Understanding policy and practice on the use of alcohol in care homes for older people in Wales

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1. Executive Summary

This research explores how alcohol use is managed and experienced in care homes for older adults across Wales. The study was commissioned by Alcohol Change UK to address a gap in the evidence base and to inform sector practice and policy development. Practice Solutions and Age Cymru carried out the research.

Care homes occupy a unique position. They are regulated services with duties of care, and they are people's homes. When residents wish to drink alcohol, staff must navigate the tension between supporting personal choice and managing risk.

The study used a mixed-methods approach, gathering data between September and November 2025. An online questionnaire received responses from 37 care home professionals across Wales. Site visits to seven care homes enabled interviews and focus groups with managers, staff, residents and family members. One-to-one interviews were conducted with Responsible Individuals and senior managers. Sixteen social care leaders also completed a questionnaire at the National Social Care Conference.

In the study, participating Welsh care homes self-reported a strong emphasis on person-centred values in their approach to alcohol use. 59% of questionnaire respondents identified promoting resident autonomy and choice as their primary goal when managing alcohol use. Staff reported going to considerable lengths to support residents' wishes, including facilitating access to preferred drinks even at end of life. At the National Social Care Conference, 88% of social care leaders who responded to the survey stated that care home residents have the same right to drink alcohol, in some capacity, as at home.

The research identified that 46% of responding homes have a written alcohol policy, while over half either lack formal guidance or have staff who are unaware of it. Training is also limited, with just 30% of homes stating that they have received training on alcohol-related issues, and only 19% have been trained specifically on supporting residents with alcohol dependency. This is significant given that 43% of respondents have supported at least one resident with alcohol dependence.

External support also appears limited. 63% of respondents rarely or never consult external professionals about alcohol-related issues. One detailed account described a crisis in which staff contacted 11 agencies over a weekend without securing support, leaving them feeling vulnerable and underprepared.

The research highlights emerging challenges. Multiple homes reported increases in younger residents with alcohol-related brain damage, particularly Korsakoff's syndrome. Managers anticipate that changing generational drinking patterns will lead to different expectations among future residents entering care. Staff recognised these shifts and expressed interest in training to prepare for a changing population.

Ethical considerations of alcohol management also emerged. The practice of providing non-alcoholic drinks to residents while allowing them to believe the drinks contain alcohol divided opinion among social care leaders. 47% of respondents stated that honesty is required and rejected this practice, while others would permit it under specific circumstances.

The report presents seven recommendations for care home providers, Area Planning Boards, those arranging placements, Care Inspectorate Wales, and the Welsh Government, as well as considerations for future researchers. These aim to strengthen the policy frameworks, training and external support that would enable staff to build on the person-centred values already evident in the participating care homes.

2. Introduction

For many people, alcohol is part of daily life. A glass of wine with dinner, a beer while watching sport, a small whisky before bed. These habits carry meaning beyond the drink itself. They connect people to routines, memories, communities and social occasions that matter to them.

When someone moves into a care home, these habits do not disappear. Yet the context changes significantly. Staff have responsibilities for residents' health and safety. Other residents share communal spaces. Medication regimes may interact with alcohol. Cognitive changes may affect the capacity to make informed decisions. Care homes must find ways to respect residents' choices while fulfilling their duty of care.

This balance is not straightforward. The Regulation and Inspection of Social Care (Wales) Act 2016 requires services to be person-centred and to promote well-being, including control over day-to-day life. At the same time, providers must protect residents from harm and manage risks appropriately. When a resident wishes to drink alcohol, these principles can pull in different directions.

Despite the complexity of this issue, there has been limited research into how care homes in Wales navigate alcohol use in practice. National policy frameworks acknowledge substance misuse among older adults but provide little specific guidance for residential care settings. The Substance Misuse Treatment Framework for Older People (Welsh Government, 2014) focuses primarily on access to treatment services rather than on supporting individuals within care homes. Welsh Government has also published a dedicated framework on Alcohol-Related Brain Damage (ARBD) (2021), which sets out an approach spanning prevention, identification/diagnosis, treatment and longer-term support. This report should be read alongside that framework.

Public Health Wales (2025) reports that alcohol-specific deaths among people aged 50 and over continue to rise, with 562 deaths recorded in 2023, representing a 15.6% increase on the previous year. Older adults account for two-thirds of alcohol-related hospital admissions. These figures indicate a growing public health challenge that will increasingly present in care settings.

This research was commissioned to address the gap in the evidence base. The study had three core objectives: to identify how alcohol use is managed in care homes across Wales; to understand the attitudes, concerns, and values of care home staff and residents, particularly regarding the balance between autonomy and risk; and to explore the rationale for differing approaches.

The research employed a mixed-methods design that combined quantitative and qualitative data collection. An online questionnaire gathered responses from 37 care home professionals. Site visits to seven homes across six health board areas enabled in-depth interviews and focus groups with managers, staff, residents and family members. One-to-one interviews captured strategic perspectives from Responsible Individuals[1] and senior managers. A brief questionnaire at the

[1] A Responsible Individual (RI) in Wales is a senior representative (director, owner, or manager) appointed by a social care provider to ensure the service complies with Care Inspectorate Wales (CIW) regulations and quality standards.

National Social Care Conference gathered views from social care leaders on ethical issues related to alcohol in care settings.

This report presents the findings from this research. Following this introduction, the review examines the existing literature on alcohol use in care home settings. It then examines the policy and legislative context in Wales. The methodology section describes the research approach in detail. The findings section presents the four main themes that emerged across the data, along with additional themes and emerging challenges. The report concludes with recommendations for care home providers, commissioners, policymakers and future research.

The research suggests a Welsh care home sector committed to person-centred values but working without consistent frameworks, training or external support. The recommendations aim to strengthen these foundations while preserving the rights-based approach that characterises good practice in the sector.

3. Literature Review

3.1 Introduction

Alcohol use among older adults in care home settings is a complex and under-researched issue. While there are broader public health narratives, these often frame alcohol use through either the lens of harm reduction or abstinence, the realities within residential care homes, however, are much more nuanced. In care homes, alcohol use comes up against questions of balancing individual autonomy and the well-being and risk management of both the individual and other residents.

As people live longer, more older adults live in care settings. In 2020-21, the most recent census data show that 20,651 people aged 65 or over lived in care homes, representing 3.1% of people aged 65 or over, up from 2.4% in 2017-18 (Older People's Commissioner for Wales, 2023). This makes it essential to understand how attitudes toward alcohol use in these settings work in practice, how policies are implemented, and how residents experience these practices. This literature review examines the current evidence base on alcohol use in care homes for older adults, with a particular focus on the lived experience, autonomy and risk, alcohol dependency and staff experience. The review draws on research conducted in the UK and internationally, providing a foundation for exploring policy and practice in Wales.

3.2 Lived Experience Perspectives

The lived experiences of residents in care homes offer insights into how alcohol is perceived and managed in practice. Across multiple studies, alcohol consumption is described by residents not only as a behaviour but as a key part of their identity, social connection, and quality of life.

In one study funded by the NIHR School for Social Care Research, researchers found that “people living in care homes and their relatives felt that drinking alcohol is an important part of living happily in old age” (Care Home Guide for Staff, n.d., p. 1). Residents and families associated alcohol with enjoyment, socialising, and continuity from life before entering care. Drinking alcohol is often about feeling socially normal, and just because you live in a care home, it doesn’t mean you no longer want alcohol.

In the literature, alcohol use is sometimes associated with improved appetite, social interaction, and reduced anxiety and as part of a care plan (NIHR SSCR, n.d.). “Residents, families, care staff and inspectors felt strongly that older people should be able to drink alcohol in care homes. Alcohol was considered to be part of having a ‘good life.’ It is a source of pleasure accessible to people with deteriorating physical function and cognition” (Alcohol Use in Care Homes Summary Report, n.d.). One care home manager noted, “A glass of wine may be better for someone’s wellbeing than a sleeping pill.”

A Healthier Wales makes clear that older people should also be “supported to live independently and treated with dignity and respect”, and this means affording people maximum possible autonomy to make decisions about their alcohol use and how much they consume. However, in the

research, we see that the extent to which this personal choice is supported varies, as it often conflicts with balancing risk, as we see in the next section.

3.3 Balancing Risk and Autonomy

A tension in care homes for older people is the need to balance residents' rights to autonomy and enjoyment with the duty of care to ensure safety and mitigate risk. This tension is reflected in various practices across care homes, highlighting the critical challenge in social care of balancing support for positive risk-taking with harm prevention.

Residents, family members, and care staff consistently emphasise the importance of maintaining personal choice. The NIHR SSCR-funded study highlights that alcohol is "a source of pleasure accessible to people with deteriorating physical function and cognition. It can create a sense of a community for residents (e.g. by celebrating special occasions together); reduce professional barriers between staff and residents; help create an authentic home environment; and help people maintain continuity between their life before and after entering the home" (Wadd et al., 2022, p. 5).

Some care homes reflect this approach through structured events. One home, for example, hosted a weekly social club and "had created a bar area, and every Tuesday night they held a 'club' where people could have their favourite alcoholic drink and play pub games for the evening" (Wadd et al., 2022, p. 4).

These examples align with findings from international literature. Emiliussen et al. (2021) describe how older people and staff view alcohol as a meaningful ritual, where consumption is "for something… a symbol of celebration, something exclusive, and a luxury not to take lightly."

Burruss, Sacco and Smith (2014) similarly report that in long-term care settings in the United States, "residents reported alcohol use as a part of their routines of socialisation and relaxation," and that "congregate care settings may act as a normaliser regarding alcohol use."

Some care homes prioritise "freedom, choice and positive risk taking, balancing these well to ensure quality of care. In these homes, alcohol was considered by care staff to be an integral part of care to enhance wellbeing... People were asked their alcohol preferences when they moved into the home; they were able to decide for themselves whether the benefits of alcohol outweighed the risks, and they had the freedom to drink in their rooms." (Wadd et al., 2022, p. 6)

However, not all homes are enabling; some are more restrictive or symbolic. In one case, a home built a pub-style room complete with bar and optics; however, "The optics were full of coloured water and were just for show" (Wadd et al., 2022, p. 6).

Other homes stored residents' alcohol, imposed limits on when and where it could be consumed, or had blanket bans. These approaches were generally motivated by safety concerns, including the risks of falls, medication interactions, confusion, and dehydration (NIHR SSCR, 2022a, p. 3). However, making these decisions may conflict with people's own choices and with the decision to make unwise choices, assuming there is capacity (NIHR SSCR, 2022b, p. 2).

The NIHR SSCR study concludes that care homes are often seeking a balance "between health, personal choice, risk, safety, equality, diversity and human rights". However, "this was not straightforward in practice" (Wadd et al., 2022, p. 4).

One of the core areas to manage is autonomy. Residents are legally entitled to make decisions, even unwise ones, provided they have capacity. As noted in the guide for residents, "Provided you have mental capacity, you have a right to make your own decisions, even those that other people think are unwise. This includes continuing to drink alcohol if you move into a care home" (Care Home Guide for Residents, n.d.).

Yet this autonomy is often balanced with concerns around risk and liability. The balancing act between enjoyment and managing safety, particularly where alcohol interacts with medication, frailty, or cognitive impairment, is a recurring theme.

According to the literature reviewed, residents' experiences are influenced not only by personal preferences but also by the care home culture and staff attitudes.

3.4 Supporting Alcohol Dependent Residents

Supporting residents who are alcohol dependent presents a more complex challenge. The literature reflects a recognition that traditional models may not serve the needs of older adults with long-term alcohol dependence, and that harm reduction approaches may be more appropriate. The Substance Misuse Treatment Framework for Older People in Wales highlights the lack of targeted services and the need for greater flexibility:

"Older people can be excluded from services for various reasons, including age cut-offs, assumptions that services are not appropriate for older people, or misattribution of symptoms of alcohol use to ageing" (Welsh Government, 2014, p. 11).

A Danish study of "wet" eldercare facilities describes models where abstinence is not the primary goal. Instead, staff work within a harm reduction framework that accepts ongoing alcohol use and aims to reduce its harm. "Residents were allowed to drink, but staff worked to reduce harms through controlled distribution, health monitoring, and interpersonal support" (Harnett and Jönson, 2022, p. 9). The same report identified three broad strategies used by staff to support residents' ongoing substance use: "looking away," "intervention and prohibition," and "intervention and distribution." These models reflect varying degrees of control and acceptance, highlighting the challenges care homes face and the approaches taken.

The Royal College of Psychiatrists advises: "If a resident with alcohol dependence moves into a care home, an abrupt enforced abstinence can cause severe withdrawal symptoms and may put the resident's health at risk." (Royal College of Psychiatrists, 2018, p. 37). It recommends individualised care planning and, where appropriate, gradual reduction strategies or medical detoxification pathways. The Royal College also calls for clearer, age-specific protocols that "balance risk management with the right to autonomy and quality of life."

Managed Alcohol Programs (MAPs), used in Canada, offer another harm reduction model. These provide controlled doses of alcohol at regular intervals to reduce harms associated with binge

drinking or withdrawal. Research into MAPs indicates that they can enhance housing retention, decrease emergency service use, and improve health and social stability. “MAPs can increase the ability to physically distance, stay in place and isolate, reduce withdrawal risks, and improve health outcomes” (Pauly et al., 2020, p. 12)

However, such approaches are rare in Wales and the wider UK. “Staff often lacked training or guidance on how to support residents who were alcohol dependent”, leading to inconsistencies in how risk was managed (Wadd et al., 2022, p. 7). Where alcohol dependency was recognised, responses ranged from overt and covert restriction to referral to external services, but rarely involved structured in-house interventions.

There is an inherent risk of not having clear guidance and support on how to support people living with alcohol dependency. For example, Wadd et al. note that “one care home originally had an open bar where residents could help themselves to alcohol. One lady had a brain injury, which meant she didn’t realise how much she was drinking, and she became very intoxicated. In another home, a resident who was in recovery from an alcohol problem was able to access an unattended drinks trolley and was admitted to hospital with alcohol poisoning.” (2022, p. 4). Demonstrating the potentially tragic consequences of an uninformed care home and staff team.

There are no dedicated care homes for older people living with alcohol dependency in Wales. There remains a gap in policy for older adults with alcohol dependence in care settings. Evidence suggests that abstinence policies may be medically unsafe, and person-centred harm reduction strategies, such as controlled supply, regular monitoring, and multidisciplinary support, should be considered.

3.5 Staff Knowledge and Professional Dilemmas

As noted previously, staff often lacked training or guidance on how to support residents who were alcohol dependent” (Wadd et al., 2022, p. 7). A systematic review by Nichol et al. (2025) found that decisions around older adults’ alcohol use in residential settings are highly variable and largely dependent on the values and knowledge of staff and families, rather than on consistent guidance or policy frameworks. It also highlights “the need for staff training to identify and manage problematic alcohol use and national guidelines to ensure consistent, ethical, and person-centred care practices.”

According to Our Invisible Addicts (Royal College of Psychiatrists, 2018), there is a shortage of training in substance misuse within older adult care settings. The report notes that “many staff working with older people have little or no training in substance misuse, leading to inconsistent and sometimes inappropriate responses” (p. 90). This report notes that because of this, “alcohol misuse in older people is often hidden, misdiagnosed or misattributed to ageing,” which delays treatment and appropriate support (p. 68).

Bjerge et al. (2024) emphasise the importance of providing systemic support to alleviate the burden on frontline staff. Their Danish study identifies a lack of coordinated guidance as a key barrier to effective care for older substance users. Staff reported feeling isolated and under-prepared to manage residents’ substance use, especially when behaviours were unpredictable or when different professional logics (e.g. autonomy versus medical safety) clashed.

In interviews conducted as part of the NIHR SSCR study, care staff described feeling torn between wanting to support residents' choices and fearing the repercussions of adverse outcomes. "You don't want to be the person who says no," one staff member said, "but if someone falls and they'd had a drink, the finger points at you" (Care Home Guide for Staff, n.d.). This quote is a good example of the accountability staff often carry, often without clear guidance.

Despite these challenges, the literature does show examples of good practice. These often arise when staff are supported to think flexibly and prioritise person-centred care. In the Care Home Guide for Staff, one home is described where staff routinely ask residents about their drinking preferences and offer drinks at times and in ways that reflect individual habits. This practice not only supports well-being but also helps maintain dignity and continuity from a life led outside of the home. As one staff member put it, "If someone's always had a glass of red with their dinner, why wouldn't they still want that now?"

4. Policy Context

4.1 Introduction

Policy on alcohol use in care homes is set out in the broader health and social care policy. There is recognition of substance misuse among older adults; however, national policies often fail to provide specific guidance for care homes.

In Wales, the Substance Misuse Treatment Framework: Improving Access to Substance Misuse Treatment for Older People (Welsh Government, 2014) recognises that older adults face unique barriers to treatment. These include stigma, under-recognition by professionals, and services that are not designed to meet their needs. The framework primarily focuses on access to treatment rather than on supporting individuals in care homes. It does recognise that joint working between primary care, substance misuse services, and older people's services is essential and that "raising awareness and understanding of issues associated with substance misuse in older age has been highlighted as an issue in the Strategy for Older People in Wales 2013-2023."

The Welsh Government has published the Substance Misuse Treatment Framework: Prevention, Diagnosis, Treatment and Support for Alcohol-Related Brain Damage (Welsh Government, 2021). The document provides guidance for health and social care planners and providers on designing and delivering services for people with ARBD, covering prevention, early identification, diagnosis, treatment and ongoing support. The framework's long-term aim is to establish dedicated ARBD services within each health board, with access to psychologists, occupational therapists and multidisciplinary support.

The framework recognises that ARBD is not a degenerative condition if the person stops drinking, and that up to 75% of those affected can achieve some degree of recovery with appropriate support. However, recent research suggests that services have struggled to translate these policy aspirations into clinical realities, with barriers including limited staff awareness, restrictive eligibility criteria, and services working in silos rather than through coordinated pathways (Heirene et al., 2025). The framework does not specifically address the operational challenges care homes face in supporting residents with ARBD, nor does it provide guidance on commissioning specialist residential placements.

Public Health Wales (2025) reports that alcohol-specific deaths in people aged 50+ continue to rise in Wales. In 2023, 562 deaths were recorded, 15.6% higher than in 2022. Additionally, older adults (50+) made up two-thirds of alcohol-related hospital admissions (12,236 admissions involving 8,147 individuals). This indicates a growing health issue in later life around alcohol use, suggesting an urgent need to strengthen provision for older adults, including those in Wales.

Care homes in Wales operate within a legal framework that balances residents' autonomy, duty of care, and public health principles. While licensed provisioning of alcohol is permitted under controlled conditions, residents' capacity and care planning remain central to ensuring safe and dignified practice. Enforcement and inspection are the responsibility of Care Inspectorate Wales under the Care Standards Act 2000 and the Regulation and Inspection of Social Care (Wales) Act 2016.

The Royal College of Psychiatrists (2018) in Our Invisible Addicts highlights how older people with substance misuse issues are often “invisible” in both policy and service design. This invisibility contributes to fragmented care and a lack of coordinated approaches within care homes. The report calls for a national strategy that includes older substance users in public health frameworks and increases investment in training and age-specific care pathways.

Scotland’s National Care Standards (Scottish Government, 2008) explicitly address care homes for people with drug and alcohol misuse problems. While more progressive in acknowledging the diversity of need, these standards are primarily oriented toward specialist residential facilities rather than general older adult care homes.

International literature, such as Bjerge et al. (2024), describes how Danish elder care services face similar policy challenges. Care professionals often navigate between contradictory expectations, for example, promoting health and safety while respecting residents’ choices. In Denmark, there are few clear national guidelines, leaving these dilemmas to be resolved locally.

Harnett and Jönson (2022) describe a similar tension in Sweden, where “wet” eldercare facilities operate with high degrees of local autonomy. These settings take a harm reduction approach but face regulatory and ethical scrutiny due to allowing alcohol use.

The general lack of policy clarity contributes to variability in practice and places undue pressure on care homes and frontline staff to make decisions for which they may not be sufficiently informed.

An exploration of the key Welsh legislation follows.

4.2 Care Standards Act 2000

The Care Standards Act 2000 is UK legislation that establishes the regulatory framework for care services, including care homes in Wales. While the Act itself does not explicitly regulate alcohol use by residents, it plays a crucial indirect role in how such matters are managed, particularly through its focus on residents' rights, dignity, and well-being. The implementation and oversight of these principles fall under Care Inspectorate Wales (CIW) and subsequent Welsh regulations that have built upon the original Act.

The key points of the Act which are relevant to alcohol use in care homes are:

1. Promotion of individual rights and autonomy

The Act emphasises the rights of residents to make choices about their lives. This includes:

- Personal freedom and lifestyle decisions, such as whether to consume alcohol, assuming the resident has mental capacity and it's not medically contraindicated.
- A care home must support residents’ rights unless there’s a safeguarding or legal reason to restrict them.

2. Registration and inspection of care homes

Care homes in Wales must be:

- Registered with Care Inspectorate Wales under the powers of the Act.

- Inspected regularly, with adherence to standards that include managing risks related to health and safety, including substance use.

3. Care planning and risk management

Under the Act and related regulations (like the Regulated Services (Service Providers and Responsible Individuals) (Wales) Regulations 2017), care providers must:

- Assess and document residents' individual needs and preferences, including alcohol use.
- Balance the resident's rights with the duty of care. For example, ensuring alcohol use does not interact harmfully with medication or lead to safeguarding issues.

4. Staff responsibilities

Care home staff are expected to:

- Be trained to understand issues like substance use in older adults.
- Handle alcohol-related situations with sensitivity and professionalism in line with care standards and individual care plans.

4.3 Regulation and Inspection of Social Care (Wales) Act 2016

The Regulation and Inspection of Social Care (Wales) Act 2016 (RISCA) governs the regulation and oversight of care services in Wales. While it doesn't specifically address alcohol use in detail, it plays a critical role in how alcohol consumption is managed, monitored, and regulated within care homes.

1. Person-Centred Care and Rights-Based Approach

RISCA establishes that care services in Wales must be:

- Person-centred
- Focused on dignity, choice, and well-being

Implications related to alcohol:

Care home residents, especially those with capacity, have the right to make choices about their lifestyle, including alcohol consumption. Providers must:

- Respect this autonomy
- Make reasonable accommodations for individual preferences (e.g. a glass of wine with meals)
- Ensure these choices are reflected in the personal plan of care

2. Duty on Providers: Well-being and Safety

Under Section 6 of RISCA, providers have a duty to promote the well-being of individuals, including:

- Protection from abuse and neglect
- Physical and mental health

- Control over day-to-day life

Implications related to alcohol:

- If a resident's alcohol use poses a risk to health or well-being (e.g. falls, interaction with medication), the provider has a duty to address this via risk assessments, care planning, and possibly multi-disciplinary input.
- If alcohol use is problematic or harmful, the home must show how it is managing the risk proportionately while still respecting individual rights.

3. Role of Care Inspectorate Wales (CIW)

RISCA empowers Care Inspectorate Wales (CIW) to:

- Register and inspect care homes
- Monitor compliance with standards
- Evaluate the quality of care, including the management of substance use and safeguarding

Implications related to alcohol:

CIW inspections may consider:

- Whether care plans appropriately address alcohol use
- Evidence of risk assessments for individuals consuming alcohol
- Staff awareness and training
- Whether the service upholds residents' choices while maintaining safety

4. Duty of Candour and Accountability

RISCA includes a duty of candour, requiring providers to be open and honest about incidents, including those that may relate to alcohol (e.g. injury after drinking, missed medication due to intoxication).

Implications related to alcohol:

- Incidents involving alcohol must be documented and, where appropriate, reported.
- Providers must learn from adverse events and implement changes to prevent recurrence.

5. Statement of Purpose & Policies

RISCA requires every provider to maintain an up-to-date Statement of Purpose, describing:

- Services provided
- How resident needs and risks are managed
- The approach to safeguarding and lifestyle choices

Implications related to alcohol:

The Statement should clarify:

- Whether the home provides alcohol
- How alcohol use is supported or restricted

- Policies for when alcohol may interact with medication, behaviour, or capacity issues

4.4 Care Planning and Resident Rights

1. Mental Capacity and Consent

Residents with capacity have the legal right to make choices, including alcohol consumption, even where risks are involved. If they have capacity, they can still make unwise decisions. It is still supposed to be their home.

For residents lacking capacity, decisions must follow the Mental Capacity Act 2005 and be in the individual's best interests. Care plans should clearly document restrictions or support needs.

2. Risk Management

- Risks associated with alcohol, such as interactions with medication, falls, or behavioural changes, must be addressed through individualised risk assessments and care plans.
- Where alcohol is part of a resident's lifestyle or social routine, care providers should promote safe access unless clinically contraindicated.

4.5 Licensing Act 2003 (England & Wales)

The Licensing Act 2003 framework applies in Wales. However, whether a particular care home's arrangements are "licensable" can be fact-specific, including whether alcohol is supplied for business purposes and the operating model (for example, sale/supply arrangements, events, or provision as part of hospitality). Care homes should consider the licensing implications of their specific arrangements and seek advice where required, including from the local licensing authority. Where a premises licence is required for the sale/supply of alcohol, the requirement for a Designated Premises Supervisor will apply. It should be noted that this report does not constitute legal advice.

5. Methodology

This research used a mixed-methods approach to explore policy, practice, and lived experience relating to alcohol use among older people in care homes in Wales. The methodology balanced broad stakeholder engagement with exploration of practice issues. Data collection took place between September and November 2025.

5.1 Research Objectives

- To identify how alcohol use is managed in care homes across Wales.
- To understand the attitudes, concerns, and values of care home staff and residents, especially concerning the balance of autonomy and risk.
- To explore the rationale behind differing approaches to alcohol use.

5.2 Study Design

The study comprised four distinct data collection strands:

1. Literature and policy review: A comprehensive review of existing national and international research, alongside analysis of national policy frameworks. This established the evidence base and policy context for the primary research.

2. Online questionnaire: A bilingual (English/Welsh) electronic survey was distributed to care home managers and staff across Wales. The questionnaire collected quantitative data on policies, training, and practices, as well as narrative responses that explored attitudes and experiences. Responses were received from 37 care home professionals.

3. Care home site visits: Seven care homes participated in site visits involving semi-structured interviews and focus groups with managers, staff members, residents, and family members. In-person visits enabled detailed exploration of practice, culture, and lived experience. Participating homes were located across five Welsh health boards and included both private and local authority providers.

4. Senior manager interviews: One-to-one interviews were conducted with Responsible Individuals and senior service managers representing local authorities and the private sector across Wales. These explored strategic perspectives on policy, training, and emerging challenges.

5. Conference questionnaire: A brief questionnaire was administered to 16 social care leaders attending the National Social Care Conference in October. This captured strategic perspectives on ethical questions around alcohol use in care settings.

5.3 Data Collection

- Bilingual electronic surveys gathered quantitative and narrative data.
- Focus groups and interviews were conducted in-person or via video.
- Residents were engaged with ensuring informed consent, using care staff to support communication where needed.

5.4 Key Definitions

For clarity, the following terms are defined as used throughout this research:

- Care home: Residential care homes providing personal care and accommodation for older adults in Wales. This research focused on residential care settings and did not include nursing homes or specialist dementia units as separate categories, though some participating homes provided these services.
- Alcohol dependence: People who feel a strong desire or need to have alcohol, usually every day, and who may become uncomfortable, and even physically unwell if they cannot get alcohol. This definition was included in the questionnaire and interviews as the definition for respondents to reflect on. This differs from risky drinking (consumption above recommended guidelines) or harmful drinking (causing physical or psychological harm without dependence).
- Capacity: A person's ability to make a specific decision at a specific time, as defined by the Mental Capacity Act 2005. Capacity is decision-specific (a person may have capacity for some decisions but not others) and time-specific (capacity can fluctuate).
- Harm reduction: An approach that aims to minimise the negative consequences of alcohol use without necessarily requiring abstinence. In care home contexts, this might include limiting quantities, offering lower-strength alternatives, or providing supervision during drinking.

5.5 Recruitment

Participation in this research was via response through information circulated via social media and established sector channels, including Practice Solutions and Age Cymru networks, and was available bilingually (Welsh/English). Because dissemination relied on open circulation through existing channels, we cannot calculate a response rate. As a result, responses are subject to self-selection bias and may over-represent those with a particular interest in the topic. Findings are therefore presented as indicative, intended to identify themes and practice issues rather than estimate prevalence across Wales.

5.6 Analysis

The thematic analysis of qualitative data was conducted by the lead researcher using a pragmatic approach appropriate to practice-focused research. Open-text questionnaire responses were organised to enable a systematic review. Interview transcripts and narrative accounts were read multiple times to identify recurring themes, which were then grouped to reflect patterns across the data. Given resource constraints typical of sector research, single-researcher analysis was employed rather than formal intercoder reliability procedures. Findings from all four data sources were triangulated to identify themes that emerged consistently across different stakeholder groups and methods. Where specific quotes are used, these are attributed to the engagement method and participant role to maintain transparency while preserving anonymity. To ensure credibility, the findings were reviewed by Age Cymru's policy department, which confirmed that the themes accurately reflected sector realities. The researcher's background in Welsh social care provided contextual understanding but also required attention to avoid imposing preconceived interpretations.

5.7 Ethics and Safeguarding

All engagement adhered to ethical guidelines for research involving older adults and vulnerable groups. Clear informed consent procedures were in place for all participants. Residents were engaged with support from care staff to ensure understanding and voluntary participation. Anonymity and confidentiality were preserved in all outputs through the use of generic identifiers (e.g. 'Manager 1', 'Staff Member 2').

The project design did not seek clinical or medical case information. However, during qualitative interviews, some participants voluntarily shared contextual details on their own or residents' experiences with alcohol, including historical drinking patterns and challenging situations they had navigated. Participants shared this material to illustrate practice dilemmas rather than being elicited through clinical questioning. Where such material appears in this report, it reflects participants' own framing of their experiences and has been anonymised to protect individual identity. No medical records, clinical assessments, or formally recorded case information were collected or accessed.

5.8 Sample Profile

The following tables summarise the participant and setting profiles across the four data collection methods.

Table 1: Online Questionnaire Responses by Health Board

Health Board	Responses	Percentage
Betsi Cadwaladr	15	41%
Hywel Dda	6	16%

Health Board	Responses	Percentage
Cwm Taf Morgannwg	4	11%
Cardiff and Vale	4	11%
Swansea Bay	4	11%
Aneurin Bevan	3	8%
Not specified	1	3%
Total	37	100%

Table 2: Provider Type and Respondent Roles (Questionnaire)

Category	Number	Percentage
Provider Type		
Private	30	81%
Local Authority	6	16%
Other/Not specified	1	3%
Respondent Role		
Care Staff	14	38%
Manager	13	35%
Responsible Individual	6	16%
Senior Carer/Other	4	11%

Table 3: Care Home Site Visits

Health Board	Participants
Aneurin Bevan	Manager, staff, residents
Betsi Cadwaladr	Manager, staff, residents
Betsi Cadwaladr	Manager, staff, residents, family
Cwm Taf Morgannwg	Staff, residents, family
Cwm Taf Morgannwg	Manager, staff, residents
Hywel Dda	Manager, staff, residents
Swansea Bay	Manager

Table 4: Senior Manager Interviews

Health Board	Role
Betsi Cadwaladr	Responsible Individual
Cardiff & Vale University Health Board	Operational manager
Betsi Cadwaladr	Responsible Individual
Swansea Bay	Responsible Individual
Betsi Cadwaladr	Responsible Individual

5.9 Limitations

Several limitations should be considered when interpreting the research findings.

1. Sample size and representativeness: While the research provides indicative data, it comprises a small proportion of the Welsh care home sector. The sample was weighted towards private providers and towards homes within the Betsi Cadwaladr Health Board. Local authority-run homes and some health board areas are therefore under-represented. Findings should be treated as indicative rather than generalisable across the sector.
2. Self-selection bias: Participation was voluntary, and it is possible that care homes with existing interest in alcohol-related practice, or those confident in their approaches, were more likely to participate.
3. Resident voice: While 32 residents participated in focus groups during site visits, the majority of data was gathered from staff and managers. The perspectives of residents, particularly those with cognitive impairment or those who may have concerns about alcohol practices in their homes, may be underrepresented.
4. Single incident evidence: Some findings, particularly around external support failures, draw on detailed accounts from individual settings. For example, the account of a crisis where staff contacted multiple agencies without securing support represents one home's experience and should not be generalised across Wales without further investigation.
5. Policy and legislative interpretation: The report's discussion of legislative requirements and regulatory expectations reflects the research team's understanding of published legislation and guidance. For authoritative interpretation of legal obligations, providers should consult the relevant legislation directly or seek legal advice.

6 Findings

6.1 Introduction

This section summarises findings from research conducted across Wales between September and November 2025, exploring alcohol use among residents in Welsh care homes.

The study utilised four engagement methods: an online questionnaire completed by 37 professionals; site visits and interviews with staff, residents, and family members across various care homes; individual interviews with Responsible Individuals and senior managers; and a questionnaire completed by 16 social care leaders at the National Social Care Conference. These sources offer insights into current practices, potential emerging challenges, and the values driving decision-making.

Across the participating care homes, respondents consistently described an approach to alcohol use that prioritised resident choice, autonomy, and quality of life. The survey revealed that more than half of the participating homes either lack formal alcohol policies or have staff unaware of them, with limited training on alcohol-related issues.

The report highlights four key themes common across all data sources: internal policy landscape, autonomy and safety, living with others, and the training gap. Additionally, it identifies several other themes that arose during the research and discusses emerging issues.

6.2 Internal Policy Landscape

The questionnaire data indicate that 46% of responding homes have a written policy on alcohol use in place, 24% report having none, and 27% are uncertain (3% did not answer). All homes with a policy in place were private homes, covering every health board area that responded; this accounted for 15% of responses. Of those who answered “no” or “uncertain,” 6 were private homes, and 5 were Local Authority homes. This suggests that more than half may lack policies or have staff who are unaware of them.

Of the seven participating care homes that received visits, only one reported having a written alcohol policy with accompanying risk assessment. However, the absence of a policy does not mean that respondents felt that one was required. One manager explained their approach:

> *“We don't have a policy. We have never felt that need to have one. We don't carry out risk assessments in relation to alcohol either.” (Manager 1)*

Another manager offered a different perspective on this gap:

> *“If we had a policy about alcohol, then we would need other policies around things like sugar.” (Manager 2)*

These comments capture a view held by some that alcohol represents one element of personal choice rather than requiring specific policies in place. However, during the senior manager interviews, concerns were identified about this approach. One manager noted the need for clearer frameworks:

> *"I think for me... the pressure sometimes that is placed on our care home managers... I think for me it would probably be a policy and guidance, a framework then to work within." (Senior Manager 1)*

Most homes included in the study do integrate alcohol-related information into individual care plans and risk assessments. The questionnaire found that 68% of respondents had care and support plans that reflect residents' preferences around alcohol, while 70% include alcohol use in risk assessments where relevant. This suggests many homes have embraced a person-centred approach concerning alcohol usage at the individual resident level, even where home-wide policies remain underdeveloped.

6.3 Autonomy and Safety

The tension between residents' autonomy and the management of their health and safety emerged as the central challenge across all data sources. The questionnaire revealed that 59% of respondents identify promoting resident autonomy and choice as their primary goal when managing alcohol use. 24% prioritised reducing potential risks or harm, while 14% focused on ensuring health and safety.

Care home visits demonstrated this commitment to autonomy in practice. One manager framed the issue around quality of life:

> *"Taking a rights-based approach to our residents is very important to us. After all, when they are here, their options are more limited. What do residents have to look forward to? Activities, food and drink. Their lives revolve around these." (Manager 3)*

Staff at another home took the following approach to enabling resident wishes:

> *"We are risk takers. We do what we can to fulfil the wishes of residents..." (Staff Member 1)*

Then talking of a specific resident:

> *Towards the end of her life, when she was really frail, her wish was to go to Sainsbury's and buy herself some cider. When residents have wishes, we do what we can to enable those wishes to happen." (Staff Member 1)*

This person-centred approach to alcohol use, however, requires navigating complex and sometimes substantial trade-offs, balancing multiple competing priorities rather than simply choosing between autonomy and safety. Decisions that prioritise individual choice can have consequences for resident safety, staff well-being, and the wider care environment. In practice, this may include a higher risk

of falls and injuries, difficulties with medication adherence and treatment effectiveness, moral distress among staff required to manage conflicting responsibilities, and adverse effects on the well-being and safety of other residents. One senior manager described supporting a gentleman who consumed a bottle of red wine nightly and became intoxicated. Staff struggled with the desire on the one hand to intervene and on the other that this was a decision he was able to make:

> *"Our team naturally want to care for somebody, and sometimes you have to kind of reinforce that, you know, he is making these decisions. And although we may perceive it as an unwise decision, ultimately it's still his decision to drink that amount." (Senior Manager 2)*

The conference questionnaire revealed social care leaders' support for residents' right to drink. 44% supported the right to drink alcohol unless it harms health or safety. In comparison, 19% supported this right with no reservations, and a further 19% preferred that alcohol access be managed within the care plan framework. Just 12% expressed uncertainty; 6% did not respond. This suggests that those in sector leadership who responded have formed clear views around resident autonomy.

An important dimension to the autonomy and safety theme was the use of non-alcoholic alternatives. One staff member explained:

> *"It is amazing the placebo effect when residents think they are drinking alcohol, but they are not. When we offer residents a drink we ask them if they want a glass of wine or beer, for example, not stipulating that it is alcoholic or non-alcoholic." (Staff Member 1)*

Another home described a similar approach:

> *"Lady in dementia unit gets given non-alcoholic red wine. Gives her a social life. Would have been a falls risk with actual alcohol. Family provided the non-alcoholic wine." (Staff Member 4)*

One manager explained:

> *"We would always offer non-alcoholic drinks like lemonade first. One lady has lemonade in a wine glass, and she's happy as long as it is in a wine glass." (Manager 5)*

However, this raises ethical and potentially legal considerations regarding informed choice; these considerations are nuanced but can be broadly categorised as follows:

- Informed choice: Some residents knowingly choose non-alcoholic alternatives. In these cases, the ethical position is clear: the resident has made an informed decision. Staff described offering non-alcoholic options openly, with residents accepting these as a way to participate in social occasions without the risks associated with alcohol.
- Ambiguous offering: More problematic from an ethical perspective is the practice of offering, for example, 'a glass of wine' without specifying whether it contains alcohol. Staff described this approach as one that avoids confrontation while enabling social participation.

However, this relies on residents not asking questions and could be seen as a form of deception by omission.

- Substitution without disclosure: The most problematic ethical concern arises when residents lacking capacity are given non-alcoholic drinks. At the same time, staff actively allow or encourage the belief that the drink contains alcohol. While this typically has good intentions (e.g., managing fall risk, preventing harmful interactions), it directly involves deceiving a person who cannot give informed consent and indirectly may affect other residents and/or family members.

The conference questionnaire revealed mixed views on this practice among social care leaders. When asked whether it is acceptable to give a resident a non-alcoholic drink while allowing them to believe it contains alcohol, 47% stated that honesty is required and rejected substitution as acceptable. 18% would permit it if clinically justified, and another 18% would accept it where a recorded best interests decision applies. Although these responses represent only a small portion of the sector, this ethical tension may warrant further discussion.

6.4 Living With Others

Resident autonomy creates an additional complexity when considering other residents who may not wish to be exposed to or be affected by other people's alcohol consumption. It is acknowledged that residents' voices were not strong in this section. As one local authority manager explained:

> *"When it impacts on the wellbeing of the person living next door, it's a different kettle of fish, isn't it? So it's about managing the impact." (Senior Manager 3)*

Several managers described situations where a resident's drinking adversely affected others in the home. At one care home, staff negotiated with a resident whose behaviour became problematic after drinking:

> *"We did have one gentleman who came in and said that he really enjoyed a glass or two of wine in the evening. Sometimes, if he had more than one, he could become abusive towards staff and other residents. He had full capacity and not wanting to infringe his rights, we spoke to him about his behaviour and agreed that he would have one small bottle of wine a night." (Staff Member 6)*

This case highlights how homes are negotiating the situation as it occurs. The research indicates that, rather than imposing blanket restrictions, staff work with the resident to reach a compromise that respects his autonomy while protecting others from harm.

The situation is made more complex when one resident's drinking affects others, especially when they may have their own vulnerabilities around alcohol use. One manager explained:

> *"Because we've got other people in the unit who are not allowed to drink, we had the discussion with him, and we had to get the social worker in to speak to him... He agreed to have non-alcoholic wine instead." (Manager 5)*

This example highlights the careful balance that is needed to balance one person's right to drink against another's need to avoid alcohol triggers.

In some cases, the impact on others contributed to placement breakdown. 16% of questionnaire respondents had challenged the suitability of a care home placement due to personal alcohol use. One described a situation involving.

> *"mental health issues and the high risk to the person against the service's ability to keep them safe. Which impacted them and others around them." (Care Professional 4)*

One staff member shared an experience from a previous role where negotiation ultimately failed:

> *"The person was desperate for alcohol to the extent that he managed to get out of the care home to look for a drink. This was before DoLS. It was a difficult situation... The GP became involved and initially suggested that he be given a small amount of alcohol each day. However, this did not work, and eventually he had to be moved to a more suitable home due to his challenging behaviour." (Staff Member 7)*

A senior manager had clear principles for managing these situations, explaining:

> *"Behaviour is not an issue unless it impacts on others... the moment it starts impacting others, we try and manage it internally." (Senior Manager 3)*

This same manager said they were willing to escalate where needed:

> *"I would not hesitate to say to people, this is unmanageable, and we give notice... if people make choices, then people need to accept that there may be consequences." (Senior Manager 3)*

However, she noted that this had never happened in practice, suggesting that solutions are typically negotiated or that homes find other ways to manage before reaching this point.

6.5 The Training Gap

The data reveal a significant mismatch between staff experience and their preparation for it. The questionnaire found that 43% of respondents have supported residents with alcohol dependence. Yet when asked whether teams have received training on supporting people with alcohol dependency, 62% said no. Only 19% confirmed having this training.

More broadly, 54% of questionnaire respondents reported that staff receive no training in managing alcohol-related issues. Just 30% confirmed their staff receive such training. Awareness of guidance is similarly patchy. Only 32% could confirm staff awareness of national guidance; 38% said staff are unaware, and 30% were uncertain.

The care home site visits reinforced this finding. None of the seven participating homes provided alcohol-specific training for staff. One manager acknowledged the need directly:

> *"There is no specific training on this issue for staff or managers. I think staff need some more guidance on this now, as people are more open about substance use and mental health issues. They need to know how to have the conversation." (Manager 4)*

Staff identified concrete knowledge gaps. One team member explained:

> *"We don't have any training specifically on alcohol. I think it would be useful to know what effects it could have on medications, the risk of falls, and the rules on capacity. When does the decision need to be made by someone other than the resident? Sometimes it is a grey area before someone has had a formal mental capacity assessment." (Staff Member 2)*

Senior managers echoed these concerns. One reflected:

> *"Are we providing our team members with enough information, you know, in terms of kind of medical education, interactions with alcohol? Is there enough information there that we could recognise culprit medications? When should we be escalating to GPs?" (Senior Manager 2)*

Looking ahead, staff anticipated future challenges. One assistant manager noted:

> *"It would be useful to get some training on substance use because the next generation of residents might be different, and it might be substances other than alcohol that are an issue." (Staff Member 3)*

6.6 Other Themes

A range of other themes were identified across the participating homes; these were less prominent than the four main themes, but nevertheless provide insight into the use of alcohol in care homes in Wales.

6.6.1 Alcohol as a Response to Loneliness

The site visits revealed a pattern where residents had used alcohol to cope with isolation before entering care. One resident shared his experience directly:

> *"I lived alone, and I think it was company. Helped me forget things. When my health started failing, and I couldn't go out, I used to drink a bottle of whisky a night. It was hard being in your late 50s and early 60s and not being able to go out." (Resident 1)*

Managers consistently observed that problematic drinking often ceased once people moved into the supportive environment of a care home. One manager noted:

> *"We did have a gentleman in one of our step-down beds who has a history of drinking at home... He didn't ask for a drink in hospital and when he came to us it had ceased*

to be an issue. However, once he went home, he started drinking again. It's a lot to do with loneliness." (Manager 4)

Another manager commented:

"There have been instances where residents have used alcohol in their own homes as a coping strategy, to combat isolation and loneliness, but that once they move into the home they have not asked for it or looked for it." (Manager 2)

This finding suggests the transition to residential care can reduce problematic alcohol use by addressing the underlying loneliness that drives its initial increase in use to problematic levels.

6.6.2 The Social Value of Alcohol

Multiple participants emphasised the positive social dimension of alcohol use. Residents articulated this clearly:

"The thought of being able to have a drink, it makes it more homely. You're not restricted." (Resident 2)

Another resident added:

"If you have a drink, of whatever you want, it's like you've had a good treat, and psychologically, it can work that way." (Resident 3)

Staff observed how alcohol contributes to the positive atmosphere within homes:

"The laughter and light-heartedness is infectious." (Staff Member 5)

Homes described specific social activities that had developed. One assistant manager noted:

"Three ladies have a glass of Baileys, a couple of times a week, chatting. It gets them out of their rooms." (Staff Member 4)

Senior managers emphasised alcohol's role in maintaining cultural identity and social connection:

"Alcohol has long been seen as a social mechanism, hasn't it? And I think that's why it could be so important for people. Having that social connection with different people. If that's having a beer or a shandy or a glass of wine, I think that's why it's so important that people should be allowed to continue that as normal." (Senior Manager 2)

Cultural traditions featured in several discussions. Managers described supporting residents watching rugby with a drink:

"The rugby is a classic, isn't it? People, you know, when we've got individuals who enjoy the rugby, like a glass of beer or whatever with that, it is part of a natural thing that people did or do, isn't it?" (Senior Manager 1)

However, as previously explored, managers have also described situations in which resident drinking has adversely affected other residents.

6.6.3 Navigating Family Dynamics

Families can function as one of the primary sources of alcohol supply. It is acknowledged that the voices of family members are not reflected in this section due to a lack of responses. One manager described a case where family members were bringing in alcohol regularly for a resident who was becoming increasingly frail and falling frequently:

> *"The family didn't really appreciate or see these implications." (Manager 2)*

On the other side, some families can be overly restrictive:

> *"Family and friends will say 'she can't have that.'" (Staff Member 4)*

The questionnaire found that families sometimes provide conflicting information before admission. One respondent described:

> *"Prior to admission, her children say she is an alcoholic, and we shouldn't let her drink. But as she has capacity, we have to be able to meet her in the middle." (Care Professional 1)*

Another senior manager reported the demands that family members made, stating that,

> *Family members have brought in the alcohol and asked for it to be watered down and advised of the amount that should be consumed. (Senior Manager 4)*

Strong relationships help navigate these dynamics. One manager noted:

> *"This conversation was easy to have with the family as our relationships with family members starts before their loved ones become residents." (Manager 2)*

6.6.4 When External Support Falls Short

The questionnaire revealed that 33% of respondents never consult external professionals about alcohol-related issues, with another 30% doing so rarely. Only 11% consult external professionals often. The lack of contact may be because external support was not needed and was being managed within the care plan and risk assessment processes.

One senior manager's interview illustrates what can happen when homes face a crisis without adequate support. One manager described a gentleman with alcohol dependency and mental health issues whose situation escalated during weekends when external support was unavailable:

> *"What happens and did happen in this case with this gentleman, it became a crisis, always on a weekend. He wanted to leave. He was absolutely not staying and it was*

an unfortunate situation that we ended up in and there was no support." (Senior Manager 1)

Staff attempted to contact multiple services without success:

"We can't get any support. We've tried the crisis team. We've tried everybody. We've tried this. We've tried that... I think it was 11 agencies they rang, so many people, mental health team, just for some support. Nobody was available." (Senior Manager 1)

The outcome left staff feeling vulnerable:

"They felt very vulnerable then because they weren't skilled enough to deal with that…situation." (Senior Manager 1)

This manager articulated the problem:

"We're more than happy to support people. We want to give people the right support, but we also need the right support to enable that to happen too." (Senior Manager 1)

While this account represents a single detailed case study rather than a sector-wide pattern, it illustrates the potential vulnerability of care homes when specialist support is unavailable, particularly outside regular working hours. Further research would be needed to establish how typical this experience is across Wales.

6.7 Looking Ahead

During the research, there were a number of themes that came through that looked forward to the future, for which perhaps the sector should be prepared.

6.7.1 The Rise of Alcohol-Related Brain Damage

Multiple homes in this sample reported an increase in younger residents presenting with alcohol-related brain damage, particularly Korsakoff's syndrome. One manager said:

"Lately we're seeing a lot of individuals coming through with either Korsakoff, which is an alcohol-related dementia... A new referral came through today. It's a 59-year-old lady with Korsakoff's, and we have another two gents up there already with alcohol-related dementia." (Manager 5)

This manager noted a post-pandemic increase:

"Staff don't get alcohol-related training, but I do feel they should because we are seeing more and more people coming to us with alcohol-related dementia. I think since Covid, we have seen an increase, and that means that staff need to understand how best to care and support these people." (Manager 5)

The ages of these residents create challenges. They are often younger and more physically able than what would have been the typical care home residents:

> *"The people who tend to come to us with this form of dementia are usually younger and, in many cases, are physically able. For example, you've got this 61-year-old lady, in a unit with people in their 80s and 90s." (Manager 5)*

Family members described the impact on their relatives:

> *"This person had two types of dementia. One of which was directly related to his issues around alcohol. Up until going into the care home 18 months ago, he had been drinking heavily. He ended up in hospital due to the alcohol-induced dementia and whilst there for six weeks experienced really bad withdrawal symptoms." (Family Member 1)*

One manager proposed a specialist approach:

> *"It would be amazing if we could make that unit specifically for people dealing with alcohol-related dementia, because the people who tend to come to us with this form of dementia are usually younger and in many cases are physically able." (Manager 5)*

6.7.2 Changing Drinking Patterns

An area coming through the research is the anticipation of a significant shift in alcohol use patterns as new generations enter residential care, who are currently middle-aged. The shift from pub culture to home drinking, along with changing consumption patterns, will require planning.

One senior manager offered a personal perspective:

> *"I'm 66 now, and I keep saying I think I am the next generation really of residential home users... I know I probably don't want this. It's good enough, don't get me wrong, it's good enough... But it doesn't look like what I want, and I think with that will come different challenges as well." (Senior Manager 3)*

Another manager reflected on how drinking patterns are shifting:

> *"Myself included. I like a glass of wine on the weekend, you know. Those are things that are becoming normal patterns of life for us. And that's going to shift our provision, isn't it? We have to be aware that those are going to be the expectations of people potentially coming into our services in the future." (Senior Manager 1)*

The change from "a tot before bed" to regular wine consumption represents more than a shift in beverage preference:

> *"The tot of whiskey or brandy or whatever it may be, that's generationally moving, isn't it? I can't imagine myself requiring a tot before bed. It's just gone out of our psyche." (Senior Manager 2)*

6.7.3 Preparing for Broader Substance Use

Linked to those, but not within the scope of the research, managers raised concerns about substance use beyond alcohol:

> *"Alcohol-related issues more prevalent. More mental health issues. More social issues coming. Damage from abuse will have to be more mindful. Training on the effects of recreational drug use for people currently in their 50s or 60s, or alcohol use in single women in their 60s." (Manager 6)*

One assistant manager noted:

> *"It would be useful to get some training on substance use because the next generation of residents might be different, and it might be substances other than alcohol that are an issue." (Staff Member 3)*

7 Conclusion

Findings from this exploratory study suggest that participating Welsh care homes place a strong emphasis on person-centred values in their approach to alcohol use. 59% of questionnaire participants prioritised promoting resident autonomy and choice. Staff showed strong dedication to respecting residents' wishes, with examples of homes going to great lengths to facilitate choice, even at the end of life.

However, while this commitment to autonomy is encouraging, it must be understood within existing legal frameworks. Practices relating to alcohol use, consent, and substitution should be informed by the Mental Capacity Act 2005 and safeguarding legislation. Staff perspectives and experiences are valuable and informative, but they should be interpreted within these legal boundaries rather than regarded as ethically conclusive in themselves. Strong person-centred values do not imply unrestricted access to alcohol in all circumstances. Staff must make proportionate and reasoned judgements that balance individual choice with safety, the rights of other residents, and legal duties of care. When carefully justified and regularly reviewed, restriction can itself be a form of person-centred practice rather than its opposite.

Most participating homes have incorporated alcohol-related details into individual care plans (68%) and risk assessments (70%). At the National Social Care Conference, social care leaders strongly supported residents' drinking rights, with 88% affirming residents' autonomy in some capacity.

However, the research identified structural gaps that may require attention. Although 46% of responding homes have written alcohol policies, over half either lack formal guidance or are unaware of it. Alcohol-related training was reported by just 30% of staff interviewed in this study, with dependency-specific training at 19%. This means that 43% of respondents have supported residents with alcohol dependence without formal training. Staff manage complex situations through their judgement and goodwill, but may lack the necessary frameworks, training, and external support to do so effectively.

Notably, few adverse events linked to alcohol decisions were reported in this study. This could indicate that respondents are managing alcohol-related situations well. However, it may also reflect reluctance to disclose incidents or engage in the research due to concerns about reputational damage or regulatory consequences. The reliance on self-reporting means we cannot be certain whether the absence of reported harm represents safe practice or underreporting.

The study also highlights emerging pressures. Respondents noted the rising numbers of younger residents with alcohol-related brain damage and changing generational drinking patterns, which will bring new expectations as future residents enter care. Staff recognise these shifts and would welcome training to prepare for a changing population.

Overall, the findings indicate a sector with solid person-centred values but underdeveloped structures. Improving policies, training, and external support would strengthen staff confidence. The recommendations aim to reinforce policy and training fundamentals while acknowledging that sustainable progress requires adequate workforce capacity, protected time for implementation, and recognition that alcohol support sits alongside multiple competing priorities in an

overstretched system. The goal is to preserve and strengthen the rights-based, person-centred approach that characterises best practice in Welsh care homes, while ensuring staff have the practical support needed to translate values into consistent practice.

8 Recommendations

8.1 For Care Home Providers

The research found that 46% of responding homes have a written alcohol policy and 68% integrate alcohol preferences into care plans. Although the study comprised a small, self-selecting sample, this may suggest an appetite for person-centred approaches, but that formal frameworks remain inconsistent.

Recommendation 1: Care home providers without a specific policy may benefit from developing one. The policy should address:

- storage and access arrangements,
- integration with care planning and risk assessment,
- guidance on supporting residents with alcohol dependency,
- framework for managing situations where alcohol use affects other residents,
- clear position on non-alcoholic substitution and informed consent,
- escalation pathways when situations exceed in-house capability.

Within this study, a substantial proportion of respondents reported supporting residents with alcohol dependency, while comparatively few had received relevant training. Although not necessarily representative of the sector, these findings highlight the potential value of clearer internal frameworks to support staff decision-making and risk management.

Recommendation 2: Providers may wish to consider ensuring staff receive alcohol awareness training as part of their overall training and development. This training should cover:

- common medications that interact with alcohol and how to identify risks,
- Mental Capacity Act principles applied to alcohol-related decisions,
- recognising signs of alcohol dependency and withdrawal,
- communication skills for discussing alcohol with residents and families.

Social Care Wales could consider supporting consistent training content and expectations across the sector to reduce variation in workforce capability.

8.2 For Care Inspectorate Wales

Care homes operate as both regulated services and people's homes. The research found variation in policy, training and practice amongst the homes included in this study, with some homes having well-developed approaches and others managing alcohol-related situations without formal frameworks.

Recommendation 3: Care Inspectorate Wales may wish to consider how inspection activity can consistently explore whether care homes have proportionate arrangements in place for alcohol-related risk. This could include considering whether homes have appropriate policies and

procedures, whether care plans reflect residents' relationship with alcohol, whether staff have relevant capability, and whether escalation routes are clear.

8.3 For Area Planning Boards

Area Planning Boards coordinate substance misuse services across Wales and are responsible for commissioning support pathways. The research identified that 63% of respondents rarely or never consult external professionals about alcohol-related issues. This may reflect situations being managed internally; it may also reflect a lack of appropriate external support being available.

Recommendation 4: Area Planning Boards may wish to consider reviewing the availability of specialist alcohol support services for care homes. This review should:

- map current pathways between care homes and substance misuse services,
- identify gaps in support, including crisis support,
- establish clear points of contact for care home staff seeking advice,
- consider whether existing commissioning adequately addresses residential care settings.

8.4 For Those Arranging Care Home Placements

The research found that 16% of care home respondents had challenged placement suitability due to alcohol use, suggesting some placements may not be appropriately matched to need.

Recommendation 5: Pre-placement assessments should include consideration of the person's relationship with alcohol. For local authority-funded placements and health board Continuing Healthcare placements, commissioners should include alcohol-related questions covering:

- current drinking patterns and any history of dependency,
- whether the receiving home has relevant policies and training,
- how the placement will support the person's relationship with alcohol while managing risks.

Care homes conducting their own admission assessments for self-funding residents should similarly consider these questions as part of their standard process. Regional Partnership Boards should support consistent regional approaches where appropriate.

8.5 For Welsh Government

The 2021 Substance Misuse Treatment Framework for ARBD provides a strong policy foundation for prevention, diagnosis, treatment and support. However, the research identified that the care homes included in the study face challenges in translating this into day-to-day practice, particularly around supporting residents with alcohol-related brain damage.

Recommendation 6: The Welsh Government may wish to consider whether additional care-home-specific operational guidance would help ensure consistent implementation of the 2021 ARBD

Treatment Framework across residential settings. This work should be developed in collaboration with Care Inspectorate Wales, Social Care Wales, Area Planning Boards and Regional Partnership Boards. Guidance could address:

- applying the rights-based, person-centred approach in care home contexts,
- pathways between care homes and specialist ARBD services,
- ethical questions around non-alcoholic substitution and informed consent,
- a framework that homes can adapt to their circumstances.

Recommendation 7: Welsh Government, working with Regional Partnership Boards and Area Planning Boards, should review whether current commissioning arrangements support adequate specialist residential provision for people with alcohol-related brain damage. Some specialist provision exists in Wales, including the Arbennig Unit in Conwy. Still, this limited research suggested a possible increase in demand, with homes included in this study reporting more younger residents with Korsakoff's syndrome and similar conditions. Regional Partnership Boards should assess whether the current provision meets regional needs and consider responses to any identified gaps.

8.6 For Future Research

This research was limited to care homes for older adults. The evidence base would benefit from further investigation in several areas:

- The rise of alcohol-related brain damage, particularly Korsakoff's syndrome, has emerged as an emerging challenge, with homes reporting increases and younger residents requiring different approaches to care. Research into the best care models for this population, and the training needs of staff supporting them, would inform service development.
- The availability and accessibility of specialist alcohol support for care homes
- Research with care home residents about alcohol use, using methods that enable participation from residents with cognitive impairment and those who may be uncomfortable discussing their care.
- The research did not explore nursing care settings, where alcohol management may differ from residential care.
- The research did not explore care homes or supported living services supporting younger adults, people with learning disabilities, or people with mental health needs; these may face distinct challenges.
- The diversity of care home residents, including nationality, gender, and generational differences in drinking patterns, could be explored. The research identified changing drinking cultures as a future challenge; understanding how these intersect with other aspects of diversity could inform more nuanced practice.

Appendix 1: References

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