do you think referral documents, assessments, digital systems, commissioning arrangements and organisational procedures are in shaping transitions into long-term care?

Probe:

- Do these systems facilitate practice?
- Do they constrain practice?

- How do they influence decision-making?
- To what extent do they shape transitional outcomes?

14. If you could improve any aspect of transitional care for people living with dementia entering long-term care, what would you prioritise and why?

Probe:

- Information sharing?
- Workforce development?
- Funding arrangements?
- Relationships between organisations?
- Assessment processes?
- Support for families?

15. Is there anything else you would like to add regarding your experiences of commissioning services that support people living with dementia transitioning into long-term care?

