Growing older in secure mental health care: the user experience.

Background: The proportion of older adults using secure forensic psychiatric services is rising. Research is needed to examine the experience of older service users and evidence how adult services can adapt to meet their needs.

Aim: To explore user experiences of being an older adult in secure forensic services and user perceptions of how their age-related needs were being met.

Method: Thematic analysis of interviews and observations of weekly routines conducted with fifteen service users aged 50 and over residing in a low and medium secure NHS unit in England.

Results: User experiences of ageing and age-related needs are reported using five themes: age related identities; ward environments; participation in activities; management of physical health; and ageing futures. Older adults living with people their own age reported more social integration than those on wards dominated by younger adults. Many participated in the activity program. Most wished to self-manage their physical health needs with the support of primary care staff. Older adults were reluctant to identify as 'old' or 'vulnerable'. Some older adults downplayed their changing care needs.

Conclusions: Placement of older people in adult secure services requires awareness of the age balance of the ward. A culture of inclusivity, sensitivity and respect for older persons' agency is key to collaboratively meeting additional care needs and discharge planning.

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Keywords: older adults; ageing; forensic; mental health; service users; qualitative

Introduction

In England and Wales people aged 50 and over are the fastest growing group in prisons, currently encompassing 15.6 percent of the total prison population (Public Health England, 2017). While there has been an awareness of poor health outcomes of older offenders for decades (Fazel, Hope, O'Donnell, & Jacoby, 2004; Taylor & Parrott, 1988), the unmet health and social care needs of ageing offenders have only recently become a policy concern in the UK and internationally (Mann, 2012; Public Health England, 2017). The UK Care Act (2014) highlights the needs of older offenders in prisons, and emphasizes that older people in the UK are entitled to good local care, irrespective of their location.

Older people are increasingly represented in secure psychiatric in-patient services, which provide for the care and treatment of mentally ill offenders (Hare Duke, Furtado, Guo, & Völlm, 2018; J. M. Parrott, Houben, Visser, & Macinnes, 2019[in press]; Graeme Yorston & Taylor, 2006). Yet their needs have been comparatively marginalised in research and policy on older offenders (Yorston, 2013) Forensic mental health services are designed to provide assessment and treatment for people with mental disorders who are charged with a criminal offence, at a range of security levels: includes as well as transfers from prison (Bartlett, 2016) The Royal College of Psychiatrists (2011) states that providing good mental health care for older people is important in all in-patient settings, and requires meeting complex and challenging needs, such as access to good physical healthcare and geriatric care to avoid long term admissions.

Placement of older mentally disordered offenders has been described as particularly difficult (Coid, Fazel, & Kahtan, 2002) with concern that care is provided in an ad hoc manner (Natarajan & Mulvana, 2017), leading to calls for the development of more specialised older adult services (Natarajan & Mulvana, 2017; Nnatu, Mahomed, & Shah, 2005; Shah, 2008; G Yorston, 1999). At present, a small number of specialist

older adult forensic services are provided by the private sector (non-NHS). While important, these provide for a minority of service users and are likely to involve placement out of their local area. NHS England's aim is to deliver secure care as close to home as possible (Mental Health Taskforce, 2016). This research examines how the current care of older adults in regional secure units, which were designed to provide local care may be assessed and improved.

A number of retrospective studies have been conducted to explore the demographic, psychiatric and criminological characteristics of older forensic in-patients which show that serious offences, such as homicide, psychotic illnesses, and comorbidities, such as mobility and sensory impairment, are common(Coid et al., 2002; Curtice, Parker, Wismayer, & Tomison, 2003; Das, Murray, Driscoll, & Nimmagadda, 2011; Farragher & O'Connor, 1995; Lightbody, Gow, & Gibb, 2010; McLeod, Yorston, & Gibb, 2008). Older forensic in-patients can be categorised as: those who have committed an offence for the first time in older age, those who have committed an offence in younger life and have aged while in secure services and those who have been in an out of services (Natarajan & Mulvana, 2017; Yorston, 2013). A range of age thresholds (ranging from 50-65 years) have been employed in researching 'older' service users (De Smet, Vandevelde, Verté, & Broekaert, 2010). These studies point to the diversity of older forensic in-patients (Fazel et al., 2004; O'Sullivan & Chesterman, 2007).

Relatively little is known about the experience of older forensic in-patients themselves, what they consider their needs, and whether these needs are being met. Qualitative methods that capture the views of forensic service users, are pivotal to improving current services (Bartlett, 2016; Dixon, 2018; O'Sullivan & Chesterman, 2007; F. R. Parrott, 2005, 2010; F. R. Parrott, Macinnes, & Parrott, 2015). However,

there are few in-depth qualitative studies available on the experience of older forensic in-patients in the UK (Graeme Yorston & Taylor, 2009). Exploratory qualitative studies with small numbers of patients in forensic hospitals in Italy (Di Lorito et al., 2017) and Belgium (De Smet et al., 2015) suggested that older forensic in-patients were predominantly positive about the care provided. In a recent UK-based study, Di Lorito et al. (2018) argued there were unique challenges to recovery for older service users including lack of awareness of older age issues among staff.

More research is needed to evidence how existing forensic services can adapt to older offenders'(Girardi, Snyman, Natarajan, & Griffiths, 2018; Graeme Yorston & Taylor, 2009). We therefore carried out a qualitative study with older adults at an NHS forensic secure unit, providing low and medium secure care to men and women, aged 18 years and above. In line with Public Health England, this study defined forensic service users aged 50 and above as older adults (Public Health England, 2017). People with severe mental health problems have a lower life expectancy compared with the general population (20 years lower for men, and 15 years for women) (Department of Health, 2017). The aim of the study was to explore older adult service user's experiences of ageing and its impact on their everyday life, and specifically, to examine service users' perceptions of any age-related needs. We wanted to learn from service users themselves and encouraged reflection in their own words. We conducted in-depth interviews and observations of daily and weekly routines, asking open-ended questions designed to elicit older adult service user views of their social, physical and mental health needs and whether they perceived these needs to be met by the adult forensic service.

Ethical Approval

This Quality Improvement Project was assessed by the Research and Development department at Oxleas NHS Foundation Trust Health and approval obtained from the Health Research Authority (Project number 844).

Materials and Methods

A qualitative service evaluation was conducted in a medium and low secure unit in an NHS trust in the south of England. At present, no age specific forensic services are offered within the units. In-patients at the unit are detained on treatment orders of the Mental Health Act (1983 as amended 2007), with the majority having committed a serious criminal offence. At the time of admission all were considered to require treatment in a secure setting on the grounds of risk to others. The unit consists of single-sex wards offering medium and low secure care to both men and women.

A records review ascertained the age distribution of in-patients.

The inclusion criterion was being aged 50 or over. 25% of in-patients (40 of a total of 163) detained at the Trust between April 2017 and April 2018 were aged 50 years and over. Ages ranged from 21 years to 73 years of age. At the time of recruitment (February-April 2018), 30 older adult service users were in residence (20 low secure; 10 medium secure), however two service users were excluded by their consultant psychiatrist as they were deemed too unwell to approach.

Two service users were involved in the initiation of the project as 'experts by experience' and invited to comment on the project proposal and a draft interview guide. Comments confirmed that the project proposal was both relevant and sensitively pitched. Input from service users and staff led to a new formulation of the project poster. The posters advertising the project asked 'what is old age?' and focused on flexibility and change in the definition of older age. The posters were displayed around

the unit. Additionally, researcher RV attended both unit wide and ward community meetings to introduce the project and to invite service users to participate.

15 service-users gave written, informed consent to participate in semi-structured interviews on older adult experience, using a guide (see Appendix 1). Interviews lasted between 10 minutes to 1 hour. All interviews were conducted by researcher RV. The location of the interviews varied per ward, but typically took place in a quiet room on the ward. Most interviews were one-on-one, however in two cases a member of staff was present at the request of clinical staff.

Participants were asked to pick an activity that would be typical of their week to which the researcher (RV) could accompany them. All participants gave written, informed consent to RV accompanying them on activities. These ranged from Occupational Therapy activities, visiting the café or watching television on the ward. Hospital wide activities, such as a talent show, food festival and the User Forum, were attended to provide a broader sense of the experience of service users in secure settings.

Interviews were recorded and transcribed verbatim by transcription services at Canterbury Christ Church University. Notes were made after the accompanied activities. Interview transcripts and observational notes were thematically coded by two researchers (FH and RV) using the framework approach (Pope, Ziebland, & Mays, 2000; Ritchie & Spencer, 1994). The framework approach is a form of thematic analysis specifically designed for policy and applied qualitative health research (Pope et al., 2000). The service user experts from the unit were not involved in this phase of the analysis to preserve confidentiality. The 5 stages of framework analysis: familiarization with the data (reading transcripts; observation notes etc.), identifying a thematic framework, charting and mapping and interpretation were followed (See Ritchie & Spencer, 1994, pp. 178–186).

Extensive discussions between researchers RV and FH took place to determine the main themes. Researcher RV had extensive observational fieldnotes which helped contextualise and deepen understanding of the interview data. For example, the theme 'age-related identities' was identified in the interview data, and analysis of transcripts showed the different ways in which participants spoke about identifying and not identifying as an older person. These statements were contextualised by observational data on inter-personal interactions among service users, and between service users and staff, such as observing an older person being treated as frail or slow.

In the second stage of analysis, themes that were dominant but did not appear to be older age specific were excluded. For example, food was a topic that was mentioned by many participants. However, while access to food was an important element of the lives of service users, it was agreed that this was reflective of the experience of most service users, not just the older age group. Consensus was finally achieved regarding a priori and emerging age-related themes in the data, which characterised the experiences of older adults in secure forensic services and user perceptions of age-related needs.

User experiences are reported using five key themes: age-related identities, ward environments; participation in activities; management of physical health; and ageing futures. Quotes selected as illustrative of these themes are presented with pseudonyms and an age in decades to preserve anonymity.

Results

Demographics

15 service users (4 women and 11 men) aged 50-71 took part in the research. Eight participants resided in low secure and seven in medium secure accommodation. One participant moved from a medium to low secure ward during the study. Towards the end of the study one participant was discharged to older adult services within the Trust. Follow-up interviews examined how their perceptions and experiences changed. The response rate was 54%. The results address each of the following themes in turn: age-related identities, ward environments and age balance, participation in activities and management of physical health.

Service users who were 50 years and over resided on every ward. No ward specialised as an 'older adult' ward, and admittance to any one ward was based on the availability of beds, and acuteness of admission. However, the proportion of women aged 50 and over was highest on the women's low secure, rehabilitation ward (69% were aged 50 and above) and highest for men on the long-term, medium secure ward (35% were aged 50 and above).

Age-related identities

Within British society there are negative attitudes towards ageing and growing older (Ayalon & Tesch-Römer, 2018). These negative attitudes were also present amongst participants. In general, observations revealed there was a reluctance to identify as 'old' or 'older'. In interviews participants emphasized their youngness:

> "I am a youngster still" (Nicholas, 50s)
>
> "I am middle aged" (Antonio, 50s)
>
> "When I look in the mirror first thing in the morning I look about 50 years of age and battered. Give it a few hours for the face to fall into place. When the face falls into place I feel very young" (Anthony, 50s).

One of the few ways in which 'being older' was considered positive among participants was in relation to managing their mental illness. Participants reported feeling "mature" (Anthony, 50s) and "experienced as an older person" (Nigel, 50s). Participants took pride in knowing their "triggers" and felt empowered by this. Specifically in relation to aggression, many male participants expressed that they were "feeling calmer" and would remove themselves from challenging situations by going to their rooms. While physical 'oldness' was considered weak, maturity and ownership of their mental health was considered important.

The experience of ageing and feeling old was strongly mediated through participants' personal experiences of mental illness and detainment, which many felt had 'aged' them.

> "I don't feel old in my mind. But I am in my body sometimes. I think it's not just about my age or anything I think it's for decades and decades of taking this medication because it's strong stuff." (John, 50s).

Patricia (50s), who was staying in self-contained flats on a low secure ward, commented she "felt like an old woman" walking up the stairs to her flat. She further explained:

> "I have come in older and I've aged since I've been here. I have arthritis so my knees play up and my lower back plays up… Being in hospital at any time is uncomfortable but when you're older you feel it more".

Patricia strongly identified with being an older person despite being in her fifties. Keith (70s), was chronologically the oldest participant, but he did not consider himself to be 'old' as he had no need for 'Zimmer's [walking frame] and wheelchairs'.

Ward Environments and age balance

Service user experiences of the social environment on their ward showed that the age balance on wards played a role in the formation of friendships and experiences of social isolation. Jane (50s) remarked:

> "The young ones [service users] stick together and then you've got a few in the middle that are in their mid-thirties and then you've got the rest of us who are in their 50s. It does not always, I don't think it always works because the topic of conversation are very, very different and varied."

Anthony (50s) noted:

> "I was talking to a mature member of staff the other day and I said to her I didn't understand these kids' [younger service users] sense of humour."

While some older participants had established a particular friendship with someone decades younger than themselves, maturity and shared generation was generally important in being able to relate to one another. Age therefore influenced sociability both between service users, and service users and staff.

Maureen's (70s) presence revealed the tension in having a single older person on an otherwise younger ward. When asked what she thought about an older age specific secure ward she commented:

> "Yes, I think that would be a good idea because everyone here is very young. So 70 is a bit too much for them I think."

She had problems with her memory, which caused frustration among the other service users. Maureen had difficulties relating to younger service users and felt quite lonely because of this.

The vulnerability of older service users offered a particular set of challenges for staff and older service users themselves. The majority of older service users experienced an increased sense of being at risk. John (50s) commented, "If I were in a fight [with another service user], I would be on the floor". His decline in strength meant John tried to avoid physical confrontations. The two oldest participants, Maureen (70s) and Keith (70s), had both been the target of bullying behaviour by younger service users. This was

considered a safeguarding issue by staff members and Maureen was moved to a different ward during the course of the study. Keith noted "people always move on" and was prosaic following the departure of the service users involved in his ward "getting a wee bit rowdy". Keith did not agree with staff concerns about his safety.

Participation in activities

Weekly routines based on everyday tasks, such as doing laundry, cooking, going to the on-site bank and food shopping (online or in store), as well as visiting family, were important for all participants. They described a detailed personal routine and were very knowledgeable about the weekly rhythm of the unit.

> "Mondays I'll get up, get my money off the finance… Tuesday I stay in bed a little bit later… Wednesday I go out to my mum's. Thursdays I [plan] where I am going to go [out]. Fridays I go out" (John, 50s)

The hospital offered a unit wide occupational therapy (OT) programme. These activities and groups were also fundamental to these routines.

> "I like filling my days … As long as you go to the groups you're fine, if you don't go to the groups you're a bit, just sitting down watching telly all day or falling asleep. I don't fall asleep but people do fall asleep" (Jane, 50s)

Older adult participants appreciated developing new skills and being challenged by these groups was an important quality.

> "I do various groups and activities within the complex… I do IT… **(RV) Do you enjoy it?** Yeah. Because you're learning something that you don't know. So you're learning something new" (Patricia, 50s)

Five of the older adult participants had been in secure services for 20 years or more. They were the least likely to participate in the OT programme and expressed feelings of boredom. They made comments like "I have done them all [all the groups] " (Andrew,

50s) or, "I cannot be bothered" (Nigel, 50s) and, "It's childish [the groups]. I don't learn nothing from it. I've done 9 groups" (Nicholas, 50s).

Among a diverse programme, observations revealed that some groups attracted predominantly younger patients. But most activities were age inclusive. All the wards had their own weekly activities organized by an activity leader. On one ward the oldest service user was successfully engaged in one-to-one activities, such as baking cakes for the weekly staff and service user meeting, and group outings, such as visits to the local cinema.

There were one-off events during the study, such as a talent show in which services users performed, and a world food festival for which service users of different ethnic backgrounds prepared dishes. Observations revealed that some, but not all, older adults with ground leave attended. Mobility and overall physical health impacted on the ability to attend groups, specifically those organised off the ward. The unit café was upstairs for example, despite the unit being predominantly on one level. Maureen (70s) said "I find it hard walking sometimes." Similarly, Eric (50s) reported having pain in his legs and commented "No, I can't get to walk around. I'm bored of sitting here".

Management of physical health

Participants self-reported a range of physical health problems including: arthritis, visual impairment (from wearing glasses, to being blind), diabetes, dementia, high blood pressure, high cholesterol, leg and shoulder pain, a stoma and hernia. Eleven out of fifteen participants suffered from one of the physical health problem and 4 out of 15 had two or more.

Physical health needs impacted on service users' everyday lives. There was a strong wish among participants to manage health issues independently. Kenneth (50s) was diabetic and found the regular check-ups for this paternalistic, "I have had diabetes for 20 years, I know how to manage my diabetes". If staff intervention was necessary, participants wanted to be treated with respect and sensitivity, particularly when they felt embarrassed about their condition. John (50s) had a long-term physical health condition. He felt self-conscious about it and felt that some staff members were not equipped to help him.

> "It's been ok, but for the first few months it was a bit, a few teething problems because it's not a physical hospital is it, it's a mental hospital" (John, 50s).

By contrast, participants described meeting with primary care practitioners positively.

Older service users may downplay their physical health needs due to wider societal prejudice against being older and being perceived as vulnerable. Keith (70s), had experienced several falls when away from the ward, and sometimes had difficulties keeping his balance.

> "I think some of the staff are more worried about it [the falling] than I am because they are always taking me out and telling me to watch out. I've stumbled a few times you know" (Keith, 70s).

For Keith minding his balance was just a part of his everyday life, and when he would feel dizzy he would sit down for a while. To the staff this was of greater concern and his care plan included 15-minute observations.

Aspirations for the future

Most participants did not know how long they would be in secure services and so planning for the future was difficult. Having aspirations, however, was important to their quality of life and how they perceived the unit. Kenneth (late 50s), had a clear vision of his future as a series of goals:

"I gave myself a target for three years and then once I get unescorted leave, about 6 months into that, then I'll apply for parole".

The majority of participants wished to leave and "move on", however, participants' older age could be a concern to them in this respect:

> "I'm x years of age. I haven't got time to waste in places like this" (Nicholas, 50s)

Those who thought about seeking employment after their release from hospital spoke of the limiting role that their age as well as their offending history could play. Kenneth (late 50s) reflected:

> "I could do security I suppose. Or work for my brother. He is in the building trade but I'll be 62 when I get out here"

Abdullah (50s) planned to work in the service industry and said he would probably work until the retirement age of 65. In this way, while life was being 'interrupted' by a secure hospital stay, participants still held conventional notions of the life course, with certain responsibilities such as being in the labour market and achieving milestones like retirement. For others, being able to have their own living space, or to just "get out" was the main goal.

Hopes for the future were complex among participants past conventional retirement age with significant mental and physical health needs, for whom consultants sought long-term supported placements. The oldest service users were ambivalent about

moving on, and conflicted about where they might move. Some were reluctant to move because of valued relationships to staff, service users, and familiarity with their current situation. Being able to observe Keith through the transition from the unit to an older adult rehabilitation service showed how he was challenged by the idea of moving to an older adult service, yet simultaneously revealed his adaptability and capacity to settle in to a new environment.

The process of "moving on" was a source of anxiety to both service users and staff arranging these moves in a limited environment with little local onward care for ageing service users with functional mental illness and history of offending. When a place became available it could be at short notice, allowing insufficient time to prepare and make their goodbyes.

Discussion

This study explored user experiences of being an older adult in a UK forensic service with the aim of exploring how their age-related needs were being met. We employed a qualitative design to generate evidence on the quality of everyday care, levels of social participation, weekly routines and ageing identities from the perspective of older service users. To date, research into older service users has been dominated by referral and case note reviews, with a focus on mental illness, treatment and offending histories (Coid et al., 2002; Curtice et al., 2003; Farragher & O'Connor, 1995; Lewis, Fields, & Rainey, 2006; McLeod et al., 2008; Tomar, Treasaden, & Shah, 2005). Yorston and Taylor (2009), in their qualitative study of the experiences of older offenders at a high secure hospital, emphasise that research with older offenders who often have extensive

experience of services is essential to guide service improvements that meet the needs of this group.

In the low and medium secure unit under study, a quarter of service users in the year 2017-2018 were aged 50 and over. Some wards included service users in their twenties and service users in their seventies. We found that participants preferred ward environments where they had access to the company of other older adults. On the other hand, the majority of participants valued an age-inclusive activity program, enjoying unit-wide events and learning new skills. These findings suggest that managing the respective needs for a safe and sociable ward environment while supporting access to a stimulating activity program should be a service goal when meeting the needs of older adults in forensic services.

Di Lorito et al (2018) in a qualitative study that included service users from all levels of secure settings found that new activities to keep the mind busy, and age-inclusive activities were important for participants. Yorston and Taylor (2009) in their research in a high secure setting, also found that peace and quiet as well as leisure and education opportunities were important to older forensic in-patients in high security, but found in addition that the admission of younger patients to an older ward altered and increased restrictions.

In line with previous research on older forensic offenders (Lightbody et al., 2010) , physical health needs were high among participants. We found that the manner in which physical health care needs were managed mattered to participants. For example, participants wished to self-manage their physical health needs with the support of visits to/by primary care staff in relevant medical specialties. We also found that the stigma of identifying as ‘old’ and ‘vulnerable’ could lead older adults to downplay changing care needs. Both findings illustrate the importance of a culture of

sensitivity and respect for older persons' agency as key to collaboratively identifying and meeting additional care needs.

Older age was a relational experience connected with, but not defined by participants' chronological age (Degnen, 2007). This highlighted how being detained and living with mental illness shaped participants' experience of ageing; Some participants who were chronologically 'middle aged' described 'feeling old' because of their detainment and treatment. Conversely, male participants in particular felt they were less likely to be aggressively confrontational, felt calmer, more mature, and more knowledgeable about their mental illness. This aspect of ageing was viewed positively.

Age-related fears and concerns about discharge, such as employment prospects and long-term suitability of placements, also impacted on participants who were concerned about their advancing age. Acknowledging this in care planning is useful. It also highlights how age-related needs must be individually assessed and not chronologically inferred (See also Graeme Yorston & Taylor, 2009).

By comparison with older offenders in prison, who struggle with inflexible institutional routines, loneliness, and poor access to mental and physical healthcare (Ginn, 2012; Mann, 2012; Wahidin, 2011), this study found that the overall experience of older offenders in forensic mental health care was positive. However, making an adult forensic service *age-inclusive* is not a given and requires investment by the institution in making all areas of the unit accessible to those with mobility issues and facilitating access to a stimulating and diverse social and occupational programme. We suggest that the explicit consideration of the age balance of a ward in placement decisions is an area for quality improvement. On wards with a higher proportion of older service users, staff could be more responsive to their needs in activity coordination, and service users experienced less loneliness and isolation.

Future studies exploring the prevalence of dementia on multiple forensic wards would be beneficial. While the number of older people living with dementia and other types of cognitive decline is rising within society, only one participant reported being faced with this. Further research on different units may report a higher prevalence of cognitive decline and may therefore suggest offering services tailored to this. However, our research showed the range of ageing experiences within secure settings which suggests services should be mindful of cognitive decline but not solely focus on this when designed age-specific activities and services.

One of the limitations of this study is the participation rate (54%). Recruiting participants was challenging. Without being compensated for their time, fifteen out of 28 service users consented to participate. The group that did not participate was more withdrawn from the structured activities of the unit, spent more time in their rooms than on the ward, and may have had difficulties trusting the researcher. They were also less likely to move on from the unit. A multi-year research strategy, in which the researcher has time to build rapport and trust with participants, may be helpful in increasing participation. It was particularly difficult to build relationships with more secluded service users.

Our study adds to current knowledge by offering an in-depth account of ageing from the perspective of older service users within secure psychiatric care. Our findings pertain to one mental health trust, and is limited to a description of the needs described by these older adults, rather than a full survey of a larger population.

Our study reveals the complexity of the place of older adults within an adult regional secure unit, that provides local care. Further mixed-methods research should be undertaken to compare the older adult populations and their experiences of different settings in a range of forensic settings and step-down care, including specialist older

adult services. Our observations suggest that the difficulties involved in discharging older adults with additional social, physical and mental health needs to community and non-forensic in-patient settings deserve further examination on a wider scale, if transitions out of secure care and service users' hopes for the future are to be successfully realised.

Conclusion

This paper reports on a qualitative service evaluation into the needs of older adults conducted in adult mental health services. We conducted in-depth interviews and observations of daily and weekly routines, asking open-ended questions designed to elicit older adult service user views of their social, physical and mental health needs and whether they perceived these needs to be met by the forensic service. It is important to monitor whether current service provision can meet the needs of older adult in-patients (O'Sullivan & Chesterman, 2007). This study showed that regional forensic in-patient units are capable of meeting many of the needs of older adults with functional mental illness detained under the mental health act. There were some challenges. Placement of older people in adult secure services requires awareness of the age balance, safety and sociability of the ward. A culture of inclusivity, sensitivity and respect for older persons' agency is key to collaboratively meeting additional care needs and discharge planning.

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