Staff and Change Management: Good Practice in the Transition to Community Residential Disability Services

August 2021

NDA

Údarás Náisiúnta Míchumais
National Disability Authority

Contents

Acknowledgements

Executive Summary

Introduction

The Health Service Executive's (HSE's) Transforming Lives Programme is a national reform programme of disability services.[1] Part of the Programme involves enabling persons with disabilities to transition from congregated settings (settings in which 10 or more people live together) to dispersed homes in the community where they will have more choice and control over their lives. The Time to Move on from Congregated Settings – A Strategy for Community Inclusion is the policy that underpins these transitions (HSE, 2011). This document notes that in 2007, the HSE set up the Working Group on Congregated Settings that identified just over 4,000 people living in congregated settings. At the end of 2019, 1,953[2] people were still living in congregated settings awaiting transition (HSE, 2020).

The aim of this research was to identify and document effective practice in change management processes relating to the transition of staff from congregated settings to small residential homes in the community. The purpose was to share learning with staff and managers currently or about to transition to the community, with a role to support individuals with disabilities, to achieve a successful transition for all.

This research focused on the experiences and learnings of staff and managers working in residential services for persons with disabilities. A deliberate decision was taken not to include residents or their families in this study due to ongoing research on residents' experiences of the transition process in the NDA[3] and to keep the focus solely on staff. Participants did of course talk about residents and their families and gave their perspective of how they were supported through the transition journey and how they adapted to the changes. However, as these are not first-hand accounts from the residents and families they are not covered in depth in this report.

Methods

This was a qualitative study consisting of semi-structured one-to-one interviews with 15 frontline staff and 12 managers working in four residential disability service provider organisations across six sites (three of the sites were from one organisation but due to their heterogeneity most of the analysis refers to sites rather than organisations) All

---

[1] https://www.hse.ie/eng/services/news/media/pressrel/transforming-lives-programme.html
[2] Note that approximately 132 residents now live in with less than 10 other residents. However the centres they live in continue to be identified as congregated on the basis that the residents remain in the original setting that does not effectively support community living and inclusion.
[3] The NDA's Moving In study will be published during 2021.

staff had worked in both a congregated and community setting and the managers had all overseen the transition of residents to the community. In addition, 10 external stakeholders working in diverse areas such as disability umbrella organisations, unions, health policy, commissioning and regulatory organisations were interviewed. Participants were asked to recall their experience of the transition process and the associated challenges from a number of perspectives. Interviews were audio taped and transcribed verbatim. Data from staff and managers were analysed inductively using a thematic analysis (Braun and Clark, 2006). Data from external stakeholder were analysed deductively which involved determining what views or further insights stakeholders held in relation to the themes arising from the staff and managers. Ethical approval for the study was granted by Trinity College Dublin. While most service provider organisations accepted this ethical approval, one organisation stipulated that ethical approval was also required from its own research ethics committee. This was subsequently granted.

Findings

The findings of the experiences of transition among the participants are grouped below under seven themes.

Theme 1: Shift in model of service and work practices

Several participants spoke of a gradual shift from the medical model of care to a more social model following the move to the community. However, the extent of this shift was organisation dependant, with historically nurse-led organisations tending to remain nurse-led, albeit with a higher ratio of health care assistants to nurses than might previously have been the case. There remained many examples of tasks and practices that seemed reflective of a medical model in place in the community settings. While one or two organisations had started to recruit social care workers they were slow to be accepted and there were fears that quality of care would not be as high.

The social model requires a more person-centred approach. Understanding among participants of a person-centred approach was evolving but not yet embedded in all services. The concept of a person-centred model that would transcend a medical or social model was proposed by one participant. Staff motivation to embrace change was considered by staff and managers to be essential for a successful transition to the community. The responses of a minority of staff demonstrated that their motivation was grounded in their understanding of human rights and an empathetic approach. Managers reported that when staff were less empathetic their practices were very difficult to change.

The transition to community working led to some changes in working practices such as changed staff rosters, working with fewer staff and sometimes lone working. A few managers reported resistance from staff and unions to changing rosters and therefore, rosters were not always person-centred.

Theme 2: Leadership and management support
There was a general consensus that strong leadership and governance was required for a successful transition. However, this was not in place in all organisations and thus many managers reported that they felt unsupported. The external stakeholders reiterated this but also reflected on a perceived lack of leadership at national level with a feeling that there was no single entity really driving de-institutionalisation. Connected to this perception of a lack of leadership were a lack of resources to adequately support transitions and a concern that often communities were not ready to provide services to residents when they transitioned.

While some managers reported a good relationship with their more senior managers, many felt unsupported. They described a heavy workload and being unsure what they were doing in relation to transition. This led to feelings of being overwhelmed, isolated and stressed. They also described fighting for resources and sufficient staffing to make the transitions work. However, managers also showed impressive resilience and many took pride in their work.

Theme 3: Preparing for transition
A few of the organisations were more ready for change than others and this often stemmed from the culture of the organisation. Organisational culture was considered very important by participants in determining the success of the transitions. The majority of managers reported that the process of transition, in conjunction with other wider issues such as simultaneously getting HIQA registration and implementing new safeguarding policies, strained the capacity of the organisation to do everything well. A few managers reported that their organisations had to recalibrate and revise expectations.

There were several lessons learned around selecting the staff to be transitioned to the community and over time managers put more emphasis on inter staff dynamics as they recognised the importance of staff getting along in smaller staff teams. No organisations included in this study reported using any sort of formal needs assessment tool to determine staffing levels. Many managers just worked it out themselves based on their knowledge of the residents' needs and historical staffing levels.

Theme 4: Training
This study found that training and development in organisations primarily focused on the training required to sustain a medical model of service and training around a social model or a person-centred model was less frequent. Where this training did take place, the support for staff to implement the changes required were not always present. Therefore, it seemed that most learning relating to transitions and community working was on the job and that staff were supported with mentoring from committed and motivated managers. There were missed opportunities to develop staff and to prepare them for the change that transition to the community would bring. It was rare, for

example, for staff to meet with colleagues who had already transitioned or to visit the houses of existing staff and residents who had transitioned to the community, even when this had occurred within their own site or organisation.

The level of transition planning for residents varied by site and even within organisations there was often more time dedicated to the residents who were the first to transition compared to those who transitioned later. There was some discontent among staff in sites where external transition coordinators were brought in to do the discovery process[4] with residents and did not consult with staff. Most of the managers involved in these sites recognised that this approach was a mistake, noting that staff have a valuable contribution to make regarding transition planning for residents.

Theme 5: Communication about the planned transition

Communication with staff, residents and relatives were all considered very important and were done with varying degrees of success. What seemed to work best for all groups was a one-on-one approach rather than a town hall style meeting which a few managers had very negative experiences with. While managers considered that they made a lot of effort around communications, several staff expressed dissatisfaction with the level of information they received about transitions.

A few managers felt that their avoidance of any union issues was down to their good communication with staff. Other managers took a proactive approach with unions and discussed all changes up front. A few managers reported a more difficult relationship with unions where they felt they were blocked by the union from implementing any changes and things became contentious.

Theme 6: Building staff support for transition

While many staff embraced the transition and could see the possibilities for residents to live a better life, managers we spoke to indicated that there were quite a few staff that did not share this outlook and some staff also admitted that they did not see the transitions working. The reasons given for those who were more resistant to the transition were around fear of change, concern for residents, practical issues in relation to new ways of working, and concerns about a lack of support working in the community.

While many families had reacted positively to the proposed transitions most of the staff and managers included in the research reported that a significant proportion of families were initially concerned about the transitions. Fears expressed often centred around health and safety concerns. Some participants felt that families' views were often paternalistic as they still saw their adult relative as a child. Managers reported having, to

---

[4] The discovery process involves finding out and exploring more about a person and gaining a deep understanding of the person in order to determine their needs and wishes so that these can be fulfilled in the most effective way.

on occasion, negotiate between residents and their families when the resident wanted to transition and the relative wanted them to stay in the congregated setting.

Many managers put a lot of effort into building buy-in for transition from staff and relatives to change their way of thinking and help them to understand the rights of individuals to have choice and control in their lives. Managers in two sites reported getting staff champions to help drive change. Managers also understand that in order to lead change they had to have a strong conviction themselves that transition to the community would lead to better lives for residents. Managers reported having to address attitudinal barriers among some staff such as the sense of ownership they had of residents, the restrictions they put in place based on historical behaviours and the low expectations they sometimes had of residents. Staff had to be supported to facilitate positive risk-taking and be constantly challenged about their attitudes. Involving staff in elements of the transition process such as decorating houses was also reported as being important. Setting clear expectations for staff working in the community was also considered key.

Theme 7: Impact of transition

The impact of the transition on staff was generally positive with many staff reporting they would never return to the congregated setting. In general, staff found management support to be good. There were some issues around communication, particularly at shift changeover but these were being addressed. Staff reported taking on a number of new roles and responsibilities. These caused challenges in about half of sites with staff unwilling to take on certain roles but in other sites participants reported better team-work with less division based on job titles and an equal sharing of roles. Acting in the role of community connector and working to integrate residents into the community was reported as being challenging for those staff who tried to do this due to a lack of meaningful opportunities available for residents to engage with non-disabled people. site

A minority of the nurses interviewed reported that they were not fully comfortable with the relatively new practice of administration of medications by non-nursing staff. However, because some residents cannot go out unless there is a staff member with them who is able to administer medication should it be required, nurses did recognise that was necessary for non-nursing staff to administer medications to allow residents to have more opportunities to get out and about. Despite this, a few nurses expressed concern about their liabilities if a mistake was made by a care worker.

Some of the key challenges that staff and managers faced were facilitating positive risk taking and organising medical services in the community. Accessing general practitioner services proved particularly challenging for some. An issue that was raised frequently was the risk of mini-institutions forming in the community and management were becoming very alert to institutional practices creeping back in and taking measures to stop this.

All participants remarked on the changes in residents as a result of the move to the community including that they were healthier, their personalities came out more, their language improved and their general demeanour was happier. They also reported that some residents had more visits relatives for and that relatives' feedback was generally positive about the improvements they could see in their family member.

Limitations of the study

This was a relatively small qualitative study and may not reflect the views and experiences of all staff and managers working to transition residents to the community. However, there was a lot of similarity in the challenges experienced by each of the sites in this study so the learnings distilled from this study are likely to have relevance to the wider disability residential sector.

This study relied on a contact person within each site to invite staff and managers to participate in the study. This could have caused two biases. Firstly, there may have been conscious or unconscious bias on the part of the contact person in the selection of people invited to participate. Secondly, those invited to participate may have felt that they could not refuse The latter issue was dealt with by emphasising to participants at the interview consent stage that they had the right not to participate if they so wished. While the former issue could not be controlled for directly, the experience from the interview was that all staff and managers were very frank in their views and shared both positive and negative experiences.

In many instances, participants, in addition to recounting their own direct experiences, discussed their views on the perceived feelings, attitudes and behaviours of other staff, relatives and residents. While this provided a rich data-set for analysis, there is unavoidably some subjectivity in these accounts. However, by interviewing several people from the sites included, there was a degree of triangulation of data whereby accounts of events or of the prevailing mood of staff or relatives recounted by one staff member were frequently backed up by the accounts from other staff in that site.

Conclusion

While the bulk of this study focused on the challenges associated with the transitions, it is in how people manage to overcome the challenges where the learning emerges. A key finding is that many of the barriers faced by managers at the site level were predictable and could have been avoided particularly if the planning for transitions had been done more strategically at the organisational level. There are almost 2000 people still to transition in Ireland so it will be important that the learnings from this study are applied to make transitions as smooth and successful as possible. There was a feeling among participants that the national level leadership for the Time To Move On policy was waning and would like to see that reignited.

One of the key predictable issues was resistance from staff but once this is expected it can be managed. For some managers it took them some time to realise that all staff were not fully behind transition and they reported mixed results in their abilities to change staff attitudes and build their support for transitions. The approaches they took, documented this study, may be helpful in supporting others to address resistance to transition. Managers who were successful in changing attitudes took pride in their ability to lead a staff team to see a different and better vision for residents. Staff were very honest and some said that they could really only see how institutionalised they were when they moved to the community. Some also expressed surprise at how they found that they developed professionally and discovered their own potential.

Several managers talked about the pressure on them to manage the change in the service relating to transitions but also to manage all the other requirements such as compliance and safeguarding and they found it challenging to manage the competing priorities. This pressure was compounded as many reported not receiving adequate support from more senior managers in the organisation. Adequate support and protected time for managers to support transitions is essential and it is predictable that managers who are overburdened will not perform as well as they would like to. However, this study found that managers were very resilient.

A significant risk of the transition to the community is that community houses become mini-institutions and in fact several participants admitted that this had already happened. Some of this was attributed to the staff being institutionalised and bringing institutionalised practices with them. The fact that some sites maintained a strong link with the old institution may also be a factor. Managers used many strategies to ward against the creation of mini-institutions that may be of use to managers of future transitions.

Other key learnings from the study were that some staff training prior to transition would have been beneficial and there were many missed opportunities to share learning and experiences both within services and across services. The changes in roles and responsibilities following transition to the communities is probably an area that deserves further research as services move to a more social model and roles continue to evolve.

The NDA plans to work with the HSE's Time to Move on from Congregated Settings Working Group to develop and disseminate a set of short leaflets on specific learnings from this study targeted at managers of disability residential services who are currently engaged in the transition process and those that are soon to transition. These leaflets will also point people in the direction of relevant resources from the HSE and others. They may also be useful for other services such as mental health services if they move to reduce the size of some of the existing 24-hour supervised community residences.

1. Introduction

1.1 Background

The Health Service Executive's (HSE's) Transforming Lives Programme is a national reform programme of disability services which seeks to bring about fundamental changes in disability services and implement the recommendations from the 'Value for Money and Policy Review of the Disability Services in Ireland' (Department of Health, 2012). One of the main elements of the Programme involves enabling persons with disabilities to transition from living in congregated settings to living in dispersed homes in the community where they are supported to exercise more choice and control over their lives. [5] The Time to Move on from Congregated Settings – A Strategy for Community Inclusion is the strategy that underpins these transitions and is now accepted as national policy (HSE, 2011).

There is a growing body of evidence that community-based alternatives to living in large congregated settings provide better outcomes for persons with disabilities (Mansell, 2007, Kozma, 2009, McCarron, 2019, NDA 2021). Mansell (2006) makes the point that, while a person with a disability may now be living in a dispersed house in the community, this does not guarantee that they have a better quality of life. However, he argues that it is a necessary condition to allow community integration to happen. Article 19 of the United Nations Convention of the Rights of Persons with Disabilities (UNCRPD) is concerned with people experiencing full inclusion and participation in the community. The transition to living in the community is an essential step in this process.

The Time to Move on From Congregated Settings strategy document notes that in 2007, the HSE set up the Working Group on Congregated Settings that identified just over 4,000 people living in congregated settings living in 72 congregated settings across the country. Persons with disabilities Intellectual disability was the primary disability among people living in these settings at 93%. By 2019, the number of persons living in these congregated settings had reduced to 1,953[6] (HSE, 2020). A review of the implementation of the strategy between 2012 and 2017 found that the reduction in the numbers in congregated settings was driven almost as much by mortality (17%) as by transitions to the community (19%) (HSE, 2017a).

---

[5] Congregated settings are defined as 10 or more people living. They can include large institutions or smaller homes but in a campus type setting. (HSE, 2011). Residential homes in the community largely refers to dispersed homes with up to four persons with disabilities resident.

[6] Note that approximately 132 residents now live in with less than 10 other residents. However the centres they live in continue to be identified as congregated on the basis that the residents remain in the original setting that does not effectively support community living and inclusion.

In its review of the Time to Move on Policy Implementation 2012-2017 (HSE, 2017a), the HSE acknowledged that the pace of change in implementing the policy has been slower than anticipated. This is attributed to the complexity involved, and to changes in the regulatory and economic environment during the time period of the review. A number of success factors were identified including effective leadership and good communication.

A number of challenges were also identified including changing organisational culture; resistance from stakeholders; the complexity of reconfiguring staffing arrangements; skill mix; capital and adaptation costs; capital costs; regulatory pressures; and accommodation challenges.

These success factors and challenges have also been identified by researchers in Ireland and elsewhere. Following transition, staff have reported positive experiences such as being less rule-bound, having less physically demanding work from having less residents, acquiring new skills, and having better relationships with residents. On the other hand, staff have also reported feeling overwhelmed, feeling isolated working alone, and having a sense of being constantly scrutinised. (Salmon 2013; McConkey et al., 2013, Linehan et al., 2015).

Staff working in disability services play a significant role in the transformation of services. The quality of the care and support offered by disability services is dependent upon the expertise, values and attitudes of the people who make up the workforce (Skills for Care, 2014). How this change is managed and how staff are supported is essential in achieving a successful transition for both staff and those they are supporting. Research, examining the required competencies and skill mix of staff in the context of working in the community, recommended that a competency framework be developed for community-based disability service staff, reflecting the need for different competencies and skills working in a community setting (NDA, 2018). The new skills required largely focus on a more person-centred way of working, providing support rather than care, allowing risk-taking, and looking for opportunities for the person supported to connect with, and be included in, the community. The report also recommended further research into the experience of, and learnings from, staff transitions from congregated to community settings in order to share findings with service providers who are in the process of change, or planning similar change. This was the genesis of the current study.

1.2 Research aim and scope

Sharing learning and experiences across organisations and communities can be supportive of transformation and building networks (Skills for Care, 2014). Learning can be very effective when it originates from people directly involved in the systems and processes that experienced change.

The aim of this research was to identify and document effective practice in change management processes relating to the transition of staff from congregated settings to small residential homes in the community.

The purpose was to share learning with staff and managers currently or about to transition to the community to support a successful transition for all.

1.2.1 Specific research questions

- What were the experiences of staff, managers and other stakeholders of the transition from the old to the new model of disability residential services with respect to staffing issues?

- What were the specific approaches and practices that worked well and that did not work well in relation to the transition to the community?

- What are the approaches used to ensure the new model of service is successful in the longer term?

1.2.2 Research scope

This research focused on the experiences and learnings of staff and managers working in residential services for persons with disabilities. A deliberate decision was taken not to include residents or their families in this study due to ongoing research on resident's experiences of the transition process within the NDA, resource constraints and to keep the focus solely on staff. Participants did of course talk about families and residents and gave their perspectives of how they were supported through the transition journey and how they adapted to the changes. However, as these are not first-hand accounts from the residents and families they are not covered in depth in this report. However, further research gathering the perspective of residents and their relatives in relation to how staff supported and adapted to transition is warranted.

Strategic leadership at the senior level in an organisation has a big impact on how successful a change management process will be. However, this study did not examine in depth the strategic leadership of the organisations included. Instead, it focussed on the middle managers who are dealing with the day-to-day activities surrounding the transition process and change management.

2. Methods

2.1 Research design

The research employed a qualitative design using semi-structured interviews and thematic analysis to generate knowledge about the process of transition to the community.

2.2 Selection of organisations and sites

Organisation selection was based on the list of congregated settings for persons with disabilities from the 2017 progress report of Time to Move on from Congregated Settings (HSE, 2018). This report listed 17 disability service provider organisations across 58 service areas with 312 centres / units providing accommodation for 2,370 persons with a disability. Across the organisations, services were provided for persons with physical disabilities, intellectual disabilities, and persons with a dual diagnosis of mental ill health and intellectual disabilities.

Organisations and sites were selected using a number of criteria including geographic spread, type of disability supported, size of residential service, and priority level for decongregation. Sites were deemed priority for decongregation as they had been earmarked for closure based on a failure to meet certain regulatory standards. These priority sites received particular support, both financial and advisory, from the HSE and the Service Reform Fund.[7]

One organisation that provided residential services for children only and one organisation with similar research ongoing[8] were excluded. Ultimately four organisations that provided residential disability services were included across six sites. Three sites were included from one of the biggest organisations but due to the heterogeneity of the sites most of the analysis refers to sites rather than organisations. The six sites were based in five widely dispersed counties throughout Ireland.

2.3 Selection of participants

Participants were recruited using a purposive sampling technique. Once a selected organisation gave approval for participation in the research, a contact person was identified at each site. This was usually the senior manager or director of the stie. This

---

[7] The Service Reform Fund (SRF) comes from the Atlantic Philanthropies, HSE and Department of Health and is administered by GENIO. GENIO is an Irish-based non-profit organisation working with government and philanthropy to transform social services. The SRF supports disability service providers to transforming disability services with a focus on transitioning to community living.

[8] Action research was being conducted by GENIO. The findings of this research are not published but a presentation of the findings seen by the NDA show alignment with the findings of this study.

contact was asked to invite eligible participants to participate with a target of two managers and three frontline staff members from each participating site.

To be considered eligible to participate, frontline staff and managers must have worked for at least two years in the site. Frontline staff (representing different skill sets / professions) must have had experience of working in both congregated and community settings. Managers must have had experience of managing the transition process. The contact person sent out the participant information leaflet and consent forms to those that were invited to participate at least 7 days in advance of the interview date (Appendix 1). The potential participants self-recruited by responding to the invitation to participate.

External stakeholders were identified, through their organisations, and invited to participate directly by the principal investigator. These stakeholders were working in diverse areas such as disability umbrella organisations, unions, and health policy, commissioning and regulatory organisations. They were selected in order to provide a range of insights from different perspectives, for their potential to provide a national overview of elements of the Transforming Lives Programme, as well as to offer comparators to the staff experience. For most external stakeholders their organisation was contacted and their participation was requested. The organisation then nominated one or two people to participate. The ten external stakeholders came from six organisations or sectors.

A total of 37 people were interviewed during 34 interviews (three interviews consisted of two participants at their request). Participants included 15 frontline staff working directly with residents, 12 managers working across the six sites of the four disability service provider organisation selected, and 10 external stakeholders.

2.4   Data Collection

Semi-structured interviews were conducted between January and June of 2019. No participants received payment for their time or expenses although the majority were released from their normal duties to attend for interview. Participants were encouraged to ask questions before agreeing to sign the consent form signifying their choice to take part. The average length of an interview was 44 minutes. Frontline staff and managers were asked to consider their experience of transition from congregated settings to community settings. External stakeholders were asked to consider their professional experience and knowledge from the national perspective of the transition to community-based settings particularly from a staffing and change management perspective. The semi-structured interview guides are included in Appendix 2.

All interviews, bar one (due to a technical issue[9]), were audio-recorded on digital voice-recorders. At the earliest possible opportunity after the interview the audio-files were transferred onto a restricted file in a password-protected server with access only by the research team. The audio-files were then deleted from the digital voice-recorders. The audio-files were transcribed within three months of data collection after which they were deleted. During transcription the researchers redacted any information which might have identified a participant, for instance their name, the name of the site or the organisation they were based in or any other specific information that could identify them. These were replaced with generic descriptors. Pseudonyms are used for participants throughout the report. Minor edits were made to the direct quotes used in this report to improve readability, however, the meaning of the quote was not altered. The text files were stored electronically in a restricted file on the NDA's password-protected computer (i.e. dual security blocks). Only the research team had access to the data.

2.5   Data Analysis

The implicit aim of this research was to develop knowledge on an area that has not been reviewed or documented in detail in the Irish context to date. Braun and Clarke (2006) highlight the appropriateness of using thematic analysis for this purpose, describing it as 'A particularly useful method when you are investigating an under-researched area, or you are working with participants whose views on the topic are not known' (2006, p. 83). Thematic analysis is a method of identifying themes and patterns within data.

The data were analysed in two phases. Data from the frontline staff and managers were analysed in phase one. An inductive approach was taken and the data were analysed without attempting to fit into a pre-existing theory or code frame. Each stage of analysis was guided by the Braun and Clarke 'Six Phase Approach' to thematic analysis. These stages are

- Familiarisation with the data
- Generating initial codes
- Searching for themes
- Reviewing themes
- Defining and naming themes
- Producing the report.

---

[9] Detailed written notes were taken of this interview but no direct quotes have been used in this report.

The researchers developed a bespoke database for the analysis in Microsoft Excel. Over several iterations where initial codes and themes were reviewed, the themes expanded, absorbed or collapsed into each other. In this way themes were refined over several sweeps of the data.

Phase two involved a review of the external stakeholders' data. Although 10 external stakeholders were interviewed, representing views from diverse angles – disability organisations, unions and health policy organisations - there were too few of any one category of external stakeholder to soundly identify intra-stakeholder themes. Instead, deductive thematic analysis was conducted. This involved taking the themes identified from the staff and manager analysis in phase one and looking at the data from the external stakeholders to determine what views or further insights stakeholders held in relation to these themes. Extracts that supported or contradicted the themes were then included where relevant. Where external stakeholder data analysis presented a new perspective not already identified by phase one analysis this is included on limited occasions where considered appropriate to give a more rounded report.

2.6 Ethical Considerations

The research was approved by the Health Policy Management/Centre for Global Health Research Ethics Committee in Trinity College Dublin. While the majority of the service provider organisations accepted the Trinity College ethical approval, one of the organisations required their own separate ethical approval. This was sought and granted.

Employees, including frontline staff members are included in this study. They may have a dependent or unequal relationship with their employer / manager but this should not extend to the researcher. However, there was a risk that a staff member may have been 'told' he/she had to participate in this study rather than being invited to do so voluntarily. This was due to the method of recruiting staff participants through a senior manager in each site. Because of this potential vulnerability, when seeking consent from participants, the researcher was careful to communicate, using both written and verbal methods, that participation was completely voluntary, as was the right to withdraw at any time.

3 Findings

3.1 Presentation of findings

The findings start with an outline of the profile of the participants and the organisations and sites included. The findings are then presented in seven sections in line with the main themes identified from the data:

- Theme 1: Shift in model of service

- Theme 2: Leadership and governance

- Theme 3: Preparing for transition

- Theme 4: Communication about the planned transition

- Theme 5: Training

- Theme 6: Building support for transition

- Theme 7: Impact of transition

3.2 Participant profiles.

Of the 37 participants 30 were female and seven were male. The average length of service for staff and mangers working in their site was 17.8 years (range: 4 to 36 years). Between one and seven participants were interviewed from each of six sites across four disability service provider organisations. In one of the sites the majority of residents had transitioned to the community and were being supported by a new organisation so there was only one person available to interview in that setting. One of the organisations provided services for persons with physical and sensory disabilities and the remaining three organisations provided services primarily for persons with an intellectual disability. The 10 external stakeholders came from six organisations or sectors.

3.3   Theme 1: Shift in model of service and work practices

3.3.1 Shift in models of service

Many participants spoke of how the model of service was moving, or failing to move, from a predominately medical model[10] to a more social model[11]. While these terms were not defined in the research it was generally understood by participants that in a medical model residents were viewed primarily as patients requiring care. Nurse-led services were frequently seen as depicting a medical model. The social model was understood to mean that the residents were seen as people first and that they were supported by staff to live a life of their choosing.

There was lots of evidence provided by participants in about half the sites that showed that the medical model was the dominant model in place. There was also an awareness that historical staffing levels were low and did not allow for a social care model to be adopted. Staff in one site reported that it is only recently that care staff are allowed to record the activities of the day on the resident's care plans. This was historically seen as a nursing duty and a few staff reported that writing up residents nursing notes still took up a lot of the nurses' time.

Many staff and managers acknowledged that their services were very nurse-led and specifically RNID-led. One manager acknowledged that her site had never employed social care workers but felt the care they would provide would not be as good as care provided by nurses. One of the managers recounted a conversation with a union official who maintained that staff trained under the medical model should not be made to do things that are considered part of the social model.

> 'Look at herself here! She's after doing her four years to get her degree in mental health nursing… if she wanted to do social care she would have done her degree in social care. But she didn't. And you're asking her to do

---

[10] The Independent living movement Ireland understands the medical model of disability (which they also refer to as the charity model) as a model that individualises disability and promotes the idea that people are disabled by their impairments or differences. The medical model always focuses on people's impairments from a medical perspective. In some ways it still looks at what is 'wrong' with the person and not what the person needs. It creates low expectations and leads to people losing independence, choice and control in their own lives. The medical / charity model never recognises the rights of disabled people and assumes that disabled people need to be "looked after" or "cared for". Under the medical / charity model professionals make decisions for disabled people. https://ilmi.ie/wp-content/uploads/2021/04/Observations_State_Report.pdf

[11] The Independent living movement Ireland understands the social model of disability as a model that looks at how society is structured and how it disables people. It is not based on a person's impairment, it is focussed on the barriers that exist in terms of attitudes, policy development, access or lack of supports that prevent people from participating in society as equals, with choice and control over their own lives. In this model it is society that disables people from achieving their hopes and dreams, not a person's impairment. https://ilmi.ie/wp-content/uploads/2021/04/Observations_State_Report.pdf

things that are social care model when that's not what she was trained for.' (Aoife, Manager, quoting a union official)

A few managers reported that it took new management with different views or a whole new organistion to come in so that a social care model could be adopted.

One of the external stakeholders spoke about how person-centred practice will not happen unless the staff are working in a person-centred environment. She spoke of research that found that residents across many services, including disability services, say that they experience 'moments' of person-centredness' rather than a consistent approach to person-centredness. She also spoke of the need for a person-centred model of service and that this 'transcends' the debate around a medical or social model of service.

Developing a person-centred culture in an organisation requires a clear understanding of person-centredness. This understanding was clearly in the development phase among some of the staff and managers in this study as it was clear that they were learning how to work using a person-centred approach. One of the external stakeholders expressed that she has frequently heard person-centredness being used without knowledge of its true meaning.

> You do hear a lot of stuff espoused around 'We're very person-centred. We just don't demonstrate it. We get a lot of thank you cards' you know, 'People come back and tell us how happy they are with the service'. But actually, that's a very technical way of measuring person-centredness, it's one small way. (Molly, External Stakeholder)

This limited understanding extended to what community living and being included in the community meant for residents. For example, some felt that the location of the house was a key part of community living rather than true involvement in the community. In one site, because the institution was located in the middle of the town, this was seen as equivalent to community living.

Person-centred service was in general discussed more by managers than by staff. Managers felt they were making good efforts with person-centred practice in the community.

> …it's individualised, it's person centred now and you can actually see that it is person centred. Whereas before, [when] you were still within the residential setting, it was [not]. (Olivia, Manager)

Participants reported that a key facilitator that allowed them to have a person-centred approach and to support people to be more independent and have a higher quality of

life was the smaller numbers of residents in the community houses and higher resident to staff ratios. Therefore, staff had more time to spend one-on-one with the residents.

> At the same time it's easier. So instead of running around the house getting 10 people up you're running around for one person. So it's slower, it's calmer, and therefore you can put more concentration into helping that person. Or talking that person into doing something. D'you know what I mean, guiding that person. (James, Frontline Staff)

Many participants gave HIQA credit for their role in driving a more person-centred approach and getting to staff to think more about their practices. They were described as a catalyst. They were also commended for going beyond looking at just whether paperwork was in order but also spending time '…sitting and observing and looking at the environment.'

3.3.2 Changes in work practices
Part of the complexity of the transition of staff to working in the community was not only that their place of work changed but for some their terms and conditions and ways of working also changed. This created challenges for some staff.

3.3.2.1   Changes to rosters
In three sites there were no or minimal roster changes as a result of the move to the community. However, in two of the sites there were reports of significant changes to rosters with mixed views from staff.

> The rosters - we also went from one roster to you know 13 different rosters. And the roster was centred around the service user as much as they wanted it. But it was also centred around what time medication needs to be administered at. You know, personal care needs and stuff like that. So rosters changed hugely. (Grace, Manager)

In one site rosters were seen as a very contentious issue. There were a large number of different shift patterns which were intermixed and tended to get 'changed and chopped' such as sleepovers, waking night staff, four day weeks, four to ten shifts, two to ten shifts, eight to eight shifts.

> Rosters are a MESS! Oh my God, they're a car, where I am they're a car crash. (Conor, Frontline Staff)

Managers and staff who were in charge of rosters acknowledged the 'huge challenges' in implementing changes to shift patterns. They wanted these changes in order to facilitate the residents' needs. In many cases they were not able to make any changes and had to work within existing contracted hours to organise rosters. This was not ideal when trying to roster based on needs of residents. However, while many staff demonstrated

flexibility this was not consistently adopted and less flexible staff stuck rigidly to their original shifts.

One of the external stakeholders said he was 'blown away' by the fact that staff could tell him when they would be working in a year's time.

> But staff could say 'In a year's time, this is when I'll be working,' and I really found that challenging because, how can that possibly demonstrate flexibility within resources, within your staffing? (Noah, External Stakeholder)

He felt that the rosters were in place to meet the needs of the staff rather than the needs of the residents and that rosters could work against a person-centred approach. He went on to say, however, that fixed rosters tended to be more associated with the congregated settings and more flexibility in rosters were seen in the community. There was a view expressed by some staff and managers that there were advantages to taking on new staff as they could be given a different contract to existing staff and those new contracts could incorporate rosters that were more conducive to the needs of the residents.

3.3.2.2   Lone working

With the transition to the community staff had to work alone at certain times which they may never have done before. This could occur where a resident lived alone and only had intermittent support, in a house with four people where other staff had taken some of the residents out, or during the night shift. Staff had different reactions to lone working. Some reported liking it but others reported being nervous of the prospect and had concerns about being isolated.

> And I myself I really wanted to go but I was nervous going. I was nervous being left, like I've never been, you'd never be by yourself in [name of unit on campus]. (Mia, Frontline Staff)

Management recognised the additional responsibility that lone workers would have to take on working in the community. One manager spoke of her main fear which was around a fire in the house where there was a lone worker. She described working with HIQA to draw up a comprehensive plan which involved making more staff available such as a floating nurse between houses and twilight support staff. While an on-call system operated in one site it was emphasised to staff that it was only for emergencies. Therefore, staff often called their direct manager or a colleague who was not working for advice.

A key concern of lone workers was if a colleague was sick and no one came to relieve them at the end of their shift. They compared this to the campus setting where there

was always cover available. The procedure described in one site to deal with a staff member being out sick was not very person-centred for the resident.

> …you might have to drive off somewhere else, drop the service user to another house. How are they going to react to being dropped to another house? Are they going to be confused? Are they going to be concerned, you know? (Conor, Frontline Staff)

3.4 Theme 2: Leadership and management support

Lack of adequate leadership was raised by many participants, particularly managers and external stakeholders, as a challenge both in relation to national level leadership and at the local service level. Insufficient resources and a lack of joined-up thinking were also raised as challenges in managing successful transitions. Managers reported difficulties due to insufficient support from their own managers or their organisation more widely.

3.4.1 Leadership

In general participants welcomed the national policy around transitioning persons with disabilities to live in the community. However, some participants, especially the external stakeholders expressed disappointment regarding its implementation. They felt that the pace and scale of transitions have been based more on available funding rather than on the readiness of residents to move. They felt that the policy was not getting the political support it deserved.

The requirement for a leader within the organisation driving and supporting the transition of residents to the community was considered crucial by many of the participants. Participants from half of the sites reported that senior management buy-in to the transition process was lacking. Senior management would nominate a manager to lead out on transition within the organisation but sometimes did not adequately support that person.

The importance of governance was brought up by several of the external stakeholders as was the importance of having a good oversight and monitoring system that worked around the clock. They linked this to the historical lack of governance that led to instances of abuse in institutions that have come to light in recent years. One manager talked about improvements in organisational governance.

> But I can see it, if you look at any of the HIQA reports and you'll see we were really in trouble for corporate governance. That doesn't come up anymore… And so, every time we do something in here in terms of Governance, we have to ensure that the impact, that it has a positive impact on the person's life. (Emma, Manager)

3.4.2 Resourcing

The issue of funding and resources was brought up frequently by all participants. They could see weaknesses in the existing block funding system that was not person-centred and provides a 'one-size-fits-all' approach. The external stakeholders spoke of the contradictions around where funding was allocated. Sites that were performing poorly were prioritised and therefore funded to transition their residents to the community. While on one hand this was positive in that it moved residents to a better living situation, it somehow unintentionally penalised residents living in better performing sites that maybe had fewer resources and less support to transition their residents. Therefore, there was a perception that poorer performing sites were being rewarded.

A few managers expressed frustration with their funder (the HSE) and felt that it did not have a full understanding of the issues facing the organisation. One participant said she would like to see the HSE coming to more transition meetings and becoming more involved so that they understood the problems, particularly the funding challenges.

> These are your clients, as much as they are our service users. You're funding this. You need to know what's happening with the funding. (Emma, Manager)

3.4.3 Support for managers

A few managers reported a good relationship with their more senior managers but the more common experience was that managers described feeling unsupported by their more senior colleagues or from the corporate services departments within their organisation. They expressed frustration at the efforts they had to go to in order to get the resources they needed to do the transitions properly. One manager reported being told to 'be creative' with funding and many reported that problems were put back on them to solve.

> It's like begging basically…yeah I begged, borrowed and stole. No it took a HIQA inspection for us to get the staff we needed. (Lucy, Manager)

Staff and managers reported the stress involved in HIQA inspections particularly when they were simultaneously working to getting HIQA registration for the existing centre and managing the transitioning residents to the community. They talked about the sense of relief when they got a positive report and the sense of trauma when they were threatened with closure. Managers provided examples of how HIQA inspections were used as a 'bargaining chip' between management and the leaders of the organisation, whereby managers would report that the facility was going to be closed down unless certain improvements were achieved by a certain date. There was also a sense among some of the external stakeholders that the regulator frequently got blamed rather than organisations accepting responsibility for the reasons a closure was necessary.

> That's where they can be, 'The big bad regulator has come in and, and closed us'. (Noah, External Stakeholder)

Managers talked about fighting for the resources for the residents to have a good quality of life and, in particular, to get enough staff so that residents were able to get out and about. Even when resources were available, there could be negativity from other managers within the site because of where the resources were going

> Oh from the other managers? I wasn't the most popular person I'd say [laughs]. All the resources were going into this… So, yerra, you know, you just take it with a pinch of salt, you just have to fight and just keep saying they've more right, as much right as anybody to move into a nice house, to be in a nice area, yeah. (Lucy, Manager)

Managers were unsure exactly what they were supposed to be doing and in most of the sites they reported a lack of structure around the transition. They reported juggling so many things at once as being very challenging. Most managers reported figuring it out as they went along and very few reported receiving training. A lot was expected of managers and sometimes they were not treated well. One manager described how she was put as the Person In Charge without being asked. [12]

> And we were thrown in at the deep end. There was no, I suppose, plan. You were literally, for the first couple of months running blind… (Olivia, Manager)

> There was challenges with housing, there was challenges with the management of the project because you're holding so many pieces. You're holding the emotional piece for the service user themselves. You're holding the piece where you're trying to convince the staff team around people that this is going to work and to have faith as well and you're also trying to control so much that's completely outside your control. (Grace, Manager)

---

[12] Regulation 14(1) of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 requires that the provider appoint a person in charge of a designated centre. This means that there must be at all times a person in charge of the designated centre, who has been appointed as the person in charge of the centre.
Regulation 14 places responsibility on the provider to ensure that the person in charge has the qualifications appropriate to fulfil the post of person in charge. HIQA (2021) Regulation 14: Person in Charge of a Designated Centre for Disability. https://www.hiqa.ie/sites/default/files/2017-05/Provider-guidance-on-Regulation-14-PIC.pdf

One key learning for managers was that they needed protected time and that it wasn't possible to do two jobs at once.

> I would have said it was a huge learning curve as in, it was an add-on role to my current role. I was given no training, no support… I definitely would have went to management to say that I probably needed protected time to do it… A lot of it ate into my own personal time, as in my time off… I never got time back for it, any payment for it. (Ava, Manager)

The lack of support led some managers to feel very isolated and emotional. One manager described being 'wounded' by the process due to lack of support and pressure.

> And I suppose one of the things that I found here was that…I was very isolated… You know, like something would happen and I could be annihilated here and I'd go home and I'd be upset and then it wouldn't ever be resolved. (Aoife, Manager)

There were lots of examples of managers reflecting on their work and doubting themselves and their decisions. They worried that placements wouldn't work out and questioned their own performance.

> And really, there was so much that we didn't know. I didn't know whether on the first night, the service user was going to just completely fall apart and be like 'I can't do this'. You know? And there was many hours of sitting outside [a new community house] on the first couple of nights in my car thinking to myself, 'What have we done?' Because it was just the enormity of it. (Grace, Manager)

There was a sense however that the managers got through it in the end and survived it, demonstrating their resilience. They were also able to see that, while maybe not perfect, they did as good a job as they could under the circumstances. Managers often displayed increased confidence and assertiveness as the process continued and just got on with things. Some managers advised to aim for perfection and not to settle for anything less. Others were more pragmatic and advised that 80% buy-in was sufficient.

> Probably that's one of the biggest things I've learned, particularly when I was more junior, you know you're less inclined to go against the tide. And now, I suppose it comes with age and it comes with confidence, I've no difficult going against the tide if I feel it's the right thing to do for the lads, even if it gets me shot… Don't settle, aim for perfect. (Amanda, Manager)

Managers often experienced frustration at things they couldn't change. They also described how they managed to stay motivated through knowing that the residents would have a better quality of life if the transition was done successfully.

3.5   Theme 3: Preparing for transition

3.5.1 Organisational and site readiness

There are many different organisational cultures within disability services in Ireland. Some organisations invested in training, learning, working with self-advocates, studying practice from abroad and in Ireland, being part of communities of learning, and working to make a positive change in the lives of their residents. Many of these organisations had for a long time been transitioning people to the community or to smaller units on campus, recognising the positive changes that this could make in the lives of the residents. When the Transforming Lives policy came about these organisations were at the forefront of embracing the transformation and continuing to transition residents to the community.

In the current study four of the six sites had been making some moves in this direction over the last few decades, particularly with regard to having smaller residential units on campus. However, none of the sites would have been considered to be leaders in implementing the transforming lives policy.

In terms of implementing the Time to Move on from Congregated Settings policy, the sites were at different stages of readiness. Some embraced the policy and perhaps moved to decongregate too quickly when they weren't quite ready for all that it entailed. Managers in two sites reported that some staff were seen as evangelical in their approach without appreciating the full picture and all the logistical and organisational issues that were necessary prior to transition. Some participants felt that many competing internal and external priorities within their organisation diluted the focused attention that the transition policy needed. Participants from four of the sites said their organisation underestimated the work involved in decongregation. Participants from two of the sites reported that staff were willing to take risks and were prepared to make mistakes.

> And what struck me was, that as an organisation, we had been overly
> ambitious. …so the people were almost I think, it was almost evangelical,
> in terms of moving people on and giving people better lives and all the rest
> of it, without actually seriously looking at every single strand of that.
> (Emma, Manager)

After one centre was fully transitioned, one manager talked about the pressure on her to continue with the process in other centres. However, she decided to stop and take stock and see how it could be done better before starting another centre.

3.5.2 Staffing

Managers discussed the key criteria used in ensuring that the correct staff were selected for the community houses. These included that staff had the right motivation and skills, got on well with their colleagues and with the residents that were also transitioning.

Managers reported using a number of methods to select staff for the community. Some had started by handpicking staff with mixed success. Most used an expression of interest approach where staff applied to work in a specific community house. If staff did not already work with the residents who were transitioning they went and worked in their unit for a month before transition to become familiar with the residents. As the transition process progressed some sites started to give first preference to staff already working with the residents that were transitioning and only if someone did not want to go it was opened up to expressions of interest. Over time managers seemed to learn to put more emphasis on the dynamic between staff, as working in the community meant working in a smaller team.

> I just think it would greatly enhance the success rate for the home, for the staff and for the residents if you had people supporting them, and working in it that genuinely wanted to be in it. (Siobhán, Manager)

From the staff perspective the process was described as being relatively straightforward and they recognised the importance of staff getting on together. One staff member described a pecking order in place where she worked.

> …it is more intense you're in a smaller environment. So it is important that you do, you do get along, (Mia, Frontline Staff)

In some sites staff had to go for interview which some managers described as an 'informal chat'. The purpose of the interview was to ensure that staff knew what would be involved in working in the community and to determine if they had the right motivation for the new roles and responsibilities they would have. Some staff found this a little bit controversial as they felt they were already essentially doing the job.

> … you're interviewing for a position you already hold. So you can't actually say you're not good enough to do your own current job basically [laughs] so it's sort of a bit strange like that. (Ella, Frontline Staff)

Staff advised that managers need to look at their skill base in advance of the move to ensure there is a good mix of staff in each house. A few staff felt that managers were not always taking into account staff's skill set and preferences. Managers acknowledged that the right skill sets was important as were aligning staff interests with resident's interests.

> Like some people are more geared to working in high dependency. Some people are more geared to working with challenging behaviour, they feel that that's their niche, but that's never taken into account. (Caoimhe, Frontline Staff)

> ...and like, you put some of those 'nursey nurses' out into houses where they're all, d'you know, that you are working off more of a social model kind of rather than a medical [model]… they want to be there, you know, with their uniforms and their cardexes and their drug trollies and all that you know… what hope has that house d'you know. (Siobhán, Manager)

Participants from three of the six sites reported paying a lot of attention to compatibility between residents and staff. Participants understood the importance of a good relationship between staff and residents and in general, staff expressed a preference to transition with residents they knew. However, in only one site was it reported that residents were consulted about what staff they would like to go with them to the community.

However, sometimes staff felt that management were not looking at issues of compatibility and were more interested in compliance rather than setting staffing levels to suit individual residents. They felt the approach taken wasn't always person-centred.

> Generally speaking, within the organisations, 'staff' is a number on a page – 'Put them there'. If they need to be a male staff, yeah, 'Put them there'. There's no, there's no analysis of matching personalities where maybe there should be a little bit of that you know. (Conor, Frontline Staff)

There was some discussion by participants on getting a whole new cohort of staff to combat problems where there was no culture of person-centredness. While this did appear to work in one site this is not an option open to many organisations. In another site a manager described bringing in some newly qualified nurses to try and change the culture with their new and fresh ways of working. However, she quickly realised that that wouldn't work.

> [I realised] that the force that we were dealing with was a lot bigger than just getting in some graduates and training them. They would not be allowed to do it [change practices] by the other staff. (Aoife, Manager)

No sites included in this study reported using any sort of formal needs assessment tool to determine staffing levels. Many managers just worked it out themselves based on their knowledge of the residents' needs and historical staffing levels. While managers acknowledged that HIQA look at staffing levels they don't specify the skill mix or exact staffing levels required. One of the external stakeholders shared how the issue of staffing levels had become a union issue because staffing decision were seen to be done in an arbitrary fashion rather than in any systematic way.

> …but I think that the concept of linking the… the assessed needs of the resident to support hours is somewhat new for disability services…I think

that's been a struggle for, for disability providers. (Noah, External Stakeholder)

3.5.3 Transition planning for residents

Prior to the transition of residents to the community, staff, managers and the multi-disciplinary team worked to prepare residents through developing transition plans, ensuring that residents moving out together were compatible with each other, helping residents develop a vision of living in the community and providing reassurance and support. Some sites felt they had done this well while others acknowledged that they could have done more to support residents.

> There were some people who found it just mind-blowingly different, hmm, and perhaps we could have done more in terms of preparation. (Jack, Manager)

The manager in two sites reported having dedicated transition coordinators to work one-on-one with the residents going through a discovery process. Views varied around the approach of bringing in a dedicated transition coordinator. It was felt that while it was valuable to have this resource, some excluded the views of staff who had known the person for a long time.

Residents rarely transitioned to accommodation where they lived on their own. Such transitions were usually confined to residents with a physical or sensory disability or a very mild intellectual disability. In this study, the majority of residents transitioned to a house with at least two other residents and not all transitioned to centres with the recommended four or fewer residents. Staff and managers in one site reported put a lot of consideration into looking at compatibility of residents such as examining common interests and personalities prior to their transition. Two sites reported doing this to some extent.

Managers in three of the sites felt that a formal discovery process was not required as they knew the residents so well. This may be an indication that there was an unclear understanding of everything that the discovery process entails.

> But I kind of knew the staff and the residents well enough that I was able to, kind of to [assess] compatibility informally, you know, similar pairs of similar interests, age, going to day service, not going to day service. We know who gets on with who. We know who triggers which person. We know how to eliminate the safeguarding because we know who targets who. We know their abilities... So we don't have to do all that discovery part... (Ava, Manager)

The limitations of this approach was borne out by comments from staff that not enough consideration was given to which residents would live together in the community. They

felt this it was often done on the basis of needs such as all being mobile or peg fed rather than on personalities.

> I think a new house is opening and I know three clients are going into it and they're all going into it because three of them are mobile. And they're nothing to do with each other. They definitely don't have the same interests. They're not the same age group, you know, I just don't think that's okay. But it's more cos they're mobile and then that house can be ran, you know, without nurses. (Chloe, Frontline Staff)

Managers have learned from their experiences and have regretted instances where they have put people living together which in hindsight wasn't fully thought through. In one example eight residents lived together but because the majority were wheelchair users the ability of staff to ensure residents got to go out was very limited.[13] Another example included putting residents with challenging behaviour together.

> You know in hindsight, five people with severe challenging behaviour in one unit... I don't think it works like you know. (Siobhan, Manager)

Many activities took place to help residents prepare for living in the community. One common activity was visiting the house as it was being prepared for transition. This process helped get the residents familiar with their new home. Staff also reported bringing residents to IKEA to help them imagine how the house and their bedroom would look. However, not everyone thought that frequent visits to the houses was a good idea. One staff member thought it was very difficult for the residents to understand or visualise that an empty room was going to be their bedroom and felt that maybe the visits were just to tick a box and questioned whether they benefited anyone.

Staff also engaged residents in other aspects of the transition such as picking a car, going for lunch, going to the post-office and exploring the local area. Many staff reported making efforts to introduce residents within the community so that the community understood that the residents were now living there.

> So we would have referenced it as community mapping but really it was just like getting out with the service user like. Going to the coffee shop. Go to the parish hall. Don't be afraid to tell people you're moving. You know, have the conversation at the post-office. You know, really, kind of try to embed people as much as you could. (Grace, Manager)

---

[13] One services, that had transitioned to the community several years ago, had community houses that still had greater than four residents.

A few staff participants reported that residents did not want to transition to the community as they were anxious about the change. However, staff reported that in hindsight some residents admitted that they were not able to see the possibilities for themselves beforehand.

> … two of them said to me that they didn't think that the change that they were afraid [of] *then*, would give them the sense of happiness that they're experiencing *now*. (Amelia, Frontline Staff)

3.5.4 Pace and scale of transition

Once organisations had made the decision to adopt a community living model the time taken to implement the required changes varied significantly. Many staff were frustrated with the pace of the transition. Some saw it as moving too fast and not allowing residents or the staff to fully prepare for and accept the move. There was a feeling among some participants that the timelines for the transition were dictated by the organisation. There wasn't sufficient time given to the discovery process and allowing the residents' time to develop their vision, absorb the proposed transition and come to an acceptance over time. They felt that insufficient attention was given to people with more complex needs and that a lot more work needed to be done on transition plans for all residents. Other participants felt the moves were very slow and that could be demoralising. A lot of the delays were attributed to difficulties in getting houses, both in finding or building suitable houses and in the financing for these.

> The whole decongregation movement was becoming more and more prevalent, you know and, and the organisation got into a wobbler over not doing it quickly enough. What I've seen so far is that people seem to be moving out in dribs and drabs. (Conor, Frontline Staff)

Staff and managers learned through their experiences during transition. For example, they realised the importance of going at the pace of the resident. They also realised that they must not raise expectations that they can't deliver on.

> So we very quickly I suppose moved away from that kind of idyllic model of one's own front door and all of that stuff. So we ended up with a pretty big mixture of people either who went to a shared apartment or three people who shared a house that *kind* of thing. Though there was a *little* bit of resistance to that in the beginning but, but that's how it went I suppose. (Jack, Manager)

One of the managers also acknowledged that the first residents that transitioned got a lot more input and support than residents who transitioned later and for whom the transition process was more rushed.

> The first people were getting bubble wrapped in everything the last people
> like we were 'Right what can we shove into a black sack so we can get
> people out!' you know [laughs]. (Emily, Manager)

Staff also talked about phasing transitions and moving at the pace of the residents. In some cases the transition was staggered, for example, where several residents were due to transition at the same time, two or three might move first and the last person follow a week or two later to allow more time for settling in. Some sites were in the position to offer a trial run and this also reassured families.

3.6   Theme 4: Training

3.6.1 Limited training on transition

Most staff and managers did not receive any specific training for transitioning to the community and many felt that some sort of transition training would have been useful. Many staff felt that while residents had received good preparation they had not received any. The lack of training led to a sense among some staff of not knowing what they were doing and feeling that a lot was expected of them. Staff also acknowledged that if they themselves weren't adequately prepared then this would impact on the residents.

> …and I did find that all right when we were transitioned out some days
> people were a bit like, 'We don't have a clue what we were doing like. Are
> you doing it right you know?' … But I did find that I would have liked a bit
> of transitioning training or something. (Hannah, Frontline Staff)

Staff from most sites acknowledged that training as a rule was good. However, it was primarily focused on clinical and management issues and meeting HIQA regulations and included medication management, use of catheters and oxygen, money management, safeguarding, food safety, and lifting and handling. A few managers mentioned specific management courses that they attended. One of the managers was very cognisant that the majority of her training budget was being spent on medication management under their positive risk taking approach. However, she knew she needed to spend more on training that promoted a social rather than a medical model of support.

Some staff mentioned attending talks about decongregation but these did not seem to have any lasting impact. One of the external stakeholders warned of how a short training course is not sufficient to change practice as staff really need time to absorb the new ideas they are being exposed to and have time to live their practice. A few staff reported discussions between managers and staff to discuss the vision for the house. However, one manager acknowledged that the emphasis was on residents in these discussions and neglected the needs of staff and that staff were not prepared enough.

> And it's one thing to just sit down with them and talk to them about and
> do some training with them about what service users need, and how they

might do that work in the community. But not actually sitting with them
and talking to them about the impact on them and bringing them through
that change management. (Emma, Manager)

Staff and managers spoke about how they learned on the job with good peer-support
from other managers who were also managing transitions within their organisation or
from transitions that had already happened within their site. They explained how any
mistakes were not repeated in subsequent transitions. The manager of one site
reported that they were conducting an internal review of their transitions in order to
improve and plan better for future transitions.

I suppose we had opened another house before …so I think we did learn a
lot from that. There was a lot of mistakes and there was a lot of hiccups.
(Chloe, Frontline Staff)

There were a few sites that took a more serious and longer term view of training. Some
staff had been sent on Facilitator Development Training which involves developing
work-based facilitators leading culture change that supports person-centred practice
within their own services. As it is difficult for one person to change a culture, the
facilitation model allows the trained facilitator to work with and support their
colleagues. To be successful, management support is required to give the facilitators the
time and space in their workplace to implement their learning. In one sites some staff
had received specific training on social role valorisation.

In two sites managers and staff report that domestic staff, many of whom were at risk of
losing their job following the transition of residents to the community, were encouraged
to do further training so they could be employed as a care worker. Managers in one site
reported having schemes in place, for example scholarships. A few staff accepted these
offers and others upskilled independently. The evolution of the role of care workers
was seen as being very positive particularly where this role evolved from primarily
domestic duties.

It's great to see the care workers having more of a say. A lot of them
would be very interested and very involved and always trying to get more
education so that they will be able to interact better… They keep coming
back with positive feedback, and 'I think we should do this and I think we
should do that, and would he benefit from this?' (Caoimhe, Frontline Staff)

However, there remains a group of staff who had no formal training beyond mandatory
training such as manual handling. One of the managers speculated that resistance to
further training could be due to lack of confidence or literacy difficulties and that it takes
time for them to gain confidence to put themselves forward for training. Over time,
new care staff with recognized qualifications have joined the organisation and are
working alongside existing care staff many of whom have no recognized care worker or

social care worker qualifications. Participants in two sites reported conflict between new care staff who were potentially more progressive and some of the older care staff who were 'set in their ways'. Some care staff were more comfortable in their domestic roles and prioritized this over their supporting and activation roles. It also took some nursing staff time to be comfortable to delegate responsibility to the care workers.

> And I suppose there was a certain amount of fear as well. You know, the staff nurse would fear that if they asked somebody [care staff] to do something, if it wasn't done right, it was they that was responsible. And I suppose it was just getting used to that, that delegation and still having responsibility, and it's the old way as well. (Amanda, Manager)

3.6.2 Learning from peers

Many staff suggested that meeting colleagues who had already transitioned would be very beneficial in alleviating their fears and in finding out more about the community based role. One participant advised that feedback from staff who have transitioned should not be restricted to positives and they should be encouraged to share the challenges they faced so that staff due to transition would get a realistic view of the process. However, there were few reports of such meetings happening in practice. Any interactions tended to be ad hoc. The personal recounting of experiences was considered important as colleagues could identify with each other and think that if it has worked for them then it could possibly work for me also.

> Well you would get mixed reviews. Some people would say it's fantastic, some people would say it's not so fantastic so we really would have mixed reviews. (Lily, Frontline Staff)

Many staff felt that having an opportunity to visit homes already established in the community would be very useful. However, the opportunity to visit other houses was not that frequent even in sites that had already transitioned some residents. When visits did happen staff had found it useful, not only for the practicalities around the actual move, but also with regard to advice on making connections in the community.

> We would have gone around to different services and looked at different services…both HSE and voluntary ones and gotten their ideas around what it was we might need changing at the time, care plans or policies or activation or whatever, or even community living. (Amanda, Manager)

A minority of managers attended and reported getting a lot out of networking events and encouraged other managers to go to these. Some sites freely shared their experience with others. However, in other sites there seemed to be issues around accessing and sharing information with the result that some sites appeared to be re-inventing the wheel due to a lack of knowledge about processes. While there was a sense that a lot of learning is being developed and there are a number of networking

events, some people are not tapping into them as they are too focused on their own service. Some managers regretted not having the opportunity to network with peers and learn from their experiences.

> …like we were doing a transition in our head, but like [laugh] it wasn't until HIQA started doing visits and saying 'Oh well where is your transition plan?' And we were kinda going, 'Transition plan?' …Hmm, so initially we would have done our own template for a transition plan then afterwards we'd discovered there were all of these things online… (Ava, Manager)

Some of the external stakeholders highlighted how, because they were involved across multiple organisations, they could see opportunities for sharing information. While they were occasionally able to facilitate this sharing in general they felt cross provider sharing was rare. They also felt that not enough positive examples of successful transitions were being shared. They acknowledged that it can be difficult to picture somebody, particularly if they have high medical needs or a profound disability, living in the community and understanding practically how it would work. One site produced a newsletter sharing news of the transitions for residents, relatives and staff. A manager in another site reported being motivated by the HSE newsletter.

> A colleague had forwarded on the newsletter from 'A Time to Move On' working group. First time I've ever seen a newsletter from that group. I knew the group existed but it was different parts of that that I read that kind of lit a fire in me again. (Grace, Manager)

3.7   Theme 5: Communication about the planned transition

This section explores communications with staff, unions and relatives. The semi-structured interview guide did not ask about how staff communicated with residents in relation to the transition so that issue is not explored here although it is acknowledged as an important issue.

3.7.1 Communication to staff

Staff described a variety of ways in which plans for transition to the community were communicated to them. Staff in half the sites reported that there was good communication around the transition with plenty of meetings and opportunities for questions and to engage with management. Others reported that information was imparted very abruptly, with no room for discussion. Some staff also described information being given in a piecemeal fashion or hearing about it through informal channels. Some staff reported having very little knowledge of what was going on regarding transition planning and being surprised when residents suddenly moved.

> I think two service users that move out, we didn't even hear any [thing] about preparation or planning. We only heard let's say, 'Next week this lady is going…pack, because she'll be moving in next week'. … They just, they move out, they're gone now. (Amelia, Frontline Staff)

Some managers described proactively engaging with staff and trying to be honest and upfront with them and giving them all the information they could. Managers advised not to drip feed information to staff. They explained to staff that working in the community was not going to suit everyone and advised staff to make an appointment to speak to a manager about their concerns and about options and alternatives.

> I'm not sure that organisationally we were proactive but at that service level we were quite proactive about it, yeah. We tried to answer questions where we could and where we couldn't we said 'We don't know', but we will bring HR down and we'll talk about this and look at what other people have done. (Jack, Manager)

While some managers put a lot of effort into communication with staff, other managers acknowledged that communication was perhaps not as good as it should have been. They acknowledged the gaps and delays in information could lead to an increase in staff fear and a sense of being overwhelmed.

> I think the staff were left waiting with no information for a long time and that instils fear in people then. When people don't know what's happening they become very afraid, d'you know? If I was to look back on it I suppose staff could be better informed. But, I don't believe the organisation had the information. (Grace, Manager)

Managers also described how difficult meetings with staff could be and how there were many issues that needed to be worked through including shift allowances, travel allowances, and breaks.

> …I explained with the staff, I was three and a half hours the first time, we were nearly getting murdered at the top of the room… (Ava, Manager)

3.7.2 Communication between sites and unions
The engagement by the managers in different sites with unions was very varied. Some reported little or no interaction, some had positive proactive engagement and some had contentious, difficult engagements.

For those sites with little union involvement a good relationship between staff and management seemed to be key. It was felt that any changes could be implemented smoothly if management were open and transparent with staff. Staff should have access to their manager so that problems can be resolved locally if possible but if it has to be

escalated ultimately it can be resolved internally. Managers understood the importance of engagement with staff and having discussions and negotiations with them and that this could either avoid union engagement or pre-empt some of the issues with unions.

However, in two sites managers reported that there was considerable negotiations with unions. The many issues discussed included contracts, staffing levels, rosters and redeployments. Some managers described being proactive with unions and giving them full disclosure about plans. They felt that mostly the unions would advise them if the proposed change was going to be in breach of any regulations and therefore avoid any negative reactions from staff.

> We have a Forum that meets regularly with the Union and with staff representatives for the whole organisation and decongregation is part of some of those conversations...We have found that has worked really well. (Emma, Manager)

Where things went wrong, on reflection managers knew they should have done things differently such as more engagement with the staff. However, managers in two sites felt that the unions could be overinvolved and that they needed to be challenged. They felt it had gone to the other extreme and that nothing could be done without the union's consent. One manager reported having a very upsetting experience with a union official on the issue of health care assistants administering medication.

> 'Who's giving out the medication?' I said, 'The staff that are here give out the medication.'... He stood up, came straight over to my face and roared at me that 'Your arrogance will see you lose your job. You cannot have those kind of people giving out medication.' And...two of the HCAs came in and just said to him, 'You need to go'. (Aoife, Manager)

Two union officials were interviewed as part of the external stakeholder interviews. Both reported that in their experience management could sometimes be difficult to deal with. One described management as deliberately leaving things to the last minute so that there was no time to negotiate. They also described the management approach as dividing and conquering staff so that they were not united. They also sometimes felt that issues were ignored by management or that they were totally uninformed when a union member came to them with an issue. They were keen to point out that the resident is the key priority for them and their staff. However, management often had a contrary view and felt that unions and staff only had their own interests at heart and not those of the residents.

> And never once, never once, did anyone ever say at that meeting 'I'm concerned for the residents'. It was always, 'What about the staff?' But I think when it comes to patient care and improving patient care, the unions should be told to back off. (Aoife, Manager)

However, it was clear that progress being blocked by unions was not an acceptable excuse from the regulator. While they acknowledged the difficulties for managers they were pushing them to deal with it.

> One of the more common excuses…during that period was intransigence of staff, intransigence of unions, resistance. So I mean, I'm sure they were, they were typical difficult issues for providers to deal with…We don't accept that as an excuse. We're not going to back off purely because providers saying 'Oh well our unions won't allow us to', you know. Our answer to that would be 'Tackle your unions. We're here to regulate for the quality and safe care for your residents. (Noah, External Stakeholder)

3.7.3 Communication with relatives

The importance of the role of the relative was emphasised by many participants as they understood that, while staff come and go, relatives are the only people who are consistently in many residents' lives. Participants advised being very transparent in communications with families and bringing them on a journey towards transition. While this was seen by one manager as preventing families creating problems, it was seen more as a trust building exercise by others.

Some participants felt there was a lack of communication with families. They may have been initially told about the move and then they heard nothing for a long time and assumed nothing was happening. The importance of keeping communication with families open and updating them on the process even when there are no firm updates was highlighted.

Managers talked about some of the difficulties dealing with families. A few reported feeling inadequate because they did not have the information to share as everything was so uncertain. Managers from two sites talked about the challenges of having group meetings with families.

> Oh Janey Mac. We have residents' forums, [family] forums here and honest to God, it was like, do you know what? It was like putting yourself in the ring with McGregor. It was, it was dreadful. Dreadful at first. And I kept saying the same thing to them… 'We don't have a choice in this. The only choice we have is in how we do it. That's all. And if we do it right, it will be a success'. (Aoife, Manager)

One of the managers got advice from another organisation at a transition meeting not to do a 'Town Hall' style meeting with relatives as these were difficult to manage and could become contentious. She therefore did all her meetings one-on-one which she acknowledged were more time consuming and involved arranging weekend and evening meetings. This was considered to be in line with the UNCRPD.

Managers also sometimes reported having to deal with a conflict between the resident's choices and what the family wanted. The individuals may have really expressed their will and preference that they'd like to move and family members may have genuine concerns about the move. Those fears needed to be explored fully and then the manager needed to develop ways to make the family feel more comfortable with the move. These negotiations with families have worked when staff see their first priority as supporting the resident and the second priority as supporting the family.

> I suppose what I would have experienced is families that weren't happy with residents moving … but the residents themselves have thrived since they've moved out there so at the end of the day you have to kind of call it. We're here for the residents not, and I'm not in a bad way, not what the family want, but the resident's needs come first. I suppose it's what's most appropriate for them, not the distance that the family might have to travel. I suppose that's, you do the best you can with what you've got [laughs]. (Olivia, Manager)

Communication between families helped in changing attitudes of some families. One site described holding a twice yearly general meeting with all the parents to update them on developments within the organisation and on national issues such as safeguarding, the national consent policy, and the Assisted Decision Making Act. Parents got a chance to mingle with each other and staff reported changing attitudes as some parents described the improvements in the lives of their son or daughter following transition. This led other parents to ask why their son or daughter has not moved.

Many families were happy with the fact that their relative was transitioning to live in the community. Some families were delighted that they were getting their own room in a new house. Many required reassurances but were in general in favour of the move.

However, participants found that many family members were fearful of the transition and had many concerns. Because relatives were somewhat removed from the transition process they found it more difficult to understand and embrace. Their fears of the unknown often manifested themselves as resistance to the transition. Some questioned the need for a move when their relative was happy where they were. Some specific concerns included those related to security or a fire in the community house or what would happen to their relative if they got sick. Managers reported spending a lot of time reassuring relatives that they would be able to manage that in the community. In many cases this reassurance was successful but on occasion families made arrangement for their family member to go to a nursing home rather than to the community.

> Like they come along here and they'd say to me 'We're very happy with the service and our, our loved one's happy here. And why are ye moving them and you know, you should leave them'. (Aoife, Manager)

Participants attributed some of the concerns of relatives to a lack of knowledge about their relative's rights and ability to have a better quality of life. One school of thought put forward by a number of participants was that families had been disempowered due to historical practices where the family were not involved or informed of the activities of their relative. and were not encouraged to be involved or to make complaints. They were only expected to express gratitude. Even when staff tried to support them in expressing their views they found that difficult.

> But you know, that goes back to, to the older people. They don't complain because they're afraid that you'll say 'Take them home'. (Aoife, Manager)

A small number of participants realised that there was a certain amount of judgment of families by staff in relation to their lack of engagement with their family member. However, they felt that a wider view of the situation of families needed to be considered. Families may have previously been told that admission to the institution was the best thing for that person when they were a child and a lot of trust had to be built with families to persuade them that now moving to the community is the best thing. Some staff felt that siblings were more open to the idea of transitioning to the community than their older parents.

Staff used various ways to bring relatives along on the transition journey. This included visiting the new houses, showing them photographs of the house and getting them involved in decorating the rooms. One manager talked about staff who were not entirely on board with the transition and asking them not to pass on their fears to relatives. Staff and residents in one community house held a small party for the relatives to meet and get to know each other and the other residents. Many families embraced the move and got involved in supporting the service post transition such as helping in the garden and bringing plants and flowers.

> The parents took great joy in decorating rooms for their children. They took great pride in that. And they were very happy to do that. (Caoimhe, Frontline Staff)

As more residents transition to the community staff felt that the fears of relatives were diminishing. Managers felt that relatives often ultimately came to the view that change in some form was inevitable and that even for those residents that did not transition, many of their friends had transitioned so there were less people living in the congregated setting which created a different dynamic.

3.8   Theme 6: Building staff support for transition

3.8.1 Acceptability of the transition to staff

Participants in this study reported a number of concerns in relation to transition that they had themselves or that they had heard other staff express. Some of these related

to the residents and their readiness or suitability for transition and concerns about their health. Other concerns were more personal and ranged from a fear of the unknown to concerns about terms and conditions, to the levels of support available to staff from their managers in the community. Many fears were attributed to staff being institutionalised.

3.8.1.1   Staff support for transition

In three of the sites participants reported that there was very little or no resistance from staff to the move to the community and for some there was a sense of excitement as they knew that residents would have a better quality of life and they were particularly interested to see how the move would work for residents with complex needs. Some staff looked forward to the freedom of working in the community and saw the possibilities rather than the risks.

> But yeah it was exciting just to kinda be moving out and kind of get away from the institution model… And I suppose the group that were going are very complex medical needs and I suppose it was exciting to see kind of how those kind of people would move out. (Kate, Manager)

A number of staff demonstrated an awareness of human rights and an ability to advocate for residents. They understood that despite cost concerns, moving to the community was what residents deserved and were prepared to fight for this. Many participants reported being surprised at how well the residents adapted to living in the community and some regretted it hadn't happened years earlier so that they could have had a better quality of life for longer.

> …she's just thriving and I suppose this is someone that has profound intellectual disability and I suppose that's the difference. You have your mild and you know that they'll probably adjust a little bit better. But someone with profound to severe you're thinking to yourself, and you can see where they're coming from, they're thinking 'Oh God', but they've thrived, they've absolutely thrived since they've moved out. (Olivia, Manager)

Several participants through the course of the interviews mentioned the deaths of residents. Some staff were upset by this particularly when it happened shortly before the person was due to transition. Staff regretted that the person did not get the opportunity to experience a more normal life in the community before they died.

3.8.1.2   Staff questioned suitability of residents for community living

Lots of staff and managers admitted that they did not think a transition to the community was going to work for residents and questioned the practicalities and the suitability of residents for decongregation. Some felt that a move for people with higher

ability was okay but that for residents with more severe to profound disabilities it was not appropriate.

> Staff said to me 'This will never work', 'They'll never be able to live by themselves', 'They can't do anything for themselves.' (Grace, Manager)

> … people with high ability levels are going to have a whale of a time. It's brilliant for them. …But when you start going down the ability level ladder I'd be interested to see how much, and how, what the quality of their life is actually going to be. (Conor, Frontline Staff)

Staff and managers spoke about the views of some staff that residents with certain behaviours that were difficult to handle would not be suitable for community living including those who were developing dementia, had challenging behaviour or who might pose a risk in the community.

> …there was loads of, 'Oh this isn't going to work, the risk, he's going to injure somebody, he's going to injure somebody in public and who's going to be liable'. (Ava, Manager)

One manager described a meeting with senior management where she was fighting to get more staff for her community house.

> We had a lot of arguments, challenges…cause let's say you had residents with high support needs okay, so then obviously you need a lot more resources and we were told, well it was awful but you know, 'They don't know where they are so why are you doing this'. (Lucy, Manager)

Some staff believed that residents were too sick to move or worried about what would happened if they got sick. They felt that the social model in the community had less emphasis on the health of the residents. However, some staff and managers dismissed these fears as being unfounded particularly in sites that still had nurses working in the houses and in sites where they had successfully transitioned residents with high medical needs.

> But you'd hear a lot like, they'll die now within six months of going out there. … So there was a lot of negativity around it going, 'It's ridiculous they're moving' and 'Blah blah blah', … and then they did actually get sick but it was just flu season but that was really in our minds going 'Oh my God were they right?' You know, that kind of thing. You felt you were under real pressure to keep them all so well cos we knew everybody would be kinda like 'Told you so!'. (Chloe, Frontline Staff)

Some staff questioned whether it was fair and right to move older residents who had spent most of their lives in the congregated setting. They felt that they should be allowed to live out the rest of their lives without such a disruption. However, other staff did not share this view and maintained that all residents, regardless of age or length of time in the congregated setting, should have a chance of a new life.

3.8.1.3 Staff concerns about transition

Many staff and managers described their own and others' general fear of change and how the transition to the community was a huge change which brought a lot of uncertainty. Participants acknowledged this fear and resistance to change as inherent to us all.

A lot of resistance was put down to the fact that many of the older staff did not want to move. The feeling expressed by many participants was that older staff were more set in their ways and more resistant to change whereas younger staff were more open to change. Older staff were considered to be on the wind down, waiting for retirement, and did not want to change their way of working. Some staff reported that older staff were extremely negative about the transition and that their views could influence younger staff.

Participants report that a portion of staff were reluctance to move because of their contentment with the current situation in terms of rosters and job location. Some staff expressed concerns in relation to the distance, remoteness or accessibility of the new workplace. One of the managers acknowledged that these views stem from knowing something so well that it is not possible to have a vision that anything else could be better.

> But I, absolutely, I was one of those who stamped my feet and said 'No I'm sorry, I'm not doing it'… (Robyn, Frontline Staff)

Many staff expressed fears that they wouldn't have adequate support in the community both from management and from their colleagues. They wondered whether they would cope with providing one-on-one support and lone working. Some staff also expressed concern about the potential lack of staff camaraderie because of working with fewer staff. Some managers expressed frustration when the focus of some staff was on 'personal things' rather than on the benefits to the residents.

> And they would of be things like 'Oh I won't be working with my friend'…'Will we still have our nights, our work nights out?' (Ava, Manager)

However, where management were able to facilitate these issues they saw that as a selling point that helped bring staff on board with the transition.

A recurring theme that came up among participants as a contributing factor to the
resistance to transition was the level of institutionalisation of staff. This was
acknowledged by staff themselves, their managers and external stakeholders. This was
partly attributed to the fact that many staff stayed in the one organisation and the one
unit within that organisation for decades. They then develop a sense of ownership of
that unit. This was not considered a healthy or ideal situation and some participants felt
it was a cause of resistance to transition. Many participants acknowledged that residents,
most of whom were also institutionalised, adapted better than staff to the transition to
the community.

> ...the older staff, there's no way around saying they're still institutionalised.
> It doesn't matter. You can take them out of the larger institution and put
> them into these new fabulous homes and that but they still carry with
> them their institution and it's a long slow process to deinstitutionalise the
> staff. It's definitely more difficult to deinstitutionalise staff than it is the
> residents. That would be my experience. (Siobhán, Manager)

Participants also acknowledged that becoming institutionalised was not the fault of staff
and that it did not detract from the care they provided. They also emphasised that the
resistance to change did not make their colleagues bad people.

3.8.1.4   Some staff were less supportive of transition
The reaction of some staff to their fears and concerns outlined above varied.
Participants recounted how some staff embraced the change over time and how they
eventually came around to the idea of moving. Some explained that the time lag
between the information and the move gave them time to adjust to the idea. Others felt
because they had no real choice they might as well make the best of it. Others, seeing it
work in practice, were convinced that it was the right thing to support the transition.
Some staff did not want to come out and say they weren't moving but rather they took
a wait and see approach.

> They did manage to buy into it. I think there were still one or two at the
> end who still thought that we were as mad as hatters 'What are you
> doing? It is never going to work,' but for most people they did buy into it.
> (Jack, Manager)

In some sites redundancies were available where there were no positions available in
the community for certain roles. These roles tended to include drivers, gardeners,
cleaning staff and kitchen staff. In organisations where part of the service was still
campus based it was possible to redeploy staff to areas where residents had not yet
transitioned to the community. However, sometimes the options available to these staff
was not discussed up front and some staff were left with a lot of uncertainty. In other
sites some staff would have liked to take redundancy but it was not available either at
that site or in the wider organisation.

Some staff were described as being forced to transition to work in the community. For others a choice was given but it was considered meaningless as it was widely known that the centre was closing. Other staff were reported as simply refusing to move and sometimes this was with the support of their union.

> …residential staff have being brought out kicking and screaming, they would avoid community like the, like the plague. (Conor, Frontline Staff)

> But ultimately what that came down to was when we got [to] the nuts and bolts of it, what that came down to it was a resistance of staff supported by their unions to prevent the staff to move. (Noah, External Stakeholder)

Both staff and managers talked about how they experienced either resentment from staff still working in the congregated setting when things seemed to be going well in the community or staff sabotage where staff tried to undermine their actions for a smooth transition. One manager described asking her staff not to visit residents that had transitioned. She felt it would be upsetting them and there were little comments being dropped like 'Oh you won't settle there and you'll miss us'.

3.8.2 Building staff buy-in for transition
Staff were seen as both a barrier and a supporter to transition and building buy-in from staff was considered by managers to be very important. This involved a number of factors including shifting staff attitudes where required, involving staff in the transition process and setting clear expectations. It also involved staff hearing from colleagues who had already moved to the community.

3.8.2.1   Shifting staff attitudes
About half the managers reported that it took some time for them to realise that not all staff were on the same page when it came to realising rights for individuals. Some managers reported finding it very difficult to change the views of some staff and to convince them that transition of residents to the community and working in a person-centred way was a right of the residents. Managers realised that in order to be able to bring staff along with them, they themselves had to have a strong belief that a transition to the community was the best thing for residents and that it would be a success.

> You've to believe yourself that it will work…You'd never stick it if you didn't have the belief yourself that there was a better life for them, you know. (Aoife, Manager)

Some staff realised that they were not working in a person-centred way and struggled with balancing their personal situations with work commitments.

> I mean I did feel awful because I was only going to go because this service user required somebody that really knew her and then I was kinda

thinking, 'I'm letting her down for the sake of hours'. (Robyn, Frontline Staff)

One of the external stakeholders spoke of the ability of all humans being able to change. However, she acknowledged that where the values of person-centredness are beginning to take root in an organization, there may be staff for whom the values are too much at odds with their own values and that over time these staff tend to leave.

Participants took great pleasure in seeing positive changes in the lives of residents. Some managers believed that seeing these changes helped change attitudes of staff and convince them that a move to the community could work.

> I remember a day four months after this gentleman moved out and he came back to the residential service to visit…and people in the residential service were like "Wow, he looks great like! He looks 10 years younger"…. I suppose, leading by example people saw that 'Oh, okay, this could possibly work'. (Grace, Manager)

In relation to bringing staff on a journey and getting them to see that residents could have a better life, there were a few specific attitudes that were identified that could hinder this process. These had to be tackled as part of the process of mind-set change required. The first issue was around staff holding residents back from doing various activities without a clear rationale as to why. Some participants described a resident getting a name for something such as exhibiting challenging behaviour or absconding and that stuck with them for a long time even if their behaviour changed. One of the strategies participants reported using to overcome this was to get one or two colleagues on side in order to be able to try new things with residents. In time other staff would begin to get involved.

> And then we've staff saying 'No, you wouldn't be bringing that person on a bus now because…that person would savage everybody around them and the bus is too enclosed, too many people on it, you can't get off because you're in the middle of a main road and you wouldn't be doing that now'….And yet if you brought that person on a bus that person would sit looking out the window thinking 'This is great! Look at this!' (Robyn, Frontline Staff)

Another issue in relation to attitudes to residents was that participants reported that some of their colleagues, particularly ones that had worked in the site for a long time, felt a sense of control over, and ownership of, the residents. This was partly attributed to staff trying to protect their position and their role saying that they were needed because they knew the residents best.

> …and there's ownership that seems to come into things. People have this thing about owning clients. They're not yours! Do you know what I mean? They're not…if anything they own you. (Aoife, Manager)

A third issue related to the low expectations that some staff had of residents. A manager described supporting a resident to interview his own staff and explained how many of the applicants spoke to her rather than directly to the resident.

> I would have put a lot of work into supporting that gentleman to be a part of his own recruitment and I remember the first [people] we recruited were really the people who came in and spoke to the gentleman himself. I had a lot of other people who would have come in and spoke to me and asked me questions about the gentleman, even though he was sitting beside me. (Grace, Manager)

Part of changing attitudes involved supporting staff to balance risk with a person's right to be more independent. Managers from three sites reported dedicated a lot of time and energy to helping the staff become more aware of the possibilities for the residents. They believed that this was one of the key ways to break down staff resistance and barriers to supporting residents to successfully live in the community. They felt that this approach worked and that staff gradually began to have a vision of a different life for people.

> I did this thing, a weekly thing about… 'Who Am I'. So I would pick a particular resident having sat down with them for half an hour discovered what they did when they were 17 and they were now 58 and try to do this pen picture on a chart for the staff and we'd give them a prize if they could work out that this was who this person was. They never did [laughs]. (Jack, Manager)

Some staff understood the importance of their attitude and motivations and that of their colleagues for the transition to be successful. Everyone had to be willing to embrace change. One staff member described trying to making every task a happy task. They clearly understood that it wasn't the new location that led to the change but that it was the staff who were the drivers of change.

One manager described what it is that makes some staff more motivated and engaged and others less motivated. She described the necessity of having genuine empathy and a desire to improve things for the residents. She described it as something internal where you want to feel like you have made a difference. She gave the example of staff coming to her and saying they had seen something in a shop that would suit a certain resident or saw an advertisement for a sensory shopping hour and suggesting that it might be good for a particular resident. She described how some people are not as naturally empathetic as others.

> ...they get through the day doing what they have/they do enough not to get themselves in trouble, ...but they take no interest in how, how the residents look, their quality of their life. (Siobhan, Manager)

3.8.2.2 Bringing staff on a journey towards transition

Managers spoke of their role of being both a leader and a manager. They felt that they really needed to be a leader to get buy-in from staff. They describe spending a lot of time with staff, talking through their fears and answering their questions. They also described 'selling' the idea of transition to staff.

> There was a lot of learning done from that …to be able to say, 'No, you know, if you want people to come with you you gotta show them the way' and it's not for us to you know say 'Listen you have to do it this way,' but we have to see it from where they see it and allay any of their fears.
> (Emily, Manager)

One managers reported adopting a Champions for Change approach through finding those staff that they felt would really buy-in and would be able to bring other staff with them. Some managers also talked about involving staff so they feel they are leading the transition with the manager and it is not all a top down approach.

In the early stages of transition managers needed to convince some staff that they wanted them, that their skills were transferrable, and felt that they could do the role. For other staff they had their doubts as to their suitability but rostered them with more motivated staff in the hope that they would be brought along by the other staff and eventually embrace transition.

> …like there is some people you would look at and think 'God I don't know how you would survive when you move out'. … You probably do need a few good people to kind of drive the people that maybe would sort of 'look this is what we do and we go out' and that's as far as it goes and maybe encourages people. (Kate, Manager)

A few managers reported involving their staff in the decorating and furnishing of houses. Staff seemed to enjoy getting involved in preparing the house. However, interestingly there was no mention of inclusion of the residents in the process of choosing furniture.

An important aspect of building buy-in from staff was not disregarding staff knowledge of residents in developing transition plans. Many staff expressed annoyance at not been asked for their ideas and input into the resident discovery process and the development of their transition plans. In sites that employed transition coordinators to work directly with residents on a transition plan there was a sense from managers in retrospect that the transition coordinators felt that taking on board staff opinions would somehow 'taint' the discovery process as their view would not be independent. One manager

described the transition coordinators as having a 'zealous approach'. This approach was acknowledged by managers as 'a mistake' and as 'an insult' to staff.

> The organisation went in and literally stepped over the staff that were on the ground. So never really gave the staff on the ground a chance to come along and change their thinking. The organisation went in with, 'D'you know what? The staff are of this attitude so we'll send people like transition coordinators in, project managers in, who will connect directly with the service user and try and bring them along'. But I think we made a mistake. (Grace, Manager)

Staff tried to encourage each other and to persuade their colleagues to give working in the community a try. There was also a little bit of cajoling involved. In some cases this worked.

> … the only thing I said to them was 'you can't say no for something that you haven't tried'. That's the only thing I said. You know, I know change is scary but sometimes at the end of that change, it's, you will realise, it's better. (Amelia, Frontline Staff)

In one instance staff felt that a negative experience of one resident's transition made staff more fearful and confirmed their fears that transitions would not work. However, these negative views could be changed as other residents successfully transitioned.

Having clear expectation around roles prior to transitioning to the community seemed to be a key learning point from staff and managers. When staff knew what they were expected to do they were able to make informed decisions. Clear information avoided them going to the community and not realising that certain duties were part of their new role and either refusing to do them or doing them but not feeling confident or supported in doing them. The change in role and the centrality of the resident in the new way of working was not always clearly communicated.

> Staff should be really informed about what the roles will be, like involving housekeeping even if it is going to be an issue that the manager mightn't necessarily want to bring up in the interview, because it would be difficult and I'm sure they would hate conflict in relation to it but at the same time it should be said, so that everybody knows going out this is what is expected of you. (Ella, Frontline Staff)

> People need to know that your role is very varied and very, very wide…I don't think people are told what their role is going to be… (Robyn, Frontline Staff)

3.9   Theme 7: Impact of transition

3.9.1 Impact on staff

3.9.1.1   Staff and management satisfaction

Staff and managers talked about the success of the transition to the community describing it as being 'fantastic', 'amazing', 'a good change'. One of the managers maintained that the majority of her staff come back and say 'It's the best thing that ever happened'. Some participants expressed real joy about their work. One staff member became emotional describing a Christmas party in the house she worked in. Other participants reported that they found a lot of fulfilment in their work. After the move to the community staff were better able to see how institutionalised practices had been in the congregated setting and how making persons with disabilities more visible in the community was a positive. Many staff reported that while they felt reluctant about going initially they would never go back to the congregated setting. They admitted that fear and lack of knowledge had prevented them from seeing how the transition could work.

> They [staff] wouldn't come back if you paid them, they just, they love it. They love I suppose, not the freedom, but I suppose their whole thinking has changed. (Olivia, Manager)

The majority of managers also reported that staff adapted very well and that in general the transition had gone smoothly. Managers attributed the success of the move to the fact that they got staff on board and built buy-in.

> … and they were terrified moving out, and they thought 'We'll never survive in the community. We're gone away from the safety net of in here'. They're thriving, both the staff nurses and the residents. (Olivia, Manager)

One of the managers mentioned that sick leave had decreased among staff since the move to the community and attributed this to increased loyalty among staff. Many participants demonstrated how they took pride in their work and their achievements with some reported as going 'above and beyond'. Staff described how they developed professionally and discovered their own potential and had to use their initiative and make more decisions in the community particularly as they had fewer colleagues to rely on.

> I only discovered my own full potential when I was being put there. I realised I can do all of that. You know the way? Looking back because then before in the residential, we were just following the lead. You know the way? (Amelia, Frontline Staff)

One manager asks residents whether they would move back to the congregated setting given the opportunity and uses this as their benchmark for successful transitions.

> Whenever I meet with service users now I'm, whether I was directly involved with the transition or not, I will always ask them 'If you had a choice tomorrow, would you go back?' And so far they've all said no apart from one. But he still wouldn't go back, he's just going somewhere else. So that's, I suppose, my measuring stick sometimes. (Grace, Manager)

3.9.1.2 Management support for staff

Despite fears of being unsupported in the community most staff were very satisfied with the level of support received from their managers following the transition. Many felt their manager was very available to them and that communication was good. Staff found it important that they were reassured by managers and told that support would be available.

> Like our manager is there every single day so we can say 'Oh look, we were thinking of doing this and changing it that way how do you feel about that' and straight away, 'Yeah that's a good idea or, oh, d'you know, what if we done that it might cause that'. It's all good you know. (Saoirse, Frontline Staff)

However, in two sites staff felt that, in general, there was poorer support in the community. Some would like an increased manager presence at their house or more frequent check-ins by management. Some questioned whether lone workers really knew that there was a team behind them.

Staff also knew that a lot was expected of them and that they had to get on with the job. Some liked the hands off approach of their manager whereby their manager was there if required but otherwise staff got on with it. Managers also realised that they sometimes expected too much and that staff could become isolated so providing support to them was considered very important. Managers understood the increased responsibility required of staff in the community compared to the congregated setting. While most people adapted to the changes a few managers shared experiences of staff who could not cope with the increased responsibility of working in the community giving examples of a staff member who consequently went on sick leave and another who left the organisation. Managers knew that they needed to lead staff by example and show staff that they are valued and that they respect and understand the difficulties they experience.

> But it's important just to stay in touch with them, all the staff, because they can get very isolated I think. Especially if one of the residents is sick or if there's a problem with a family member or something. (Lucy, Manager)

Managers also saw the importance of preparing staff for the negatives so that when things went wrong as it was felt they inevitably would, they would not be de-motivated.

Some staff gave examples of when a placement did not work out and how that led to a lot of stress.

> I just think be very open and honest with the staff, you know to let them know that there is going to be highs and there's going to be lows, and just even to reassure them that they're there for them ... (Hannah, Frontline Staff)

Some of the managers found a partnership approach worked well whereby staff and management were learning together and that management did not have, and weren't expected to have, all the answers. Managers also felt it was an advantage where they already had a relationship with the staff group having worked with them in the congregated setting. Many managers and staff had very high regard for their staff and colleagues and tended to have a lot of trust in their teams in the community.

> As I say there was such a good team amongst us and we had such a good camaraderie between us that we were able to kind of bounce off one another. (Emily, Manager)

However, a few staff reported that there was a lack of trust in and respect for management and there was a sense in some cases that management were actively working against staff.

Many staff and managers talked about a settling in period with many sites who had recently transitioned saying they were still in that phase.

> Because I do think, like probably the first six months, everyone is just finding their feet (Kate, Manager)

In general, there seemed to be an improvement in staffing levels with the move to the community. Some staff were nearly embarrassed to say how well staffed they were because so many other places were understaffed.

> … you've people saying 'Four staff and for four clients!', and they can't believe it and I'm just nearly afraid that it's going to be pulled because people are all giving out about it because everywhere is so short staffed and everything. (Hannah, Frontline Staff)

3.9.1.3   Changes to skill mix

There was a sense that with the transition to the community the role of the Registered Nurse for Intellectual Disability (RNID) was being lost. This was seen by some participants as having a negative impact on persons with intellectual disabilities. Historically most organisations were nurse-led but with the transition to the community staff with new skills such as social care workers were being introduced in some

organisations and the divisions between roles became a bit blurred. One of the external stakeholders reported that they advised services not to necessarily replace like with like when a role became vacant and to look at opportunities to widen their skill mix and bring in other professionals such as social care workers who are trained more around the community model or the social model of care. Some nurses felt that a clearer definition of the RNID was now needed for the community setting. There was a sense that the lack of role clarity could lead to some conflict and less respect although some staff embraced the openness of their roles.

> At the same time then it can lead to conflict cause, [sighs], I don't know how, say a person's knowledge mightn't be as respected… whereas experience has to be respected as well but it's more difficult when everything is so blurred. (Ella, Frontline Staff)

Many participants felt that the high level of nursing support in some sites was a legacy issue and that not as many were required in the new model of community living. More recently, nurses were reported as being more difficult to recruit which was leading some sites to gradually bring in social care workers or a higher ratio of care staff to nurses. One participant disagreed that fewer nurses were being recruited due to a shortage of nurses and thought it was because of a de-medicalisation of the service with the move to the community where some consider it 'politically incorrect' to have nurses. The reduction in nurses in community settings was not seen as a positive by all staff. Some were afraid to lose nurses as they liked the security of having nurses around.

> The skill mix in community would be much different I think than the skill mix [in the congregated setting]…Huge reduction in nurses, yeah… And not always a good thing either now I have to say… You'd have to wonder what skills are being left behind on campus here? I think every area should have at least two nurses in it that they can have a bit of comfort in knowing that there is somebody about the place, d'you know? (Robyn, Frontline Staff)

In one site there were particular conflicts between nurses and care assistants. Staff described how a care staff might feel that a nurse wasn't allowing them to do what was done in another unit or a nurse might feel that a care staff was taking on far too much responsibility and being overconfident. Another area of conflict was when a site brought in an external organisation to take over a service or to take residents to their service. They shadowed the staff for a period of time in advance of taking over. However, this was not well accepted by the nursing staff because the new staff were health care assistants and social care workers. One manager described the situation as always a 'them and us'.

> Nurses don't like healthcare assistants. Especially mental health nurses
> because they think that anyone who's a healthcare assistant coming in is
> taking their job. (Aoife, Manager)

3.9.1.4   New roles and responsibilities

Participants reported having to take on new roles and responsibilities with the move to
the community. Participants described the more defined roles that everyone had in the
congregated settings compared to being the 'one who has to do everything' in the
community. While some staff embraced these new roles and enjoyed the challenge,
others were not prepared for them and some found the responsibilities they had to take
on overwhelming.

> You were buying beds, you were buying furniture, you were picking paint,
> you were ringing landscapers, I'd a septic tank that broke down and I'd to
> go out and look at it. Now I'm an RNID, I know nothing about septic
> tanks, I was looking into the hole going 'What am I supposed to do with it
> like'. There was a leak in an attic, you'd to get SKY in, internet in and
> there was a problem running cables. The SKY man wanted me to come to
> the attic. I says 'There's no point me looking in the attic, I don't know
> what I'm looking at. I'm a nurse'. D'you know in that way it was a struggle.
> You got through it, you did get through it. (Olivia, Manager)

In general participants said that as they settled into their new houses staff found a
balance between the different roles among the team. Team members gravitated to tasks
they liked such as cooking, doing the administration on the computer or driving the bus
and this frequently worked well. While having a strong team that can agree tasks among
themselves is ideal it is not always the case and in and in a few sites participants
reported that teams perceived that there was not an equal division of labour. Although
staff still had specific job titles in the community staff reported working more as a team
and having a less hierarchical approach when compared to the congregated setting.

A key skill that many staff and managers talked about was the community connector
role whereby staff worked to integrate residents in the community. Many staff saw this
as a very challenging role and struggled to be able to find opportunities for their
residents to engage meaningfully in the community. The external stakeholders talked
about ideally having staff with community development type backgrounds who
understand much more about working with the individual at their local level to find out
their interests, what they would like to get involved in and how to link them with
groups. They also talked about the risk of residents becoming very isolated in the
community and having a reduced quality of life if sufficient relationships in the
community were not developed. Some staff weren't on board with their community
connector roles. One staff member spoke of his colleagues who were unwilling to
support a resident with his part-time job.

'Ah, no I'm busy on Sunday,' because they don't want to, they want to come in, make a dinner, watch the telly, go for a little walk, but they don't want the hassle of 'Oh if I go all the way to [place of work] and what time will I get back and what about my lunch break'. (Daniel, Frontline Staff)

There were many situations where the residents, although they had moved out to the community, retained a strong link with the congregated setting through attendance at day services, using the café or attending some of the multi-disciplinary team services. Staff were sometimes advised to do this with residents as part of the transition plan.

A number of staff and managers acknowledged that the community integration part of the transition had not yet been developed sufficiently as they were in a settling in period and that it would be looked at in the future.

Some participants reported that their organisation initially had an unrealistic expectation around what support the community would provide such as neighbours taking on certain responsibilities. They acknowledged that work needs to be done with the community to increase their understanding and acceptance.

> …this goes back to the kind of evangelical kind of feeling that there was around then, was that people would move into an apartment, they would get to know their neighbours.. I don't know that anybody gets to know their neighbours? So, if there was a fire in the apartment, neighbours would come and help the person out. I think that was unrealistic. (Emma, Manager)

In most community houses the cleaning and cooking and household management was done by the staff as there are no separate housekeeping staff. These were new duties that most staff would not have done in the congregated setting. One manager pointed to the lack of experiential learning among some staff in their personal lives in terms of household management as many of the younger staff had not lived outside their parent's home. There was a difference in the perception of these tasks by staff. A minority saw it as another thing to do and an additional burden whereas others found it enjoyable. In many sites participants reported that the cooking and cleaning was shared between staff regardless of their title or seniority. Some people did not feel confident in cooking but found creative ways to learn.

> I work with two girls that are incredible cooks so I watch [over] their shoulders and if I'm confused and I have uncle Gordon Ramsey, he's my uncle, I use him a lot on Facebook or YouTube quite a lot. (James, Frontline Staff)

One of the managers acknowledged the lack of training and preparation for staff around cooking and supporting residents to cook. In some cases there were issues with the

quality of the food served with staff perhaps taking some short-cuts by having too many take-away or frozen foods but this tended to be addressed quickly.

> The organisation make a great leap in assuming that somebody has the skills to cook. Somebody, you know, understands proper nutrition or proper hydration in order to support somebody with a disability who can't, maybe can't cook for themselves. We also make a great leap in assuming that people have the skill set to teach people to do things in their own home and that change for care support workers has been huge. The majority of the people that redeployed out into community services took it on the chin and made a success of it and there was a couple of people who just were not able for it at all. (Grace, Manager)

In many of the congregated settings drivers were employed, but with the move to the community staff were encouraged to take on this role with most community houses having access to a vehicle.

Staff described taking on a lot more administrative duties in moving to the community and some staff reported disliking this role. A few staff felt that their colleagues were not willing to learn to use the computer as they did not want to take on these new administrative tasks. One challenge reported by staff related to not having a separate office for administration work and record keeping.

One of the key new skills taken on by non-nursing staff was medication management. It also allowed previously nurse-led services to be transitioned to a more social care model where nurses were not present all the time. Staff and managers clearly recognised the need for this training in the community setting and the benefits it had for residents. A key reason for this was to facilitate residents, particularly those with uncontrolled epilepsy, to be able to go out without a nurse. Many staff were sent on Safe Administration of Medications (SAMS) training. One manager described how some staff were initially reluctant to do SAMS training but when they got out into the community and realised that they could not go anywhere unless a nurse was present they tended to accept the training. She also said it became an issue with HIQA when there weren't many staff trained as it was restricting the activities the residents could do.

There were some mixed views on care staff being trained to administer medication. A few staff reported that nurses see medication as their domain. They went to college for four years to be trained so training a non-nursing staff in a day was considered insufficient. A few of the nurses interviewed said that the administration of medications and other interventions like peg feeding were becoming task orientated with risks relating to the lack of knowledge behind the task. It was considered a major issue that there was no national agreement in place for social care workers to administer

medication. Allowing non-nursing staff to administer medication was seen as blurring the role of the nurse further.

> There's no competency test. They're coming out with these certificates saying oh we're certified but you're not – you're certified you attended [laughs]. But nobody's tested your competence. So I have difficulty with it. (Ella, Frontline Staff)

The use of technology within sites for documentation and record keeping was limited. One staff member referenced all the changes in paperwork required following transition and how much easier the process would have been if the records were electronic. Where computers were in place and were networked to the campus this was considered very helpful. There was a sense among some that more investment in technology was needed.

Staff talked about using WhatsApp groups and e-mail for communication and to prevent things from getting missed. However, there were some difficulties with using this technology as not everyone wanted to participate.

Staff also supported residents in their use of assistive technology. In general the use of assistive technologies seemed to be minimal and seemed to be on the more basic rather than innovative end of the scale, although this varied by site. A number of safety and security devices were reportedly used such as maglocks to hold doors for a resident who did not like closed doors, and a call button system to contact the person on-call. Many residents also reportedly used electric wheelchairs. In some houses staff reported that there was Wi-Fi, electronic picture frames, I-Pads, Skype and mobile phones. These were generally used for entertainment purposes or for connecting with family. However, this was not universal and some services said they used no technology with residents. The more advanced use of assistive technology was reported among residents without intellectual disabilities. One resident was reported to be using OK Google to turn on their television and laptop and to use Facebook.

When asked about the use of assistive technology, participants either said that their residents' disabilities were too severe to get much benefit from it or acknowledged that it was a gap that needed to be explored further. A few managers raised safeguarding and data protection issues and there was some uncertainty around what exactly was allowed. In one situation staff were using WhatsApp to communicate with a resident's family on her behalf but had concerns about potential data protection issues.

3.9.2 Impact on residents

The majority of participants reported they felt the lives of residents improved following the move to the community. There were reports of residents being more involved in their communities or getting out more and having new experiences. Residents were reported to have a happier demeanour, to have thrived, and to having their personalities

become more apparent. This was often attributed to staff having more time for residents in the community, having less crowded and quieter homes and being able to spend more time outdoors. However, this study did not include interviews with residents who would be most appropriate to explore this issue further.

3.9.3 Relatives visits and attitudes

While some staff reported no changes in the number of visitors since the move to the community in several sites there were many examples provided of more frequent and possibly better quality visits. Staff also spoke of how the more normal environment of a home, made visiting easier and some sites had adopted an open door policy in their community houses.

> But since they moved out one of the things that really, really has increased is visits from family…People didn't want to come in here [to the congregated setting] and you must remember that when you come in here…when you pulled up a car there, you had 8 or 9 people running at it. The fright that you got [laughs], you know what I mean… you didn't have the privacy either that you wanted even though there was a visitors' room. Unless you were locked into there, there was somebody going to come in and out. And not only were you there and maybe a little bit afraid of your own but you were afraid of some of the others as well. You know. (Aoife, Manager)

Staff reported that feedback from relatives post-transition was generally very positive. Many reported seeing huge improvements in their relatives. Some family members admitted that they hadn't been able to see the vison of living in the community for their relative. One of the managers reported that relatives perceived their family member differently when they were in the community.

> And indeed, some of the family we met with actually said 'I didn't really see it but now that I do see it, it's fantastic'. (Sean, External Stakeholder)

The only issue where families were reported to have expressed some dissatisfaction following the transition to the community was where their relative has been moved multiple times between community houses. This could be for individual personal reasons or for service reasons such as the needs of another resident.

3.9.4 Challenges
3.9.4.1 Balancing person-centred support with risk

Some participants spoke about balancing residents' choice and autonomy with risk and how the level of risk is likely to increase for some residents in the community. They realised that increased risk needed to be accepted and flexibility needed to be built in to person-centred plans.

> The service user is at the heart of it and you know, sometimes we'll be disagreeing with what the service user wants or it's not practical or it's not safe or whatever. But ultimately it comes down to you're in that individual's home and you're there to support that individual. So overall, I think it's been hugely positive. (Grace, Manager)

There were reports of staff beginning to do risk assessments well and giving residents more opportunities to get involved in the community and achieve their goals. The concept of dignity in risk was mentioned. Also mentioned was the balance needed between regulation on the one hand and human rights and equality for the resident on the other hand and how the regulations can sometimes restrict the resident. It was acknowledged as a complex area and that services are going to have to really think about how they will deal with the commencement of the Assisted Decision Making (Capacity) Act.

> A ship is safest in the harbour but that's not what it is built for …so that sometimes risk *has* to be taken and sometimes you have to make a bit of a leap past if you're going to achieve something past what the conventional wisdom might be at the time. (Jack, Manager)

3.9.4.2 Staff turnover

Staff turnover and retention was a problem in some sites. In one site the high level of turnover was linked to the rostering system. Staff did not like the uncertainty of when they were going to be working. They wanted more than two weeks' notice of their shifts and thought that the service wasn't considering their lives outside of work. Staff members advised having a 'clear and concise' roster that doesn't change. They felt that this would help with staff turnover along with a clear retention policy. They also felt that the organisation gets a bad reputation if there is a high turnover of staff. Staff turnover also leads to the loss of vital information about clients that may never have been recorded. This was an issue both in relation to staff turnover in general and in relation to a service closing and staff leaving during the transition process.

> …and I suppose the biggest thing we had to put on the risk register was would we lose continuity in terms of the staff because they'd start going. And we did, we lost a good few staff... (Aoife, Manager)

One manager felt that there was no loyalty among some care staff who are in demand so they can pick and choose where they go to work, many of whom prefer not to have a full time contract and might be working in different services. She felt that this transience made it difficult to build up a solid team.

3.9.4.3 Communication with staff

Some staff felt that communication between each other and with management suffered with the move to the community. There were challenges in ensuring that staff got timely

updates during shift changeovers. Often different shifts did not meet up so handover notes were written. However, frequently staff found that some things were not being followed up. Some staff felt that leaving written notes was challenging as the tone could be misinterpreted whereas speaking to someone face-to-face led to better communication. Team meetings were seen as an effective mechanism for information sharing. However, some staff found that they did not always have an input into decisions that affected their work, for example, if they missed a staff meeting, and felt frustrated when they were not asked their opinion.

Good communication played an important part in conflict resolution and conflict prevention. Managers encouraged staff to resolve conflict at a local level before escalating. Staff emphasised the importance of managers listening to their staff so that problems can be sorted out early on.

3.9.4.4 Risk of mini-institutions being created

Study participants were asked whether they felt there was a risk of mini-institutions forming in the community. There was a general understanding among participants that a mini-institution meant bringing institutionalised practices into a home in the community so that while the environment had changed the life of the resident had not. The consensus was that this was a real risk and staff and managers in several sites acknowledged that it had already happened. Several participants emphasised that changing the organisational culture and transforming thinking are key to achieving meaningful change. This was reiterated by other participants who knew that while the house might be nicer, if residents' behaviour and staff practices remain the same, there will be little change overall.

Participants described some of the factors that led to mini-institutions in the community. In some of the larger houses participants described a lack of privacy leading to noisy environments. Staff and managers seemed to indicate that institutional practices were more likely to be in place in larger houses where residents had higher dependency needs or had medical issues.

> Well I mean out in [name of house] was one of the older ones and there's still 10 residents. There's two paraplegics, they're all profoundly handicapped, there's three or four challenging behaviours, there's a few with physical problems, so it's still more or less an institution. (Caoimhe, Frontline Staff)

The houses themselves were sometimes considered to be a bit institutionalised looking. This was put down to the standards that had to be met and the requirements of residents such as having shower trollies and ceiling hoists. One of the external stakeholders felt that services were now adapting to meet the regulations in a more unobtrusive way.

One staff participant talked about keeping the routine similar to the institution to avoid confusion and disorientation of the residents. This was a key part of the transition plans of some residents. In some sites a strong link remained with the institution and staff would bring residents back there to the day services, the restaurant or to use the medical facilities. Often this was done using the service bus. This was sometimes also recommended as part of the transition plan to help residents settle into the community but it was unclear as to when and if it should stop. Many staff and managers wanted to see this changing so that they operated more independently and were more centred in the community.

One manager felt that because staff weren't changed when residents moved to the community the same medical model came with them and therefore the institutionalised practices remained. She felt that staff were as institutionalised as the residents. Examples were given of staff using restrictive practices, carrying keys, talking between themselves, sometimes in a non-English language, and not talking to the resident. One manager described how residents in her site had no access to the kitchen, no free access to the toilets '…they couldn't even turn on their own light and the water in the sinks in their bedrooms was turned off'. She also spoke about the challenges she had in trying to get staff to change these practices.

> I wouldn't say that the staff hold back the service users but I think the staff coupled with the service users' previous behaviours or known behaviours hold them back and, and, and help to build mini-institutions in the community (Robyn, Frontline Staff)

Staff reported a huge amount of paperwork, much of which they felt was unnecessary, repetitious and meaningless and that it detracted from time spent interacting with residents. One staff member reported that there was so much written on residents, much of it seeming to be a hangover from institutionalised medical model of care, that it was difficult to find the information you were looking for.

> 'Slept well, eyes closed, chest rising and falling' every single night that's if nothing happened. You have to write all that every night for 10 of them. So by the time you've got through all this useless material to find what you are looking for… I think it takes away from the client care… (Caoimhe, Frontline Staff)

The application of person-centred approaches, positive staff attitudes and adequate staffing numbers were considered to be a very important elements in preventing the creation of mini-institutions. Participants reported that staff need to be motivated, happy, open to change, and open to trying new things.

A key strategy used by managers to combat institutionalisation was regular checks and visits to the house to ensure that there were changes in the houses and that lives were improved for the residents. They felt that this avoided complacency and that if staff knew that a manager would be 'popping in' and asking them about their plans and activities that it would prevent the development of poor practice. One of the managers talked about constantly challenging the staff around the purpose of their work in order to prevent the formation of a mini-institution.

> Well, would you be happy if this was your life? If you were here, how would you want your life to be lived? That constant challenge in thought process and exposure and trying different things. That has to be active and that has to be a current piece of work in order for that, in order for it not to become a mini institution. (Grace, Manager)

Staff and managers were conscious that they needed to be aware of institutional creep whereby institutionalised type practices could creep back in or that 'service activities' such as 'going for spins' and 'going to the library' could end up being the main activities rather than doing things that are of interest to the residents. One of the managers provided some examples of how institutionalised practices had crept in. In one instance a staff member wanted to bulk buy for the house such as buying enough toilet roll for six months and requesting more storage. In another instance, a staff member bought three big bins for the kitchen for recycling and rubbish because she thought the normal bins under the sink were too small. Other examples were related to institutionalised practices around residents' clothes.

> Oh yeah, one of the girls said to me yesterday 'Here's so and so's labels' and I said 'What are you giving me labels for her, she's living with three other people you don't need labels on their clothes anymore.' It's just old habits. And they could creep in, I know they could creep in very easily. (Lucy, Manager)

One strategy used by management in about half of the sites was rotation of staff throughout the community houses to prevent people becoming set in their ways or to prevent staff feeling ownership of certain residents or of a certain house and to provide fresh ideas, fresh eyes and fresh momentum. A potential disadvantage of this approach is that the residents have built up relationships with staff who are then moved. However, by rotating only one or two staff per house annually a major disruption to residents can be avoided. However, not all staff were happy with this strategy and did not like being moved or resisted moving and it sometimes became a union issue.

3.9.4.5   Medical management in the community

Some participants felt that there was an issue in the community settings around non-nursing staff not recognising health problems in residents, particularly where the service

is no longer nurse-led or where nurses are only occasionally present. There were also concerns about non-nursing staff accompanying residents to medical appointments where it was felt that some would not be able to adequately advocate for the resident.

Many participants felt the loss of the convenience of accessing wrap around services including medical care in the campus setting. One of the new skills they had to take on was organising medical care for their residents in the community. This included getting a new GP, pharmacy and dentist and linking in with the public health nurse and others in the multi-disciplinary team. This caused a number of challenges. There was a strong sense among staff that this part of the transition was not properly planned for or thought through.

> And you're sent out very quickly to the community with nothing really properly organized in relation to how to gain access to these services… The services obviously have a big workload themselves and these people are just sort of shoved at them you know [laughs] which increases their workload as well. It's very difficult. (Ella, Frontline Staff)

One manager talked about the lack of specialist mental health teams for people with ID. Services can be particularly difficult to access in the community when it is seen that the service provider organisation already has enough resources. For example, one staff participant recounted that a public health nurse said she wouldn't get involved because there is a nurse working in the community house but the staff had to explain that they needed to be trained in wound management and that they did not have access to supplies.

A particularly challenging issue was getting GPs in the community to take on the residents. In many cases the fact that most residents had medical cards was seen as a barrier to GPs as they were perceived as high burden and the GPs would not get adequate reimbursement for the work involved. High existing GP caseload was also seen as a barrier. Ultimately, some managers had to request a GP through the General Medical System (GMS). There were a few difficulties with this. Each resident in a house may now have a different GP with different ways of doing things which made coordination of medical appointments and prescriptions more difficult. In addition, the allocation by the GMS did not account for accessibility issues and one resident couldn't access her GP as she was a wheelchair user and the GP surgery had steps.

Suggestions by participants as to what could be done to improve medical management in the community included having liaison nurses to support people to access mainstream health services, particularly around communicating with people with an intellectual

disability. Also mentioned was a health passport[14] which includes their care plan and which follows the individual when he or she uses health service, getting residents onto community waiting lists and having the GMS take account of accessibility issues.

3.9.4.6   Managing residents still in the congregated setting

Post transition many of the managers still had dual responsibility for residents in the community and residents who were still living in the congregated setting. In organisations where staff who transitioned were primarily more motivated staff who volunteered to go, the congregated setting could be left with staff who were less willing to change and try new things and were perhaps working in a less person-centred way. Managers tried to mix staff in such a way that the skill sets were available to best support residents living in the congregated setting.

> But it's about being creative then, you know, what's left in your pool…
> But it's knowing your skill mix and knowing who to monitor more closely
> and whom to maybe mix. (Ava, Manager)

There were some advantages for the residents who remained on campus such as the place got quieter and they may now have had their own bedroom for the first time. One of the external stakeholders spoke of one site where remaining staff, learning from the community transition process, made changes for the residents left behind such as making their rooms more personalised. However, in retrospect some managers regretted that they may have neglected to some extent the residents who were not transitioning.

> I suppose we concentrated so much on the people we are moving out we
> forgot about the people here which was sad too d'you know … and then I
> look back at it I said, 'D'you know we actually didn't do that much with
> the residents here then. (Lucy, Manager)

---

[14] Launched in 2019 the Health Passport is a communication tool to help people with intellectual disabilities communicate aspects of their health and social care needs. The Health Passport helps healthcare staff understand the abilities and needs of people with an intellectual disability who come in contact with healthcare setting. https://healthservice.hse.ie/about-us/onmsd/onmsd-blog/hse-health-passport-mission-possible-short-film.html

4   Discussion

4.1   Introduction

This study has demonstrated that, in general, the workforce in residential disability service organisations are dedicated, motivated and worked extremely hard to transition residents to the community. While the bulk of this study focused on the challenges associated with the transitions, it is in how people manage to overcome the challenges where the learning emerges that can be shared with others. A key overall finding is that many of the barriers faced by managers at the site level were predictable and could have been avoided particularly if the planning for transitions had been done more strategically at the organisational level. The NDA intends to distil the main learnings for managers into a separate Effective Practices document in conjunction with the HSE that will complement the existing range of resources available[15] and to help signpost where specific pieces of information can be found.

This discussion section focuses on each of the seven themes to reflect on the findings, examine if they are in line with other research and determine what areas require further work or focus to progress new transitions and to ensure that residents who have already transitioned are supported in the best ways possible.

4.2   Theme 1: Shift in model of service and work practices

The Quality Framework developed by the HSE (HSE 2018b, unpublished) highlights that person-centred organisational culture, structures and processes strongly influence the quality of the person-centred planning process and the achievement of personal outcomes. The values and principles underlying quality of life outcome domains are central to attaining outcomes and organisations must put them into practice in order to provide person-centred services that support persons with disabilities to achieve personal outcomes (NDA, 2016). Researchers have long theorised that organisational culture is predictive of quality of life outcomes for residents with intellectual disabilities who live in group homes. A recent study has shown that effective team leadership, alignment of staff values with organisational values, and supporting residents' wellbeing were predictive of certain domains of an improved quality of life (Humphreys et al., 2020). The focus for most of the participants in the current study was on the transition to the community without too much consideration of the next stage of integration into the community, including finding employment opportunities for people or other valued social roles. There was acknowledgement by some that the service remained a medical

---

[15] HSE Residential Service Provider Guidance Documents
https://www.hse.ie/eng/services/list/4/disability/congregatedsettings/service-providers/

model even following transition and the understanding of person-centredness was underdeveloped in some organisations.

An examination of the administrative aspects of regulatory compliance required in community residences may be warranted. A question to look at is whether the philosophy of living ordinary lives in ordinary places can be better aligned with the administrative work required to meet regulations.

A key change in work practices to facilitate transitions to the community was around staff rosters. Where staff have concerns that their working conditions will deteriorate with the transition to the community their support for the process can diminish (EU Agency for Fundamental Rights, 2018). Many participants acknowledged that rosters were not person-centred and did not vary based on the needs of the residents. Some roster changes and the nature of community working meant that there were now more staff working alone and some struggled with this. Some participants also reported that frequent roster changes led to a high staff turnover which could have a negative impact on residents.

4.3 Theme 2: Leadership and management support

The requirement for strong leadership within the organisation to lead change was highlighted by participants and there were mixed reports as to whether this was in place. Studies from Europe that investigated de-institutionalisation found there was widespread transfer of responsibilities from the national to the local-level and that lack of national guidance was a barrier to implementation of policies around deinstitutionalisation (Šiška and Beadle-Brown, 2020, EU Agency for Fundamental Rights, 2018). This delegation of responsibility was not always supported by adequate resourcing and issues with coordination, consistency and competency of services have been reported.

Some interviewees in the current study highlighted that leadership was lacking and that transitions are not being prioritised at the national level and at the local service level. Skills for Care (2014) in its guidance on supporting workplace change emphasises that organisations should take a whole systems view of organisational change. Many participants in this study reported that this was not the case with complaints that there was no joined up thinking and an apparent lack of preparedness and planning in terms of community readiness for the transitions. This is reflective of what the EU Agency for Fundamental Rights described as 'confusion about responsibilities' and a tendency for disability organisations and mainstream health services to focus only on their own role rather than on the process as a whole (EU Agency for Fundamental Rights, 2018).

Several managers talked about the pressure on them to manage the change in the service relating to transitions but also to manage all the other requirements such as compliance and safeguarding and they found it challenging to manage the competing priorities. Some managers also expressed frustration around things they had no control

over. This reflects the complexity of disability services and the need for complex adaptive systems as outlined by Barry and Dalton (2018) in their review of change management in health and social care settings. This approach recognises that change is not a linear process, that change is 'unfixed' and unpredictable and that managers need to develop skills in working with uncertainty.

It is clear that sites in this study would have benefited from a more structured approach to change. Traditionally change has been managed as part of programme management cycle. The HSE's change management guide: People's Need Defining Change (HSE, 2018a) outlines how change management needs to be combined with a focus on people and culture in the organisation in order to succeed (HSE, 2018a). The Framework was published in 2018 and the data gathering for this study took place in the first half of 2019 so it is perhaps not surprising that no participant mentioned the tool. However, there is potential for the Change Framework to be beneficial to managers of disability residential services in progressing the Transforming Lives Programme leading to a smoother transition process for both residents and staff.

4.4   Theme 3: Preparing for transition

This study found that while some organisations and sites were ready for change and embraced change, others were slower to do so. For all sites there was a suggestion that the transitions were driven by government policy and other factors such as HIQA regulations rather than purely the motivation of the organisations themselves.

Skills for Care (2014) developed practical guidance for involving people in planning and delivering care and supporting workplaces change. They emphasise that a planning and workforce development process that is participatory, inclusive and evolving has more chance of success. The workforce redesign process they talked about was lacking in this study with evidence only of organisations tinkering around the edges rather than standing back and really examining the type of staff and skills that they required.

Shifting the focus from recruitment based on qualifications and different cadres of staff to identifying the specific skills and competencies that staff need to support persons with disabilities to live a full life in their community is beneficial to the residents (Genio, 2014). McConkey et al. found that some organisations developed new job titles, new job descriptions and person specifications that included people who like challenges and who are good at building relationships and making friends (2013). A policy of critically scrutinising every vacant post that arises and utilising the natural turnover in staff to bring about a change in skill mix has also been adopted (HSE, 2017b). The external stakeholders in this study recommended this approach. However, in most cases in this study, sites that were historically nurse-led still tended to be nurse-led in the community and some seemed to lack an openness to new types of staff such as social care workers joining their service. None of the more innovative practices discussed by others were reported by participants in this study.

While there was a lot of discussion around how staff were chosen to transition to the community and familiarity with residents was a key criteria, there was only one account of staff supporting an individual to recruit their own staff despite this being considered best practice (Genio, 2014).

The HSE's guidance on creating a home in the community is firmly underpinned by Article 19 of the UNCRPD and puts the resident at the heart of decision making (HSE, 2019). Despite this, a small recent Irish study found that one third of people with intellectual disabilities who had transitioned to the community had no choice about where they live and who they live with (Salmon et al., 2019). In the current study many sites went through a thorough discovery process with residents and developed detailed transition plans. Others however, thought the discovery process unnecessary as they knew the residents so well. This was also the case with assessing compatibility between residents. Staff tended to group residents based on their own knowledge of resident compatibility but there were rarely reports of residents being involved in that decision making process.

4.5 Theme 4: Training

This study found that training and development in organisations primarily focused on the training required to sustain a medical model of services and training around a social model or a person-centred model was less frequent. Where this training did happen the support for staff to implement the changes were not always present. Therefore, it seemed that most learning relating to transitions and community working was on the job and that staff were supported with mentoring from committed and motivated managers. Many staff felt they would have benefited from some sort of transition training. Training, along with effective communication, can reduce the uncertainty and anxiety related to change and reduce the resistance to change (Skills for Care, 2014). Training and support should reinforce the strengths staff already have, and identify and meet their learning and development needs. A training and learning needs analysis may be useful to identify gaps (Skills for Care, 2014). The EU Agency for Fundamental Rights (2018) also emphasised the importance of staff training stating that it was 'an essential component of instilling an independent living philosophy in disability services'.

There were a number of instances however, where it was clear that managers were not linked in to developments at the national level to support the Transforming Lives programme and were reinventing the wheel and repeating mistakes in their own service.

There was limited evidence of ambition among the organisations and sites included in this study to be 'learning organisations' although research has found that organisations need to adopt a 'learning organisation' approach so that staff can develop the ability to interpret and adapt to new knowledge (Linehan et al, 2015). There was some sharing of knowledge and experience between sites and examples of providing support and visiting other organisation, however, this tended to be restricted to managers and tended to be

on an ad hoc basis rather than through any structured process. There would appear to be a significant missed opportunity for both formal and informal peer-networking between staff and managers who have gone through the transition process and those that have not. Although the HSE organised many events to share learning the majority of managers and staff in this study did not participate in these. Opportunities for staff to visit homes in the community of those who had already transitioned were infrequently reported. Other research has found that staff visiting successful demonstration projects or shadowing colleagues who already work in the community are useful in allowing staff to see the feasibility of the community approach (Linehan et al, 2015).

4.6 Theme 5: Communication about the planned transition

The aim of staff communication in the HSE's Stakeholder Mapping Tool is to ensure that they are fully briefed on the policy and the specific plans for their own organisation.[16] It is also to ensure that they are aware of their roles in relation to the roll out of the policy and to allow any questions or concerns to be addressed. While this approach was implemented in all sites in this study it was done with varying degrees of success, with some staff feeling that communication was poor and some managers admitting that they could have done better. The outcomes of a change management process will be improved if people are well informed, reassured, and understand why something is happening. Therefore, regular and effective communication between managers and teams and between team members is crucial and will go some way to reducing the fear and anxiety that comes with change (Skills for Care, 2014, Linehan et al, 2015). There were no reports in this study of frontline staff being consulted about or being involved in decision making regarding transitions and a few reported being very uninformed.

Rosters and related contract changes were some of the key reasons for union involvement in the transition process. Advice from managers and unions was to keep lines of communication open and to inform unions about planned changes. Unions tended to say that they were concerned about both resident and staff interests but some managers reported that staff interests was the only factor that unions considered. This conflict between the priorities of managers and unions has been identified as a challenge in other Irish research that looked at supports for persons with disabilities (McConkey et al, 2013). Trade unions are included in the HSE communications plan and management are encouraged to take a pro-active approach regarding changes that will impact on staff practices. While participants spoke of bringing staff, residents and families on a journey to understand person-centredness and the rights of residents this did not extend to unions and there may be further work to do in this areas.

---

[16] HSE. Time to Move On from Congregated Settings Communication Plan- Stakeholder Mapping Tool. https://www.hse.ie/eng/services/list/4/disability/congregatedsettings/commsplanmappingtool.pdf (Last accessed May 2021)

Communicating with relatives was also important. Managers reported learning lessons around communicating with relatives such as the benefits of adopting the more labour-intensive one-to-one approach to communicate rather than town hall style meetings.

4.7   Theme 6: Building staff support for transition

The resistance to change found in this study is not unique. Resistance to organisational change has been found to be due to fear of the unknown, lack of information, fear of failure and lack of perceived benefits and it presents challenges for managers (Proctor and Doukakis, 2003, McConkey et al., 2013). Linehan et al. (2015) describes how particular mind-sets and ways of behaving are developed through the assumptions, attitudes and practices of managers and staff, including taken-for-granted customs and practices, rituals and routines. Emotions around this culture can lead to resistance to change which can affect all staff to a greater or lesser extent. Interestingly, many staff and managers in this study recognised that resistance to change among staff did not make them bad people and that many resistant staff cared deeply about residents. Skills for Care (2014) described a continuum of change starting with 'Sabotage', 'Resist', and 'Ignore', and moving to 'Accept', 'Embrace', and 'Initiate'. At the start of a change process staff can be at any point on the continuum and in this study staff and managers gave examples of colleagues at each of these stages.

As evidenced in this study staff can respond differently to change with many staff questioning the benefits of change for residents, highlighting the potential negatives, taking a wait and see approach, refusing to transition or ultimately resigning. Similar mixed reactions have also been in other studies (Salmon, 2013, Skills for Care, 2014). When change is imposed on people without consultation, it can lead to a negative reaction from staff, and some level of conflict is therefore predictable (Greenhalgh et al, 2004, Salmon 2013). Resources to support change, including time, need to be in place if transformation is to be successful and sustainable (Skills for Care, 2014). Over time, and with adequate support and communication, most staff will move from a more negative to a more positive attitude in terms of the transition to the community. Involving and using the innovators and early adopters can help promote changes and should be encouraged (Skills for Care, 2014). Several of the managers reported doing this often through nominating a staff member as a Champion of Change.

Another key issue in building buy-in of staff was to consistently challenge their views, to help them to think differently and ultimately to change opinions and attitudes that are contrary to the values of the organisation. This approach has been described by others (Skills for Care, 2014, Linehan et al., 2015) and while this approach can be time intensive and requires specific skills on the part of the manager, over the longer term it can result in a more motivated workforce with outcomes that are more successful. Managers reported mixed results in their abilities to change staff attitudes and build their support for transitions in this study. Those who were successful took pride in their ability to lead a staff team to see a different and better vision for residents.

The importance of involving families in the transition process was emphasised by the EU study examining de-institutionalisation. Their involvement can help allay any fears and build their support for the transition (EU Agency for Fundamental Rights, 2018). In this study managers reported dedicating substantial time to families through one-on-one meetings and frequent updates. This was required as the initial view of relatives to the transitions were frequently negative and staff had to combat views that were often described as paternalistic and sometimes negotiate the conflict between how a resident wanted to live their life and how the relative wanted them to live it. However, by the end of the process participants reported that many families had embraced the transition.

4.8   Theme 7: Impact of transition

Continued management support and leadership are required beyond the process of transition itself to embed changes in working practices. Good supervision can minimise the negative effects of change. Supporting staff to develop the confidence, skills and expertise they need to work in redesigned services is an essential part of the change management process (Skills for Care, 2014). People learn and change at different rates, so supervision needs to recognise and accommodate this. Practice leadership is essential to providing good support whereby managers lead by example, model, coach, and review practice through supervision and team meetings (Beadle-Brown, 2015). Many managers in this study exhibited strong skills in maintaining a motivated workforce in the community through their support for staff although there was room for some managers to delegate more. Many of the managers displayed strategic and practice based leadership. This is one of the thematic areas identified as a predictor of quality of life outcomes for persons with disabilities in HSE research (HSE, 2018b). However, there were several reports from managers that they felt unsupported in their own roles by more senior managers and the leadership of their organisations. As discussed previously the success of the transitions often lies strongly with organisational leadership so where managers are unsupported there is a risk that transitions will be less smooth and perhaps less successful.

Staff and managers mentioned many positive experiences to working in the community. Many enjoyed the fact that they could now work in a more person-centred way with more time to spend with residents and give them one-to-one support. They took great pride in the improvements they saw in the residents lives and knew they had played a part in that. The fact that many relatives were visiting more often was seen as a sign of success of the transition. Similar positive aspects of working in the community have been found by other researchers (Salmon 2013; McConkey et al., 2013; Linehan et al, 2015).

Staff were very honest and some said that they could really only see how institutionalised they were when they moved to the community. Staff also expressed surprise at how they found that they developed professionally and discovered their own potential. However, this was not the experience of all staff with some reports of staff finding the move to the community overwhelming and eventually resigning.

A study by the EU Agency for Fundamental Rights found beliefs that persons with disabilities should be 'looked after' and 'cared for' remained strong. These beliefs can be a barrier to deinstitutionalisation but can also result in the creation of mini-institutions in the community (2018). Staff who are used to caring for people and assisting them in all their activities of daily living can find the transition to promoting a resident's independence and letting them develop their own autonomy difficult (Genio, 2014). They can face a conflict between their role of promoting individual decision-making and their role of providing a duty of care (Jingree et al, 2006). Staff require a change in 'mind-set' to allow people to do more for themselves, make more decisions and allow residents to take control of their lives (McConkey et al., 2013) and this can be particularly challenging but important for those with complex support needs (Šiška and Beadle-Brown, 2020) . Staff and managers in this study demonstrated a range of approaches with some struggling to promote independence and others embracing this element of their work.

In the current study the participants were very aware of the possibility of a mini-institution forming and in fact several admitted that mini-institutions existed. Some of this was attributed to the staff being institutionalised and bringing institutionalised practices with them. Some sites maintained a strong link with the old institution with many services such as day services still provided on-campus so residents would travel there daily. Managers used many strategies to ward against the creation of mini-institutions. This included frequent supervision visits and periodically rotating staff to prevent stagnation of care or mixing staff with different attitudes in the hope that good practice would be copied by staff who had a less positive attitude to working in the community.

Participants in this study did find that that the blurring of roles could be problematic for some and clear expectations needed to be set along with support for positive risk taking. While there were frequent references to skill mix and new roles and responsibilities for staff working in the community there was very little mention of staff competencies. Developing staff competencies for community roles may be beneficial in providing a framework that can be used in recruitment and performance management and assist in continuing to move staff along the continuum toward fully accepting transition and supporting residents to live a life of their choosing. The NDA has done some previous work in this area (NDA, 2018a and 2018b).

Linehan et al (2015) found that nurses, in particular, reported that they were worried that their nursing role would become obsolete. Some participants in this study, while not worried that the role would become obsolete, were concerned that RNIDs were losing their role definition and their role was not as respected as it was previously.

Staff mentioned many new skills and roles required for working in the community that were not often expected of them in institutional settings. These included decision making, using initiative, taking on a community connector role, and taking on more

administrative and housekeeping tasks. These are similar to the skills and roles mentioned in other research (McConkey et al., 2013). One area where there seemed to be a skills gap was around supporting the use of technology to promote independence. This study found that the use of technology was rarely used by residents apart from entertainment or communication. Remote support technologies can have potential to increase independence, give an increased sense of security and home safety and could be part of the solution to address the problem of insufficient staff to provide in-home care (Tassé, 2020). There seems to be a missed opportunity to exploit this area fully and there was a sense that some services did not have the capacity to do this. There is work ongoing by the HSE which will likely lead to improvements in this area.

Many participants recalled the deaths of residents with one manager speculating that the transition itself could have precipitated some of the deaths. Other research has found an increased mortality rate following relocation of older persons to nursing homes even accounting for other factors such as health and social status (Aneshensel et al., 2000, Robards et al., 2014). There is scope for research in Ireland to look at any association between relocation and mortality.

4.9   Limitations of the study

This was a relatively small qualitative study and may not reflect the views and experiences of all staff and managers working to transition residents to the community. However, there was a lot of similarity in challenges experienced by each of the six sites in this study so the learnings distilled from this study are likely to have relevance to the wider disability residential sector.

This study relied on a contact person within each site selected to invite staff and managers to participate in the study. This could have caused two biases. Firstly, there may have been conscious or unconscious bias on the part of the contact person in the selection of people invited to participate. Secondly, those invited to participate may have felt that they could not refuse The latter issue was dealt with by emphasising to participants at the interview consent stage that they had the right not to participate if they so wished. While the former issue could not be controlled for, the experience from the interviews was that all staff and managers were very frank in their views and shared both positive and negative experiences.

In many instances, participants, in addition to recounting their own direct experiences, recounted their views about the perceived feelings, attitudes and behaviours of other staff, relatives and residents. While this provided a rich data-set for analysis, there is unavoidably some subjectivity in these accounts. However, by interviewing several people from the sites included, there was a degree of triangulation of data whereby accounts of events or of the prevailing mood of staff or relatives recounted by one staff member were frequently backed up by the accounts from other staff in that site.

Given the number of stakeholders and knowledge-holders involved in the transition process, this study sought to gather information from several different sources. External stakeholders were recruited from a number of organisations including disability umbrella organisations, unions and health policy organisations. While they all offered very valuable insights into the transition process from their different perspectives it was beyond the scope of this study to recruit the requisite number of participants from each category of organisation to approach data saturation. In order to balance what could be gained by interviewing these participants with the limitations of qualitative analysis of the data generated from this group, the researchers chose to deductively analyse the external stakeholder interviews using the themes identified by the analysis of staff and manager interviews. This allowed for some targeted insights that frequently augmented the themes and on occasion to present new issues that were not mentioned by staff and managers but that were considered important.

No interviews were conducted with residents. Their lives are most impacted by staff and their insight into the transition process would be valuable. However, their inclusion would have led to slightly different research questions that did not focus so much on the staff experience of transition and the change management process. We were also aware of another piece of significant research ongoing by the NDA on the quality of life of users of disability services that examined elements of the transition process and quality of life of residents living in the community (NDA, 2021 forthcoming). Therefore, while views of residents regarding staffing could have added to this study it would ultimately have changed the research question. The same is true with regard to this study not having interviewed relatives.

5   Conclusion

While the bulk of this study focused on the challenges associated with the transitions, it is in how people manage to overcome the challenges where the learning emerges. A key finding is that many of the barriers faced by managers at the site level were predictable and could have been avoided particularly if the planning for transitions had been done more strategically at the organisational level. There are almost 2000 people still to transition in Ireland so it will be important that the learnings from this study are applied to make transitions as smooth and successful as possible. There was a feeling among participants that the national level leadership for the Time To Move On policy was waning and would like to see that reignited.

One of the key predictable issues was resistance from staff but once this is expected it can be managed. For some managers it took them some time to realise that all staff were not fully behind transition and they reported mixed results in their abilities to change staff attitudes and build their support for transitions. The approaches they took, documented this study, may be helpful in supporting others to address resistance to

transition. Managers who were successful in changing attitudes took pride in their ability to lead a staff team to see a different and better vision for residents. Staff were very honest and some said that they could really only see how institutionalised they were when they moved to the community. Some also expressed surprise at how they found that they developed professionally and discovered their own potential.

Several managers talked about the pressure on them to manage the change in the service relating to transitions but also to manage all the other requirements such as compliance and safeguarding and they found it challenging to manage the competing priorities. This pressure was compounded as many reported not receiving adequate support from more senior managers in the organisation. Adequate support and protected time for managers to support transitions is essential and it is predictable that managers who are overburdened will not perform as well as they would like to. However, this study found that managers were very resilient.

A significant risk of the transition to the community is that community houses become mini-institutions and in fact several participants admitted that this had already happened. Some of this was attributed to the staff being institutionalised and bringing institutionalised practices with them. The fact that some sites maintained a strong link with the old institution may also be a factor. Managers used many strategies to ward against the creation of mini-institutions that may be of use to managers of future transitions.

Other key learnings from the study were that some staff training prior to transition would have been beneficial and there were many missed opportunities to share learning and experiences both within services and across services. The changes in roles and responsibilities following transition to the communities is probably an area that deserves further research as services move to a more social model and roles continue to evolve.

The NDA plans to work with the HSE's Time to Move on from Congregated Settings Working Group to develop and disseminate a set of short leaflets on specific learnings from this study targeted at managers of disability residential services who are currently engaged in the transition process and those that are soon to transition. These leaflets will also point people in the direction of relevant resources from the HSE and others. They may also be useful for other services such as mental health services if they move to reduce the size of some of the existing 24-hour supervised community residences.

References

Aneshensel CS et al,. (2000) 'The Transition From Home to Nursing Home Mortality Among People With Dementia.' **The Journals of Gerontology**, Series B; 55(3), S152–S162 https://academic.oup.com/psychsocgerontology/article/55/3/S152/607093 (Last accessed May 2021)

Barry S, Dalton R. (2018). Understanding Change in Complex Health Systems – a review of the literature on change management in health and social care 2007-2017, commissioned by Organisation Development and Design Services, Kells, Co Meath, Ireland. Available at: https://www.hse.ie/eng/staff/resources/changeguide/resources/hse-understanding-change-literature-review-2007-2017.pdf (Last accessed May 2021)

Beadle-Brown J, Bigby C, Bould E (2015). 'Observing practice leadership intellectual and developmental disability services.' **Journal of Intellectual Disability Research,** 59, 1081–1093. https://doi.org/10.1111/jir.12208 (Last accessed May 2021)

Braun V, Clarke V (2006) 'Using thematic analysis in psychology.' **Qualitative Research in Psychology,** 3(2). pp.77-101.

Department of Health (2012) Value for Money and Policy Review of the Disability Services in Ireland. Department of Health. https://www.gov.ie/en/publication/ed3564-value-for-money-and-policy-review-of-disability-services-in-ireland/ (Last accessed May 2021)

European Union Agency for Fundamental Rights (2019) From institutions to community living for persons with disabilities: perspectives from the ground. European Union Agency for Fundamental Rights. https://fra.europa.eu/en/publication/2018/institutions-community-living-persons-disabilities-perspectives-ground (Last accessed May 2021)

Greenhalgh T et al., (2004) 'Diffusion of Innovations in Service Organisations: Systematic Review and Recommendations.' **The Milbank Quarterly**, 82 (4): 581-629

Humphreys L, Bigby C, Iacono T (2020) 'Dimensions of group home culture as predictors of quality of life outcomes.' **Journal of Applied Research in Intellectual Disabilities,** 00:1–12. DOI: 10.1111/jar.12748

HSE (2011) Time to Move on from Congregated Settings. A Strategy for Community Inclusion. HSE https://www.hse.ie/eng/services/list/4/disability/congregatedsettings/time-to-move-on-from-congregated-settings-%E2%80%93-a-strategy-for-community-inclusion.pdf (Last accessed May 2021)

HSE (2017a) Review of Policy Implementation 2012-2017. Time to Move on from Congregated Settings: A Strategy for Community Inclusion. HSE. https://www.hse.ie/eng/services/publications/disability/review-of-time-to-move-on-policy-implementation-2012-2017.pdf (Last accessed May 2021)

HSE (2017b) Progress Report On the Implementation of Time to Move On From Congregated Settings: A Strategy for Community Inclusion Annual Report 2016 https://www.hse.ie/eng/services/publications/disability/progress-report-on-the-implementation-of-time-to-move-on-from-congregated-settings-a-strategy-for-community-inclusion-annual-report-2016.pdf (Last accessed May 2021)

HSE (2018) Progress report on the implementation of Time to Move on from Congregated Settings, A Strategy for Community Inclusion. Annual Report 2017. HSE https://www.hse.ie/eng/services/list/4/disability/congregatedsettings/time-to-move-on-annual-progress-report-2017.pdf (Last accessed May 2021)

HSE (2018a) People's Need Defining Change. Health Service Change Guide. HSE https://www.hse.ie/eng/staff/resources/hrppg/change-guide-organisation-policy-people-s-needs-defining-change-health-services-change-guide.pdf (Last accessed May 2021)

HSE (2018b) A Quality Framework: Supporting persons with disabilities to achieve personal outcomes. Working Group Four Report. Unpublished.

HSE (2019) Making a home. A practical guide to creating a home and moving to the community. HSE. https://www.hse.ie/eng/services/list/4/disability/congregatedsettings/making-a-home-a-practical-guide-to-creating-a-home-and-moving-to-the-community-july-2019.pdf (Last accessed May 2021)

HSE (2020) Time to Move On From Congregated Settings: A Strategy for Community Inclusion Annual Progress Report 2019. HSE https://www.hse.ie/eng/services/list/4/disability/congregatedsettings/time-to-move-on-annual-progress-report-2019.pdf (Last accessed May 2021)

Jingree T, Finlay WML, Antaki C (2006) 'Empowering words, disempowering actions: an analysis of interactions between staff members and people with learning disabilities in residents' meetings.' **Journal of Intellectual Disability Research**, 50(3) 212-226

Linehan C et al., (2015) Moving Ahead. Factors contributing to the successful transition of people with intellectual disabilities from congregated to community-based residential options in two regions in Ireland. Dublin: School of Social Work and Social Policy, Trinity College Dublin.

Mansell J (2006) 'Deinstitutionalisation and community living: progress, problems and priorities.' **Journal of Intellectual and Developmental Disability**, 31(2), 65-76

McCarron M et al., (2019) 'Effect of deinstitutionalisation on quality of life for adults with intellectual disabilities: a systematic review.' **BMJ Open,** 2019;9:e025735. doi:10.1136/bmjopen-2018-025735

McConkey R et al., (2013) An Evaluation of Personalised Supports to Individuals with Disabilities and Mental Health Difficulties, University of Ulster and Genio. https://www.genio.ie/multimedia/publications/research-reports/full-report-an-evaluation-of-personalised-supports-to (Last accessed May 2021)

National Disability Authority (2016) Outcomes for Disability Services. NDA. http://nda.ie/Publications/Disability-Supports/NDA-paper-on-outcomes-for-disability-services.html (Last accessed May 2021)

National Disability Authority (2018a) Staff competency and skill mix for a community-based model of disability services. NDA http://nda.ie/Publications/Others/Research-Publications/Staff-Competencies-and-Skills-Mix-for-a-Community-Based-Model-of-Disability-Services.html (Last accessed May 2021)

National Disability Authority (2018b) Review of competency frameworks for disability services staff. NDA. http://nda.ie/Publications/Others/Research-Publications/Staff-Competencies-and-Skills-Mix-for-a-Community-Based-Model-of-Disability-Services.html (Last accessed May 2021)

National Disability Authority (2021) Moving In, Moving On. An evaluation of the outcomes and costs of new or emerging models of service in the disability sector (Draft unpublished). National Disability Authority.

Proctor T, Doukakis I (2003) Change management: the role of internal communication and employee development. **Corporate Communications: An International Journal,** 8(4) 268-277

Robards J, Evandrou M, Falkingham J, Vlachantoni A (2014) 'Mortality at older ages and moves in residential and sheltered housing: evidence from the UK.' **J Epidemiol Community Health,** 68:524–529. doi:10.1136/jech-2013-203097

Salmon R, Holmes N, Dodd K (2013) 'Reflections on change: supporting people with learning disabilities in residential services.' **British Journal of Learning Disabilities,** 42, 141-152

Salmon N et al., (2019) 'Our Homes: An inclusive study about what moving house is like for people with intellectual disabilities in Ireland.' **British Journal of Learning Disabilities,** 47 (1) 19-28.

Šiška J, Beadle-Brown J (2020). Transition from Institutional Care to Community-Based Services in 27 EU Member States: Final report. Research report for the European Expert Group on Transition from Institutional to Community-based Care

Skills for Care (2014) Workforce redesign: people, planning, performance. Practical guidance for involving people in using the 'Principles of workforce redesign' to plan and deliver care and support workplace change that helps implement the Care Act 2014. Skills for Care

Appendices

Appendix 1 – Participant Information Leaflets and Consent Form

Appendix 1.1: Participant Information Leaflet – Staff and Managers

Study Title: Staff and change management: good practice in the transition from old to new models of residential disability service delivery

Name of Investigator: Dr. Rosalyn Tamming, National Disability Authority[17],

1. **Introduction:** You are being invited to take part in a research study, which was initiated by the National Disability Authority and is being funded by and conducted by experienced researchers from the National Disability Authority. Before you decide whether or not you wish to take part you should read the information provided below carefully. You should clearly understand the risks and benefits of taking part in this study so that you can make a decision that is right for you. This process is known as 'informed consent'

2. **Why this study is being done**? Irish government policy supports and promotes moving people with disabilities who are living in institutions or congregated settings to live in the community where they have more choice and control over their lives. This transition process is ongoing but progress is slow in some areas. When people with disabilities move they have to adjust firstly to the idea of moving and then to a new place and a new way of living. Similarly, staff who have moved from working in a congregated setting to a community setting have to adjust to the idea of moving and then to working in a new place and in a new way. This study sets out to document the change management practices relating to managing and supporting staff through this transition process in order to identify good practice to share with disability services still undergoing the transition.

---

[17] The National Disability Authority is the independent state body providing expert advice on disability policy and practice to the government and the public sector. 25 Clyde Road, Dublin 4.

3. **How will the study be carried out?**

   We are inviting staff and managers working in a number of disability services, and a number of external stakeholders who have experience of some element of the transition process, to participate. For staff and managers we are selecting people who have worked for at least two years in the service and who have experience of working in both the old (congregated) and new (community) service model, or of managing the transition process. We wrote to your organisation asking them to invite staff who meet these criteria to participate. In total we plan to interview between 35 and 40 people.

4. **What will happen if I agree to take part**? If you decide to take part in the study you will be invited to participate in a one-on-one interview with a member of the research team. The research team have experience in conducting interviews and in analysing qualitative research. You will be asked to talk about your experience of the transition process particularly in relation to staff issues. For example, you may be asked what was good and bad about the transition, whether you would do anything differently and how you think things are going now in the new model of service. The interview will take place in your place of work (if appropriate) or another location that is convenient for you. The interview is expected to take one hour. The interview will be recorded on a digital voice recorder and later what you said will be written down and analysed along with all the other interviews.

5. **What are the risks and discomforts**? In recalling your experiences of the transition process you may feel upset if the process was a difficult one for you.

6. **What are the potential benefits**? There will be no direct benefit to you in taking part in the research. However, your participation will contribute to the development of good practice that can be shared with, and used by, other disability service providers. This should in turn contribute to a more streamlined and efficient transition process in disability services.

7. **Is the study confidential?** Your information will be kept confidential. Your name will not be associated with the transcript of your interview and, if a quote from you is used in the final report, it will not be ascribed to you. Pseudo-names will be used instead. Any other information that you provide that could identify the name, location, another staff member, or a service user of the organisation that you work for will also be kept confidential. Only the primary investigator and the small research team will have access to the data. Data from the digital voice recorder will be transferred as soon as possible to a computer with restricted file access. The voice file will then be deleted from the digital voice recorder. The voice file will be transcribed as soon as possible and then deleted within three months of recording.

   Your signed consent form and interview transcript will be stored for 10 years as per the NDA's research data retention policy. After this time they will be securely

destroyed. The hard copy consent forms will be stored in a locked cupboard and only the research team will be able to link them to the transcripts. The interview transcripts will be stored electronically in a restricted folder on a password-protected computer.

You may request a copy of the final report of the research. If you do, we will retain your contact information in order to furnish you with a copy when the research is completed.

As with all research, if one of the research team are told anything that gives us a strong belief that there is, or has been, a serious risk of harm or danger to either you or another individual we are obliged to report it to the relevant authorities.

8. **Data protection:** We will be using the information you give us to find out what are the factors that helped or hindered a smooth transition for staff between institutional and residential disability services. This data is being processed under the following legal basis - legitimate interests and scientific research purposes. [18] Only the primary investigator and the small research team based at the National Disability Authority will have access to the data. Your signed consent form and interview transcript will be stored electronically for 10 years as per the NDA's research data retention policy. You have the following rights:

   - to withdraw your consent at any time

   - to lodge a complaint with the Data Protection Commissioner

   - to request access to your data and a copy of it

   - to restrict or object to processing of your data

   - to have any inaccurate information about you corrected or deleted

   - to have your personal data deleted

   - to move your data from one controller to another in a readable format

   Such rights may be limited if a request would make it impossible or make it very difficult to conduct the research. There will be no automated decision making used.

9. **Voluntary participation and the right to discontinue participation without penalty:** Your participation is completely voluntary and you have the right to refuse participation, to refuse to answer any question and to withdraw at any time without any consequence whatsoever and without having to provide any reason.

10. **Termination of participation by the investigator:** It is not anticipated that your involvement will be terminated by the research team unless you request this or unless you become distressed during the interview making it difficult to continue.

---

[18] Article 6 and 9 of the General Data Protection Regulation 2016

11. **Permissions:** We have written to your organisation requesting permission to conduct this study and have been granted that permission. The study has also obtained ethical approval from Trinity College Dublin (the joint Health Policy and Management and the Centre for Global Health Research Ethics Committee).

12. **Access to transcripts:** A copy of the transcript of your interview will be made available to you should you so wish. You are entitled to review and edit the information you have provided at any time.

13. **Contacts for additional information:** If you have any questions about the research please contact the primary investigator: Dr. Rosalyn Tamming, Senior Research Officer, National Disability Authority, 25 Clyde Road, Dublin 4
Telephone: 01 6080409, E-mail: RETamming@nda.ie

If you have any concerns or complaints about the research or research process please contact the primary investigator's manager: Dr. Aideen Hartney, Head of Research, Policy and Public Affairs, National Disability Authority, 25 Clyde Road, Dublin 4
Telephone: 01 6080800. E-mail: AMHartney@nda.ie

The National Disability Authority are the data controller for this research. The Data protection officer for the National Disability Authority is Ms. Elaine Monaghan (01 608 0421)

<div align="center">

THANK YOU

</div>

Appendix 1.2:   Participant Information Leaflet – External Stakeholders
Study Title: Staff and change management: good practice in the transition from old to new models of residential disability service delivery

Name of Investigator: Dr. Rosalyn Tamming, National Disability Authority[19],

1. **Introduction:** You are being invited to take part in a research study, which was initiated by the National Disability Authority and is being funded by and conducted by experienced researchers from the National Disability Authority. Before you decide whether or not you wish to take part you should read the information provided below carefully. You should clearly understand the risks and benefits of taking part in this study so that you can make a decision that is right for you. This process is known as 'informed consent'.

2. **Why this study is being done**? Irish government policy supports and promotes moving people with disabilities who are living in institutions or congregated settings to live in the community where they have more choice and control over their lives. This transition process is ongoing but progress is slow in some areas. When people with disabilities move they have to adjust firstly to the idea of moving and then to a new place and a new way of living. Similarly, staff who have moved from working in an institutional setting to a community setting have to adjust to the idea of moving and then to working in a new place and in a new way. This study sets out to document the change management practices relating to managing and supporting staff through this transition process in order to identify good practice to share with disability services still undergoing the transition.

3. **How will the study be carried out?** We are inviting staff and managers working in a number of disability services, and a number of external stakeholders who have experience of some element of the transition process, to participate. In total we plan to interview between 35 and 40 people.

---

[19] The National Disability Authority is the independent state body providing expert advice on disability policy and practice to the government and the public sector. 25 Clyde Road, Dublin 4.

4. **What will happen if I agree to take part**? If you decide to take part in the study you will be invited to participate in a one-on-one interview with a member of the research team. The research team are experienced in interviewing and in analysis of qualitative data. You will be asked to talk about your experience of change management generally and of issues relating to the transition process in disability services, particularly in relation to staff issues. The interview will take place in your place of work (if appropriate) or another location that is convenient for you. The interview is expected to take one hour. The interview will be recorded on a digital voice recorder and later what you said will be written down and analysed along with all the other interviews.

5. **What are the risks and discomforts**? No risks or discomforts are anticipated.

6. **What are the potential benefits**? There will be no direct benefit to you in taking part in the research. However, your participation will contribute to the development of good practice that can be shared with, and used by, other disability service providers. This should in turn contribute to a more streamlined and efficient transition process in disability services.

7. **Is the study confidential?** Your information will be kept confidential. Your name will not be associated with the transcript of your interview and, if a quote from you is used in the final report, it will not be ascribed to you. Pseudo-names will be used instead. Any other information that you provide that could identify the name, location, another staff member, or a service user of the organisation that you work for will also be kept confidential. Only the primary investigator and the small research team will have access to the data. Data from the digital voice recorder will be transferred as soon as possible to a computer with restricted file access. The voice file will then be deleted from the digital voice recorder. The voice file will be transcribed as soon as possible and then deleted within three months of recording.

8. Your signed consent form and interview transcript will be stored for 10 years as per the NDA's research data retention policy. After this time they will be securely destroyed. The hard copy consent forms will be stored in a locked cupboard and only the research team will be able to link them to the transcripts. The interview transcripts will be stored electronically in a restricted folder on a password-protected computer.

9. You may request a copy of the final report of the research. If you do, we will retain your contact information in order to furnish you with a copy when the research is completed.

10. As with all research, if one of the research team are told anything that gives us a strong belief that there is, or has been, a serious risk of harm or danger to either you or another individual we are obliged to report it to the relevant authorities.

11. **Data protection:** We will be using the information you give us to find out what are the factors that helped or hindered a smooth transition for staff between

institutional and residential disability services. This data is being processed under the following legal basis - legitimate interests and scientific research purposes.[20] Only the primary investigator and the small research team based at the National Disability Authority will have access to the data. Your signed consent form and interview transcript will be stored electronically for 10 years as per the NDA's research data retention policy. You have the following rights:

- to withdraw your consent at any time

- to lodge a complaint with the Data Protection Commissioner

- to request access to your data and a copy of it

- to restrict or object to processing of your data

- to have any inaccurate information about you corrected or deleted

- to have your personal data deleted

- to move your data from one controller to another in a readable format

    Such rights may be limited if a request would make it impossible or make it very difficult to conduct the research. There will be no automated decision making used.

12. **Voluntary participation and the right to discontinue participation without penalty:** Your participation is completely voluntary and you have the right to refuse participation, to refuse to answer any question and to withdraw at any time without any consequence whatsoever and without having to provide any reason.

13. **Termination of participation by the investigator:** It is not anticipated that your involvement will be terminated by the research team unless you request this or unless you become distressed during the interview making it difficult to continue.

14. **Permissions:** We have written to your organisation requesting permission to conduct this study and have been granted that permission. The study has also obtained ethical approval from Trinity College Dublin (the joint Health Policy and Management and the Centre for Global Health Research Ethics Committee).

15. **Access to transcripts:** A copy of the transcript of your interview will be made available to you should you so wish. You are entitled to review and edit the information you have provided at any time.

16. **Contacts for additional information:** If you have any questions about the research please contact the primary investigator:

    Dr. Rosalyn Tamming, Senior Research Officer, National Disability Authority, 25 Clyde Road, Dublin 4

---

[20] Article 6 and 9 of the General Data Protection Regulation 2016

Telephone: 01 6080409,   E-mail: RETamming@nda.ie

If you have any concerns or complaints about the research or research process please contact the primary investigator's manager:

Dr. Aideen Hartney, Head of Research, Policy and Public Affairs, National Disability Authority, 25 Clyde Road, Dublin 4

Telephone: 01 6080800.   E-mail: AMHartney@nda.ie

The National Disability Authority are the data controller for this research. The Data protection officer for the National Disability Authority is Ms. Elaine Monaghan (01 608 0421)

THANK YOU

Údarás Náisiúnta Míchumais
National Disability Authority

Appendix 1.3 Consent Form
RESEARCH TITLE: Staff and change management: good practice in the transition from old to new models of residential disability service delivery**.**

I have read and understood the **Information Leaflet** about this research project. The information has been fully explained to me and I have been able to ask questions, all of which have been answered to my satisfaction.	**Yes** ☐	**No** ☐
I understand that I don't have to take part in this study and that I can opt out at any time. I understand that I don't have to give a reason for opting out.	**Yes** ☐	**No** ☐
I have been assured that information about me will be kept private and confidential.	**Yes** ☐	**No** ☐
I have been given a copy of the Information Leaflet and this completed consent form for my records.	**Yes** ☐	**No** ☐
I fully understand the processes involved in being audio-taped	**Yes** ☐	**No** ☐
I consent to be audio-taped for the purpose of this study only	**Yes** ☐	**No** ☐
I understand the audio will be securely destroyed following data analysis and data verification	**Yes** ☐	**No** ☐
I consent to take part in this research study having been fully informed of the risks and benefits	**Yes** ☐	**No** ☐
I give informed consent to have my data processed as part of this research study.	**Yes** ☐	**No** ☐
I would like to be informed of the outcome of this research and consent to my contact information being retained for this purpose	**Yes** ☐	**No** ☐

PARTICIPANT'S NAME: …………………………………………………………..

CONTACT DETAILS: ………………………………..…………………………..

PARTICIPANT'S SIGNATURE: ……………...…………………………………..

Date:…………………………

Statement of investigator's responsibility: I have explained the nature and purpose of this research study, the procedures to be undertaken and any risks or benefits that may be involved. I have offered to answer any questions and fully answered such questions. I believe that the participant understands my explanation and has freely given informed consent.

INVESTIGATOR'S NAME:………………………………………..
QUALIFICATIONS:…………………..

INVESTIGATOR'S SIGNATURE:………………………………………..
Date:…………………..

Appendix 2: Semi-structured interview guides

Introduction

Thank you for coming here today and giving me your views and experiences in relation to staff transitions from institutions to the community. To mitigate any potential GDPR issues, I would remind you before the interview that you are bound by confidentiality agreements within you own employee contracts and that participating in the research does not absolve you from that responsibility. You are reminded not to give any personal information during the interview so please do not mention any names or personally identifying information, Thank you.

Appendix 2.1: Semi-structured interview guide for Service Providers (Managers)

Thank you for coming here today and giving me your views and experiences in relation to staff transitions from institutions to the community. To mitigate any potential GDPR issues, I would remind you before the interview that you are bound by confidentiality agreements within you own employee contracts and that participating in the research does not absolve you from that responsibility. You are reminded not to give any personal information during the interview so please do not mention any names or personally identifying information,

1) Can you tell me a little about your role, how long you have worked here.
2) Can you tell me about your service and the process of decongregation?
   a. Size of service and services offered?
   b. How many service users living in a congregated setting?
   c. How many service users living in a community setting?
   d. Pace of change?
3) What have been the greatest challenges in transitioning service users and staff to living and working in the community?
4) What was your main challenge in relation to staffing in the transition process and how did you handle it? What was the outcome?
5) What steps did you take in preparing for the transition?
6) What supports, if any, did you/your service receive to implement the change process?
   a. Genio funding/training
   b. HSE training / guidance/ funding
   c. Information sharing with colleagues internally and externally
   d. Visit to other sites / service providers
   e. Reading change management or associated literature
   f. Support from HR department
   g. Support from board / leadership of organisation

7) Did you have to deal directly with unions and what were the main challenges? How did you overcome these?

8) Did you reduce your staffing levels/change your skill-mix/develop new rosters with the move to the community?
   a. Specifically did you reduce the number of nurses
   b. Did you bring in new staff?
   c. Do you have night cover (sleeping/waking) or runners/floaters?
   d. If residents are generally out during the day are there staff still available (what if someone sick? Doesn't want to go? Retired?)
   e. Do you use technology in place of / to compliment staff
   f. Did many staff leave, were made redundant, retired, given a severance package, higher natural attrition?
   g. How did you develop new rosters. How were they accepted by staff? Was lone working an issue?

9) Were relatives supportive of the move to the community?

10) For the staff that have already moved how do you retain them and keep them motivated, What ongoing training do you do

11) What steps are in place to prevent the creation of mini-institutions in the community houses? Do you think this is a risk? If yes how can it be avoided?

12) What do you think the impact of the move has been on service users?

13) What piece of advice in relation to staffing would you give to a manager in a service just beginning the transition process?

14) Is there anything you have done differently if you were doing it all again?

Appendix 2.2: Semi-structured interview guide for Service Providers (Frontline staff)

Thank you for coming here today and giving me your views and experiences in relation to staff transitions from institutions to the community. To mitigate any potential GDPR issues, I would remind you before the interview that you are bound by confidentiality agreements within you own employee contracts and that participating in the research does not absolve you from that responsibility. You are reminded not to give any personal information during the interview so please do not mention any names or personally identifying information,

1) Can you tell me a little about your role, how long you have worked here.
2) Can you tell me about your service and the process of decongregation?
    a. Size of service and services offered?
    b. How many service users living in a congregated setting?
    c. How many service users living in a community setting?
    d. Pace of change?
3) What did you think when you first heard that everyone was going to be moved out to live in the community?
    a. Did you know it was HSE policy or did you think it was just your service?
    b. Did you think the moved to the community would be beneficial for service users?
    c. Would you say initially you were resistant to the change or did you welcome it?
    d. In general would you say staff were happy with the move to the community?
4) What have been the greatest staff challenges in transitioning to community working?
    a. Change in rosters,
    b. Working with less staff so less camaraderie, more lone working
5) How do you think in general that the transition was managed? Why?
    a. How was communication? Regular meetings, group / one-on-one, ability to ask questions?
    b. How was negotiation? Were unions involved? What were the main issues?
    c. Was training provided? What? For who? Enough?
    d. Were there opportunities to visit services that had already transitioned or talk to staff that had already transitioned? If no would this have been useful? If yes, was this helpful?
6) Did the staffing levels change, was there a change in the skill-mix
    a. Specifically were the number of nurses reduced?
    b. Were new staff employed with community experience?
    c. Do you have night cover (sleeping/waking) or a runner/floater?

       d. If residents are generally out during the day are there staff still available (what if someone sick? Doesn't want to go? Retired?)

       e. Is technology used in place of / to compliment staff

       f. Did many staff leave, made redundant, retired, given a severance package, higher natural attrition?

7) Were relatives supportive of the move to the community?

8) What do you think the impact of the move has been on service users you support?

9) What steps are in place to prevent the creation of mini-institutions in the community houses? Do you think this is a risk? If yes how can it be avoided?

10) What piece of advice in relation to staffing would you give to a manager in a service just beginning the transition process?

Appendix 2.3: Semi-structured interview guide for other stakeholder

Thank you for coming here today and giving me your views and experiences in relation to staff transitions from institutions to the community. To mitigate any potential GDPR issues, I would remind you before the interview that you are bound by confidentiality agreements within you own employee contracts and that participating in the research does not absolve you from that responsibility. You are reminded not to give any personal information during the interview so please do not mention any names or personally identifying information,

1) What is your impression of the process of decongregation to date?
2) What have been the greatest challenges in the transition process particularly in relation to staffing?
    a. Do you think there were sufficient supports provided to staff and managers?
    b. Do you think there is sufficient sharing of information between services about decongregation?

Specific questions for union officials

- What sort of approach did management take to dealing with unions?
- How easy was it to resolve the issues that arose
- Would you describe the process as collaborative or combative?
- Were staff largely satisfied at the end?
- What do you think the impact of the moves has been on service users?
- What piece of advice in relation to staffing would you give to a manager in a service just beginning the transition process?

Specific questions for healthcare commissioners

- Have there been significant changes to skill-mix?
- Have there been significant changes to rosters?
- How do you think that services can prevent the creation of mini-institutions?
- Were you aware of any difficulties involving relatives of service users in relation to the move? How were these handled?
- What do you think the impact of the moves have been on service users?
- What piece of advice in relation to staffing would you give to a manager in a service just beginning the transition process?

Specific questions for Disability Umbrella Groups

- How do you think the process of decongregation is going?
- What issues (if any) were brought to your attention regarding staff by disability service providers with regard to transitioning?

- What changes do you think need to be made to make the transition function more efficiently?
- Were you aware of any difficulties involving relatives of service users in relation to the move? How were these handled?
- What do you think the impact of the moves have been on service users?
- What piece of advice in relation to staffing would you give to a manager in a service just beginning the transition process?

Specific Questions for Healthcare Regulators

- What is your impression of the process of decongregation to date?
- What have been the greatest challenges in the transition process particularly in relation to staffing?
    - Do you think there were sufficient supports provided to staff and managers?
    - Do you think there is sufficient sharing of information between services about decongregation?
- Have there been significant changes to skill-mix? Have these been appropriate?
- Have there been significant changes to rosters? Have these been appropriate?
- How do you think that services can prevent the creation of mini-institutions?
- How well do you think staff are balancing positive risk taking with compliance and health and safety issues since decongregation?
- How do you handle situations where a service is trying to both register and decongregate at the same time?
- Are there risks that when a timeline around a closure order is instituted the pressure to close means that there is inadequate time to ensure an appropriate home in the community for the service users i.e. compromises may be made?
- Were you aware of any difficulties involving relatives of service users in relation to the move? How were these handled?
- How much of a role do you think you have had in driving decongregation?
- What do you think the impact of the moves have been on service users?
- What piece of advice in relation to staffing would you give to a manager in a service just beginning the transition process?