Making a move: care-home residents' experiences of relocation

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ABSTRACT

Studies in environmental gerontology have progressed our understanding of the ways in which older people respond to and manage the environments in which they live, including their decisions about relocation and the influencing factors. Much of this work, however, has been done with relatively healthy and mobile older people living in domestic environments. It is often the case that when care-home residents move, the decisions are taken by others while the residents are passive and maybe hardly consulted. Far from the residents' preferences and initiatives being instrumental, they are moved by imposition. In the United Kingdom, the setting of this study, such imposed moves are common, partly because registration regulations restrict the range of care that a home can provide, and make some moves unavoidable. A questionnaire was distributed to care homes in two English local authorities to determine the incidence of relocation, and 10 homes were approached to take part in further studies, which included case-note audits, and interviews with staff and 12 older people who had relocated. The study found that the pattern of moves was complex, and that some residents were active in deciding to relocate and in the selection of the relocation home. The study concludes, however, that for residents to have an active role, they must be given support both to access the information required for decision-making and to implement their decisions.

KEY WORDS – older people, relocation, care homes, environmental gerontology, autonomy.

Introduction

Over the past 20 to 30 years there has been an increasing interest in the relationship between people growing older and the environment in which they live. The importance of location and place has attracted more recognition with the development of 'environmental gerontology' in health

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and social care research, and has become more significant in understanding both people's experiences as they grow older and the factors that shape these experiences. As Wahl (2001) has argued, the development of environmental gerontology offers a way of conceptualising and investigating older people's personal histories and aspirations for living in particular places, in the context of the social, emotional and physical factors that come into play. Lawton (1989), for example, has described the sociophysical functions of the environment as being maintenance, stimulation and support, and environmental gerontology has explored all three.

The role of the environment in maintaining lifestyle and the sense of self, including the meaning of home and attachment to place, has been explored by Golant (1998), Rowles (1979) and Sixsmith (1986) among others. The way in which the environment can act as a stimulant, particularly neighborhood and locality environments, has been explored by Smith (1991), who described the shopping patterns of older people, and Mollenkopf *et al.* (1998) who investigated their use of transport. Research on the role of the environment in supporting older people has included work on the adaptation of the home environment to identify and reduce hazards (Gill *et al.* 1999), and to aid the activities of daily living (Pynoos and Regnier 1991).

Much of this literature has explored person-environment relationships in domiciliary and community settings, but there is also a body of work on institutional environments, one of the earliest studies being Gubrium's (1975) *Living and Dying at Murray Manor*, in which the relationship between care home residents and their environment was explored using residents' accounts of the meanings they attached to their living space. Another study, by Groger (1995), concluded that the nursing home can feel like home, depending on three factors: the circumstances of the placement (*e.g.* the time available for anticipation of the move), the residents' subjective definitions of home, and the continuity achieved after moving to a care home. This work suggests that inter-personal and subjective characteristics of the care home environment are most important in determining the sense of being 'at home'.

Another topic of environmental gerontology research has been the relocation of older people. Relocations can be between private residences, from private residences into institutional settings, or between institutional settings. Both the residential mobility and the migrations of older people have attracted numerous studies by economists, geographers and sociologists in Australasia, Europe and north America (for reviews see Longino 1996; Rogers *et al.* 1992; Warnes 1996). Residential moves are undertaken for many reasons, and a long-established practice has been to conceptualise them as 'push' or 'pull' factors (for useful discussions see Lee 1966;

Rossi 1955; Haas and Serow 1993). Push factors may be reactive to the current environment that has become unsuitable (through change in either the older person or the environment). Pull factors are those that attract people to new environments, such as proximity or ease of access to amenities or families.

The push-pull model of relocation decisions suggests that an older person exercises choice among various options. One concern about the relocation of frail or institutionalised older people is that often they do not have this control, and that moves are imposed rather than informed choices – described by Nolan *et al.* (1996) in a study of older people moving *into* a care home as *faites accomplis*. This concern is also demonstrated in the media reports of moves between care homes as a result of home closure. While the evidence is anecdotal, there is a fear that the forced relocations of residents are stressful and dangerous experiences. As the care-home sector becomes more volatile in a changing market, home closures may well increase (Telford 2002).

In part these concerns about the relocation of care-home residents, and some of the debates in environmental gerontology, presume that older people are passive in their relationship with the environment. Environmental gerontology, however, is now developing conceptual frameworks which more clearly address issues of control and agency (Wahl 2001). Similarly some of the work on older people in care-homes has argued that they can be active in shaping their living environment in various ways, including: becoming familiar with the care-home environment using cues from past life experiences; by developing relationships with other residents; by evaluating the care that is given and the facilities on offer; and by actively engaging in the home's activities (Reed and Payton 1996; Oldman and Quilgars 1999; Raynes 1998; Reed, Cook and Stanley 1999).

This literature challenges traditional views of older people, especially those who are residents in care-homes, as unable to exercise any degree of control over their living environment. For older people who relocate from care-home to care-home, however, little is known about their experiences. It is often assumed that entry into a care-home is a final step, that people do not move again. Eley and Middleton (1983) used the phrase 'the escalator of care' to describe services that are structured around assumptions of linear and one-directional changes in dependency. As they argued, once an older person has taken the first step on to the escalator, by accessing services or entering a care facility, they find themselves being moved to increasingly supportive facilities, with no option of a reduction in the level of support they receive, only intermittent increases. Previous research, however, has indicated that this path is not universal, and that older people can and do move in and out of different levels of provision (Reed,

Payton and Bond 1998). This is not necessarily a failure of accurate assessment or careful placement processes, but of the fact that over time some people's needs change, and some reduce.

It would be easy to assume that these moves are rare, or that they are the result of 'push' factors arising from incompatibility between the older person and the care home, for example when care needs change. There is also, however, the possibility that 'pull' factors are operating, whereby residents are making active choices to move to homes that they perceive will be more appropriate or satisfactory for them. Understanding the nature of moves between care-homes is then important in developing a deeper understanding of the relationship between residents and their living environment, not only in the way that their preferences and views influence their response to the care-home environment, but also in the extent to which they wish and are enabled to be active in formulating strategies for moves.

This paper reports a study that examined older people's relocations in the care-home sector. Building on previous research (Cook *et al.* 2001), the study aimed to identify patterns of relocation across care-homes, describe the strategies used by care-home staff to manage moves, and to explore older people's experiences of relocations. The paper concentrates on this third topic, the experiences and narratives of older people who had relocated from care-home to care-home. Details of the full study are available in a research report (Cook *et al.* 2001).

Methodology and the study setting

Two local authorities in northeast England (site A and site B) were selected as data collection sites. Both areas have lively cosmopolitan inner city districts and quiet remote villages, and in both authorities 18 per cent of the population were aged 65 or more years. Care-homes were identified through the local authority inspection unit's list of approved homes.[1] In authority A in 1999–2000, there were 44 residential, 12 nursing and 26 dual-registered homes; while in authority B, there were 52 residential, 12 nursing and three dual-registered homes. This information informed the sampling strategy, which was to ensure that the selected care-homes were located in diverse areas, and represented all registration categories. A potentially important difference between the two local authorities was that A had developed in partnership with the local National Health Service Health Authority a Joint Inspection Unit for the approval and registration of residential and nursing care-homes, while in B the two inspection units remained separate. The sample sites therefore included contrasting joint working between the local health and social care agencies.

Research design

The study design was explicitly based on the need to understand the experiences of relocations in relation to the residents' individual needs and preferences, local organisational characteristics, assessment and placement processes and family dynamics, to mention but a few factors. It was therefore decided to adopt multiple methods: quantitative methods were used to define and analyse the incidence of resident relocations, and qualitative methods to describe and illuminate the movers' experiences from both user and provider perspectives. The main themes of the investigation included:

- the needs and preferences of the residents who relocate;
- the environment of the care-home into which they moved, and its strategies for managing relocations;
- the processes of assessment and placement undergone by older people.

The study had three component strands which concerned: the frequency and nature of relocations into and between the care-homes; the strategies that the care-homes had developed to accommodate changes in a resident's needs; and the experiences of older people who had relocated into or between the homes.

Strand 1: The frequency and characteristics of the relocations

Questionnaires were distributed to the managers of all the 149 care-homes identified in the records of the two local authorities. Eighty four questionnaires were returned, giving a 56.4 per cent response rate. The questionnaire requested information on: the number of residents in the home, its registration category(ies), the circumstances and details of resident relocations, and the management strategies to meet changing resident needs. The managers were also asked if they would be prepared to participate in more detailed research which, using 'matrix sampling' (a form of quota sampling), enabled the team to identify homes for further investigation (Reed, Procter and Murray 1996). The characteristics important to the study were:

- registration category(ies)
- number of residents living in the home
- single owner or linked to a small/large organisation
- care home manager's experience of relocation of residents
- evidence of recognition that relocation is an important issue for the residents.

Using this list, 10 homes were identified and approached for more detailed study, which involved interviews with staff (Strand 2) and interviews with

older people who had relocated (Strand 3). As the study progressed, however, two homes withdrew, although staff interviews had been conducted in one before this occurred. There was insufficient time to include replacement homes.

While the questionnaires provided information about the incidence of relocations, the care home managers' returns did not provide a comprehensive record of the moves between or into the homes. A case-note audit of 255 resident records in eight care-homes was therefore carried out to collect retrospectively details of the residents' placement histories. The number of residents who had relocated was recorded, relocation histories were traced, and the number of moves each older person made and their origins and destinations were identified.

Strand 2 : The experiences of the care-home staff of resident relocation

For this element of the study, nine focus groups and two individual interviews were carried out with care-home staff to explore the strategies for managing changing residents' needs, and the staff's experiences of and responses to resident relocation. Thirty nursing and care staff participated in the interviews, including 10 care-home managers (two of whom participated in individual interviews) and 20 care staff. During the interviews the staff were asked questions about:

- their experience of the changing needs of the residents
- the strategies for managing changing needs of residents
- support from external agencies to meet the needs of the residents
- their observations and contacts with residents who had relocated
- what they felt were the key issues in supporting residents through this process
- proactive strategies to minimise relocation in situations where changes in residents' needs could be predicted.

The aim of the interviews was to gather authentic accounts and rich descriptions of the participants' experiences, so following the introduction of a topic, open-ended discussion was encouraged.

Strand 3 : Experiences of older people who had relocated

The case-note audit identified the older residents who had relocated into or between care-homes. Care-home staff members were consulted about the selection of individuals for interview, and two from each home were invited to participate. Some residents were not included because they were unwilling to take part, too frail, ill or cognitively impaired. Consequently 12 older people participated in individual interviews. Relatives were not

routinely invited to take part in interviews, to avoid any constraints on the residents' replies, but when discussing participation in the study, and negotiating consent, the residents were invited to discuss their participation with family and friends before deciding whether to take part.[2]

In these interviews, the participants were asked about the history of their relocation, including the reasons why they had moved, and their feelings about this. Using this narrative framework allowed residents to 'story' their experiences in ways that made sense to them (Gubrium 1993). The integrity of these stories therefore lay in their coherence and self-reflective utility for understanding the moves, rather than in the accuracy of reported events when checked against external reference points.

Data and analysis

The questionnaires were coded using a numerical identifier to maintain the respondents' confidentiality. As the majority of the questions were semi-structured, content analysis was undertaken to identify themes and key practice issues. This provided details about the incidence of relocation, who was involved in the relocation decisions, and the types of facilities in dual-registered care homes. A case-note audit was also undertaken, to establish their placement history. Flow diagrams were developed to map the moves that were made to different care-environments, *e.g.* the movement for one resident was described by the sequence: living in own home; moved to a residential care-home; and moved to a nursing-home. In this way, the flow data represented the pathways of care for every resident.

The interviews were tape recorded and transcribed *verbatim*. The research team carried out the analysis, with members reading interview transcripts individually, and identifying key themes and patterns in the data. These individual analyses were then discussed in the group until a consensus framework was reached, which all team members felt was fair and accurate and which reflected important aspects of the data. Subsequently, all of the interviews were analysed using this framework. As analysis proceeded, the codes in the content analysis framework were extended to denote the themes emerging in the analysis, and new codes were generated to reflect emergent issues.

Ethical and selection considerations

The approval of the Local Research Ethics Committee in the two areas was granted. As the study raised concerns about confidentiality and the

information discussed during the interviews was potentially sensitive, particular attention was given to creating a system whereby the care-homes and participants' details were anonymised. The participation of the residents presented particular challenges. Residents in nursing and 'elderly mentally infirm' (EMI) care-homes can be frail and dependent, and their ability to understand and make decisions about their participation in research requires careful assessment. This was addressed through collaboration and discussion with the care staff who identified eligible and possible participants. The residents who were approached were given basic information sheets about the study by the staff, and they were encouraged to discuss the study with family, friends and staff and to ask questions which could be passed on to the researchers. Only when they were comfortable with the idea did the researcher visit and discuss the study in detail. The negotiation of informed consent had several stages, beginning with discussion of a written summary of the project, and culminating in recorded verbal consent. This strategy relied on the good will and ability of the staff to identify potential participants, and may have created a bias towards residents with positive views. As relocations from another facility do not directly involve evaluative comments on current care, there was no reason for staff to be selective on those grounds.

The incidence of moves

Of the care-home managers who responded to the questionnaire, 83 per cent reported that they had had experience of resident relocations. The audit of the residents' records indicated that 157 residents (62%) had moved directly from their own homes to the care-home, 83 (33%) had experienced one relocation between care-homes, and 11 (4%) had experienced two or more relocations. Complex circumstances surrounded every relocation, as several push and pull factors influenced whether the resident should remain in a care-home or move to another. Residents, their families, the care-home staff and care managers were all involved in these decisions, and they had markedly divergent views about the importance of various factors. Whilst there was a consensus about some relocations, this was not always found.

Types of resident participation in relocation

The interviews with residents were analysed separately by individual members of the research team to identify the prominent themes and

patterns. These were then compared in research team meetings and both a thematic framework and a consensus typology of relocations were developed. The typology is based on moves rather than movers, as it was apparent that people made different types of move depending on their circumstances and the context. This is not to deny that some reflected on their moves in a lifecourse framework: about their attitudes to life's challenges, and some comments suggested that the resident would adopt the same stance towards all moves. It was beyond the scope and aims of this study, however, to investigate the association of 'personality type' with the response to relocation. The data represent residents' own descriptions of their responses to the moves that they had experienced.

The interviews suggested that the extent to which the residents' views are considered and they are involved in relocation decisions varied greatly. The iterative analysis of their replies revealed patterns in the older persons' representation of their involvement in the decisions, which can be categorised and labelled as:

1. *Preference relocations*: moves in which residents, by their own description, had exercised choice.
2. *Strategic relocations*: moves which residents had planned to pre-empt changes in their circumstances.
3. *Reluctant relocations*: moves which residents had resisted or disagreed with; reflecting arguments about their changing needs and the limitations of the care provider to meet them.
4. *Passive relocations*: moves described by the residents as arising from the decisions of others about the level and type of care required and that they had accepted and not questioned.

These types were circumstance-dependent and not mutually exclusive. In other words, it was not the case that an individual would respond to a move in the same way each time. The interviewees described the different ways in which they participated in decisions during different relocations. For example, one woman described her initial move from a residential to a nursing care-home in terms which conveyed passivity about the proposed relocation, but some months later she actively pursued and participated in another move to a nursing home near her son (a preference relocation).

Residents who had been involved in preference relocations stressed the importance of having choices for their initial and subsequent moves into, within and between care-homes. Many had initiated relocation decisions, and if they were unable to access the information required to make an informed choice about alternative rooms or homes, they commissioned the help of others. For example, one older woman was unhappy with the

attention that she was experiencing in a home and asked her son to help find others near to where he lived:

No, I left because, well, there's much more attention here than in that one. My son … went to care homes and he advised me that this is the nicest one. My son works in Social Services. [After a three-day visit to the home she felt that] there's much more attention here than in that one: a lot more attention. … I came for three days actually and decided to stop. My son told them that I was staying.

This example illustrates the way that residents can make decisions about relocation by being given appropriate information. This may involve visits to the potential accommodation. Indeed as one resident who had visited several homes in a search for one she liked put it, '[people looking for a home to move to] should go to it and decide if it's for them.' Attraction or 'pull' factors, such as a home's reputation for high standards of care, its location, and its religious or cultural orientation, influenced older people's and their relatives' choice:

Resident: She [his daughter] picked on home M first you see, and then somehow she found out about this place … and she came here and saw it and realised it was a better place, you see, and I don't know what it was because this place … has a sort of Christian background.

Researcher: But was it important to you?

Resident: Not me, no, not me, no. I did go to church but that wasn't part of my life at all really … I was a member but I just did it for social reasons, not for religious reasons, a lot of people are like that. I've been used to it [Christianity] all of my life, you see, and it's something I rely on in a way.

Another participant had built up knowledge of a particular home in several ways, by getting to know people who had visited, lived or worked there, and becoming familiar with the home as a local landmark. This resident had resisted all attempts to make her move elsewhere. She told us, 'I'm not going to be pushed. I have a right to choose where I'm going … I will not be pushed. I wanted to go to home W [and] I always said that if I had to move, I'd go [there]. This was achieved because a room was available when the decision to move to a care home was made.

Relocations for strategic reasons

Older people who participated in these moves were aware that their circumstances would change, for example when the imminent closure of the home or the merger of the parent company with a different organisation became known. They were active in the planning and initiation of their move to another facility, as recounted by one resident: 'I got to know that it was going to close. So I said, "right, I'm getting out while I can because

if I stay here much longer they'll just put us anywhere they want and I want it to be my choice"'. The three residents who had faced moves in these circumstances were saddened by the inevitable move from a care-home with which they were familiar, and where they knew the staff and other residents. Their moves were therefore impelled, and they left for reasons beyond their control. They wanted to be involved in the relocation decisions rather than have their circumstances, or other people's views, determine their living arrangements.

One participant who left a home when she discovered it was going to close described what happened to the residents who stayed: 'That one closed down straightaway. The people from there were told on the Thursday afternoon to get their bags packed because the place was closing down and they were going to be moved somewhere else'. As she said, she 'just couldn't cope' with such a forced change. She said, 'look, it's my decision and my decision only, if I want to move, I'll move'. Taking pre-emptive action was one way of maintaining choice and control.

Relocations where residents were reluctant to move

Some older people indicated that they disagreed with others' views about their personal or nursing needs and how they should be met. One resident, for example, articulated well that her needs had been adequately met in her residential care-home: 'I was put there to see if I could cope and I have coped alright up to now'. But following a reassessment of her needs, she was categorised as requiring nursing care. Because the care-home was not registered to provide nursing care, she had to move to an appropriately registered home. Decisions about this woman's needs were dominated by the views of professionals, and she was relocated to a nursing home without her agreement. Her views were clear:

Well I wasn't very happy, well, you cannot stop in a place when you have all your faculties can you, and I thought I couldn't stand this. Well where I am there's a lot of poor people, well I mean, they sleep most of the day.

Her interview was held two months after the move, when she questioned the professionals' judgement and decision. Even though she stated that the current home was a 'nice place', she would have preferred to remain in the previous care-home. This case illustrates the way in which some older people are relocated on the basis of their assessed need, not their views and preferences for stability. The resident had to move to a nursing home and had little involvement in this decision, but she did influence the choice of which home. It is clear that bureaucratic rules and customary practice limit residents' involvement in decisions about their care and

accommodation. One participant who was unhappy with her move bluntly described the process: 'I did not want to move – I was pushed'.

Relocations in which residents were passive

For many relocations, the residents seemed to acquiesce in the views of others about the level and type of care required to meet their assessed needs, as in the following exchange:

Resident: It [a residential care-home] was entirely different. It was in N [location]. I was in hospital when they told me I had to go into a nursing home.

Researcher: How long had you been in the residential home?

Resident: About five years.

Researcher: Who decided that you needed to go into a nursing home?

Resident: The doctor, it was his decision.

The resident accepted the doctor's opinion and did not question the proposed move to the nursing home. In such cases it is unclear, however, whether the residents had willingly accepted the decision as a *fait accompli*, or would have preferred another option. It is also usually unclear whether they were made aware of other possibilities. The residents' acceptance of the verdicts of doctors and other professional 'experts' seemed to be unquestioning, as in this quotation: 'They said that the residential home staff could no longer look after me. I need help to go to bed, get up, have my dressings done – with everything really. My family helped me to find a nursing home nearby and I moved.'

The way in which people who had been passive in their moves talked about the decision-making process was striking. They report the decisions as being taken by unidentified 'them', and themselves being 'put' in homes. A relative who was present at an interview succinctly described what happened in one case: 'She didn't ask to come here, it was all arranged that she came here, she was never asked'. This description implies a lack of autonomy and choice. It could be a case of a willingly delegated decision (Collopy *et al.* 1991), but there was no evidence of this process, just statements that others made decisions about moves, and that residents played no part.

Residents' involvement in relocation decisions: a continuum?

One of the questions raised in the introduction was whether the dichotomy of 'push' or 'pull' influences on residential moves applied to people moving into or between care-homes, given that it was developed as a model of

rational choices in non-institutional environments. The question was whether the degree of personal choice enjoyed by less frail older people living in domestic environments would be similar to or different from those who were more frail and living in an institutional setting. The above descriptions suggest that the resident's influence in a relocation decision is related to context and circumstances.

At one end of the continuum, among those making preference relocations, the locus of control rests with the older person: they make judgements about their situation and take the decision to move or remain in the home. One woman, for example spoke of her wish to move to another home in the neighbourhood where she had lived and that she had known for a long time. Although she indicated to the staff that she was 'happy living in the home' into which she had initially moved, she decided to move to the other. Following a visit to the preferred home, arranged by the matron of her first home, *she* made a decision, as she made clear in her interview: 'So when I came back here, and they were all looking at me, I said, alright, I'm going to stay here'. She had had the opportunity to explore an alternative and make a choice about moving, but after her visit, which showed the other care home to be not as nice as expected, she had decided to stay and the decision was based on her preference.

In these situations the residents' views and preferences were acknowledged by others, some of whom then helped to execute the decision. These cases evince 'decisional autonomy', as termed by Collopy *et al.* (1991), in which people have the freedom to make decisions while others execute them on the subject's behalf (executional dependence). Decisional autonomy was supported by the extent to which others would provide or find information about choices on behalf of the resident, or the extent to which they had direct access themselves. Sometimes this information was general and vague, and residents would 'construct familiarity' by magnifying the content and significance of sparse information (Reed and Payton 1996). Residents were however dependent on others to execute their decisions, for example in arranging the transfer of fee payments, and organising the removal. Nonetheless, the decision to move was the resident's.

In contrast, the views of others dominate the decision-making process at the other end of the continuum, when residents were passive and had minimal involvement in the decision to move. The way in which the professional assessment of an older person's needs shapes decisions about the level and type of care has already been illustrated. The judgements of staff about the need to move to another care-home were based partly on their understanding of care-home registration categories, but there was some evidence that residents' preferences could also be taken into account. In the following quotations from focus groups of care-home staff discussing

their experiences of decisions about the relocation of residents, tensions between professional assessments and residents' wishes were evident:

It's just general old age deterioration, you know and you cannot just chuck them out [of the residential home]. I mean you just cannot do it you know [although the residents required nursing care]

We've got two ladies at the minute who have become really frail over the last three weeks and it's so noticeable … but I wouldn't dream of moving them on. I'll care for them until the last.

An interesting feature of these group discussions was the way that the needs of all the residents in the home were taken into account when considering the relocation of one resident. In other words, some relocations could be in the interests of other residents, as in this comment about a dual-registered home:

I think that you can continue to care for a resident but they can deteriorate so much, and then it affects the care of the other clients in the building because you're having to spend more time with one person, and that's taking other time from the other residents. It's not just the one person that suffers, it's all of them. I don't think it's a nice feeling for them to be shipped out to another place … but you can only care for somebody to a certain extent and then you're reaching the limits really and you're having to look for this person 24 hours a day, whereas those 24 hours could be spent shared between the other residents.'

Our findings suggest that there is a continuum of residents' involvement in relocation decisions, from maximum to minimum participation in decisions to move to another care-home. As the involvement of the residents diminishes, that of others increases. Others monopolise the decision with passive relocations. At every point along this continuum, those participating in making decisions consider several factors. Both push and pull factors may encourage moves, and judgements about their relative importance and strength in comparison to the reasons for staying are considered by residents, their families, care-home staff and other professionals. In some situations a resident's views and preferences are paramount, and in others they are discounted.

Discussion

The evidence presented in this paper suggests that relocation between care-homes is a complex process, and that each move generates contrasting accounts that reflect the different ways in which older people relate to the care-home environment. Some people were involved only passively, usually when the decision-making process appears to be beyond their control or

influence, and they acquiesce. For others, there is some degree of active response – even if only to dispute or disagree with the decisions made for or about them. Those who took part in 'preference relocations' and 'strategic relocations' were however able to exercise judgement and make choices. This level of involvement only occurred, however, under certain conditions, namely that the resident was aware of their rights and choices, was able to communicate and debate these choices with others, and was able to access and evaluate information about the options. When these conditions applied, residents were able to make choices and exercise 'decisional autonomy'. When not in place, residents were unable to exercise choice, and indeed in the case of passive relocations seemed unaware that they had choices.

These observations point to the strategies that could be introduced to support older people in making choices about their living environment. First, there should be promotion of the awareness of choice and the right to choose. This could be implemented through information leaflets about options, and discussions with care managers, care home staff and other people in contact with residents. Secondly, help in evaluating information about options should be provided. More than the mere provision of leaflets or brochures about care homes is required. These tend to be general and self-promotional, and need to be read critically. Spending time in the care home and talking to staff and residents is another way of obtaining information, and allows older people to ask the questions that are important to them. Such visits may well be costly in terms of staff time and difficult to organise, but the activity is consistent with the role of the local authority care-manager and should be enabled.

Perhaps the key message of this study is that we need to think about older people and their relationship to the care-home in a different light. Rather than conceptualising older people as to be 'placed' in a care-home, which implies passivity, we should think about them as 'living' in the home, where they make active choices, decisions and judgements about their living environment. They may not like the setting, and they may want to move. The responsibility of service providers and researchers is to be aware of and to respect their own evaluations of their living environment.

NOTES

1 Before a new system of inspection, approval and registration of care homes was introduced in England and Wales in 2002, there were both local authority and National Health Service registration units. The procedures distinguished 'care' from 'nursing' homes. Some homes were registered to provide both types of care: they had 'dual-registration', and other finer distinctions were made, *e.g.* the number of beds for 'elderly mentally ill' residents was registered. For more details see Holden (2002).

2 In one case a relative was visiting at the time the interview was to take place. The resident indicted that she wanted her relative to take part in the interview, therefore this person was approached and involved.

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