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**‘*You’re at their mercy’*: Older peoples’ experiences of moving from home to a care home: A grounded theory study.**

**Background**

Internationally it is recognised that the transition to a care home environment can be an emotional and stressful occasion for older people and their families. There is a paucity of research that takes into consideration the initial phase of the relocation process, incorporating individuals’ experiences of the move.

**Aim**

To explore individuals’ experiences of moving into a care home. This paper has a specific focus on the pre-placement (7 days) and immediate post-placement (within 3 days) period of the move to the care home.

**Design**

A grounded theory method was used to conduct semi structured interviews with 23 participants.

**Results**

Data analysis revealed five distinct categories that captured the experience of the pre-placement and immediate post-placement period. These were These were 1): Inevitability of the Move ‘*I had to come here’*, 2) Making the Move ‘*Abrupt Departures’*, 3) Decision Making and Exercising Choice: ‘*What can I do, I have no choice’* 4) Maintaining Identity, ‘*Holding on to self’*, and 5) Maintaining Connections. ‘*I like my family to be near’*. Together these five categories formed the basis of the concept *‘You**’re at their Mercy’ which* encapsulates the perceived transition experience of the older people within the study. Participants felt that the move was out of their control and that they were ‘at the mercy’ of others who made decisions about their long-term care.

**Conclusions**

Moving to a care home represents a uniquely significant relocation experience for the individual. Key factors influencing the move were the individuals’ perceived lack of autonomy in the pre- and post-relocating period of moving to a care home. Nurses have a key role to play in working with older people to influence policy and practice around decision-making, planning and moving to a care home with greater emphasis on autonomy and choice so that older people do not feel ‘*at the mercy’* of others as they navigate such a major transition.

**What does this research add to existing knowledge in gerontology?**

**What is already known about the topic?**

* It is recognised that the transition to long term care can be an emotional and stressful event for older people.
* Numerous factors including health and social issues can influence the adaptation and adjustment process for older people when relocating to a care home.
* The extent to which residents are able to exercise control over the decision to move from their home to a care home is recognised as an important determinant of their relocation experience.

**What this paper adds?**

This study identifies that:

* There was a perceived lack of autonomy for most individuals in their decision to move to a care home, and in having a choice in the selection of the care home.
* The lack of participation in decision making and choice about the move created a negative experience causing emotional disturbance and personal loss leading to individuals’ feeling anxious and at the mercy of others during the move.
* The importance of bringing a sense of home and possessions to the care home environment is highlighted, as having a significant psychological and emotional impact on the individual.

**What are the implications of this new knowledge for nursing care with older people?**

* There is a need to standardise approaches and develop person centred interventions to support older people considering relocation to a care home and nurses have a key role to play in making this happen
* Best practice policy directives on moving to a care home should include the development of auditable guidelines to include equal access to health and social care

services post transition.

* Future research should include the perspective of health care professionals involved in supporting older people in making the move to care homes.

**How could the findings be used to influence policy or practice or research or education?**

* Nurses have a key role to play in working with older people to influence policy and practice around decision-making, planning and moving to a care home with greater emphasis on autonomy and choice so that older people do not feel ‘*at the mercy’* of others as they navigate such a major transition .
* Nurses and other health care professionals must work in partnership with older people to support and empower them to plan for the future when deciding on their own long-term care needs.
* This study highlights the need to make decisions about relocating to a care home in partnership with older people and has the potential to inform policy and practice.
1. **Introduction**

The population of the world is ageing (WHO, 2018), and internationally, there is an increasing trend for older people with complex care needs to reside in care homes. Within the United Kingdom (UK) there are approximately 17,678 care homes caring for 426,000 older people (Age UK, 2017). This figure represents 4% of the population aged 65 years and over, rising to 16% of those aged 85 or more.

It is recognised that the transition from living at home to living in a care home is a uniquely significant experience for older people that can be an stressful, challenging and an emotional event for individuals and families, as it involves a major adjustment in their daily lives (Cheek, Ballantyne, Byers & Quan., 2007; Ellis 2010; Brandburg, Symes, Mastel-Smith, Hersch, & Walsh, 2013; Sury, Burns & Brodaty, 2013; Ryan & McKenna, 2015; McCarthy, 2016) Relocation to a care home normally occurs at a point in life when an individual is at an advanced age with increasing likelihood of multi-morbidities and dependency, (Marengoni et al., 2011;Barnett et al., 2012; Ryan & McKenna, 2015).

The transition experience includes the decision-making process, planning process and preparation of the older person and their family (Lee, Simpson & Froggart, 2013). Numerous factors including health and social issues can influence the adaption and adjustment process for older people when relocating to a care home (Bradshaw, Playford & Riazi, 2012; Brownie, Horstmanshof & Garbutt, 2014; Križa, Warren & Slade, 2016). Additionally, there were heightened feelings of loneliness and isolation when the care home admission was unplanned and not discussed with the resident, (Thein, D'Souza & Sheehan, 2011; Brownie et al., 2014; Bowers, Nolet & Jacobson, 2015).

The transition process begins before the move into the care home, and the extent to which residents can exercise control over the decision to move from their home to a care home is recognized as an important determinant of their relocation experience (Chao et al., 2008; Johnson, Popejoy & Radina, 2010; Fraher & Coffey, 2011; Lee et al., 2013; Ryan & McKenna 2015). Moreover, individuals reported that having greater involvement could have eased the negative feelings surrounding the move (New, D'Souza & Sheehan, 2011; Sury et al., 2013). Residents admitted to care homes ‘against their will’ and those who felt that they ‘had no choice’ were more likely to experience sadness, depression and anger compared with those individuals who relocated willingly (Johnson et al., 2010; Fraher and Coffey, 2011; Ryan & McKenna, 2013; Brownie et al., 2014). It is known that good communication can enhance the move for residents and families, allowing them to feel confident in their decisions, able to ask questions and make suggestions without fear of repercussions. On the other hand, poor communication can lead to uncertainty, worry and anxiety (Graneheim, Johansson & Lindgren, 2014; Ryan and McKenna 2015).

Older people are often not involved in research processes even when studies are care-home focused (Backhouse et al., 2016). Some studies that have focused on the decision-making processes surrounding the move have highlighted that older adults rarely initiate relocation decisions relying instead on family, professionals or both to determine when relocation is called for (Reed, Cook, Sullivan & Burridge,2003; Keister, 2004; Fraher & Coffey, 2011). Moreover, the processes involved in moving to a care home from home or following acute hospitalisation is still poorly investigated and there is a paucity of research that takes into consideration the relocation experience with a focus on the pre-placement and immediate post-placement phase of the move. This study aims to address the dearth of research in this area. It is predicted that the knowledge gained will inform care delivery in determining the nature of ongoing support needed by individuals at this critical time point in their transition to life in a care home.

**2. Design and Method**

Adjustment to care home life is a process that occurs over a period of time. Part of understanding this process requires recognition of variances in the experiences of older adults whose permanent move to a care home was either planned or unplanned. A grounded theory approach, consistent with the work of Strauss and Corbin ([1990](https://onlinelibrary.wiley.com/doi/full/10.1111/opn.12052#opn12052-bib-0044), [1998](https://onlinelibrary.wiley.com/doi/full/10.1111/opn.12052#opn12052-bib-0045)), was therefore chosen as it facilitated the development of a new perspective on the phenomenon of entry to long-term care. Consistent with grounded theory methodology, the overall aim of this study was to explore individuals’ experiences of moving into a care home with a specific focus on the pre- placement (7 days) and immediate post-placement (within 3 days) period of the move to the care home.

*Data collection*

Semi‐structured interviews were utilised to collect data from 23 individuals who were due to move to a care home on a permanent basis between April 2017 and August 2018. As outlined in Table 1, most of the participants were female (n = 14). Semi‐structured interviews were utilised as they provided both focus and flexibility, consistent with Strauss and Corbin's grounded theory method. This approach also facilitated the process of constant comparison, a key cornerstone of grounded theory methodology. Purposive sampling was adopted in the initial phases of data collection, and thereafter, theoretical sampling was employed. The initial selection criteria stipulated that participation in the study was confined to individuals who 1) were due to move to a care home on a permanent basis; 2) were within one week of moving into the care home and 3) minimal or no cognitive impairment as defined by the Mini Mental State Examination (MMSE >24) (24 or over). A one week ‘cooling off period’ was given to participants after which time the researcher contacted them again to confirm their willingness to take part in the study and to arrange consent prior to undertaking first interview. However, accessing the sample within a week prior to the move proved to be problematic due to pressures on staff to free up hospital beds and fill care home places. This meant that once the funding was approved for the care home bed, individuals awaiting such beds, were often transferred within 2-3-days and in some cases, pre-admission assessments were being undertaken by care home staff on the morning of the older person’s admission to the care home. While this issue further highlighted the importance of exploring this particular time point in the transition to life in a care home, it became clear that we would not be able to recruit the numbers we required. We therefore revised our selection criteria to enable us to recruit individuals within one-week pre and post the move to the care home and obtained ethical approval to revise ‘cooling off period’ to one day after which time the researcher contacted them again to confirm their willingness to take part in the study and to arrange consent prior to undertaking interview. Of the 23 participants recruited to partake in the study six were interviewed in hospital, five at home and 12 within three days of admission to the care home. Of these 12 care home participants two had interviews on day one, seven on day two and three on day three, thus individuals were ‘very new’ to the care home environment’

Participants were recruited through social workers within older people’s community teams and by waiting lists held by care home managers within a large Health and Social Care Trust in the U.K. The Trust provides health and social care services to a population of approximately 300,000 people. The care homes (n=8) were registered with the Regulation and Quality Improvement Authority and were located within both rural and urban care facilities. Full ethical approval to conduct the study was granted by the University Research Ethical Committee, The Office of Research and Ethics Committee, Northern Ireland and by the Health and Social Care Trust where the study was carried out. The interviews occurred at a time and place convenient for participants and theoretical sampling continued until the emerging concepts and categories reached saturation.

*Data analysis*

Consistent with grounded theory methodology, data collection and analysis occurred simultaneously. Constant comparative analysis underpinned data analysis and data management techniques. Participants gave consent for the recording and transcribing of interviews. NVivo 12 qualitative data analysis programme software (QSR International, 2012) facilitated the organisation, management and retrieval of transcribed interviews and field notes and provided tools for coding, categorising and linking qualitative data (Bazeley, 2013). Two researchers reviewed all the data collected. Repeated ideas, concepts or elements became apparent, and were tagged with codes extracted from the data. Grouping of codes into concepts, and then into categories was undertaken after more data collection and review. As analysis progressed, coding moved towards being “selective”, focusing on those codes which related to emergent main categories. In the final stage of coding the process of identifying and choosing the central concept occurred by systematically connecting it to other categories and validating those similarities and relationships (Strauss & Corbin, 2008). The concept of ‘*You’re at their mercy’* ‘emerged from the final analysis. Using the framework recommended by Strauss and Corbin (1990, 1998), Table 2 shows how the paradigm model is developed to represent the findings that emerged from this study.

*Ensuring Rigour*

Various strategies were utilised to ensure the rigour of the study. The study was conducted with an awareness and application of the underlying principles of the authenticity criteria developed by Nolan et al (2003) and further developed in care homes research by Wilson and Clissett (2011). Equal access promoting accessible and comprehensive information to all participants about the nature of their involvement with the study was given. In the grounded theory approach, validity depends on theoretical sensitivity, which refers to the ability to give meaning to data and the capacity to understand; the sources of theoretical sensitivity (Strauss & Corbin, 1990). The initial interviews were recorded and checked to ensure the rigour of the data collection procedures. No formal member checking was performed within this study; however, the constant comparison of emerging data facilitated the verification of findings and minimised the likelihood of personal bias. As data collection proceeded and the basis of a theory began to emerge, it became necessary to theoretically sample older people in residential and rural care homes as interim findings would indicate something different about the experiences of older people in care homes within an urban environment. Strauss and Corbin (1998) have described theoretical sampling as a means to “maximise opportunities to discover variations among concepts and to densify categories in terms of their properties and dimensions” (p.201). Therefore, potential participants moving to these types of care homes were invited to take part in the study. Similarly, if individuals mentioned anything that was considered to be of interest, this was followed-up in subsequent interviews. The process of theoretical sampling continued until the emerging concepts and categories reached saturation. Repeatedly emerging concepts and categories were thought to have high levels of truth and value, while concepts and categories that were not verified by subsequent data were considered to be lacking in truth and consistency. During the open and axial coding stages, two members of the research team independently viewed the original uncoded manuscripts and confirmed themes thus ensuring that interpretations represented the experiences of the individuals. After the selective coding process, four members of the research team enhanced trustworthiness of the data by meeting to discuss the emerging themes and these themes were reviewed and revised as needed. Therefore, interpretations of the data were seen as credible, dependable and confirmable (Lincoln & Guba 1985).

*Profile of Participants*

The twenty-three participants in this study comprised of fourteen females and nine males with an average age of 82.4 years. Thirteen participants were admitted directly from hospital. Six of these individuals were female and seven were male. In comparison, eight female and two male participants were admitted to the care home directly from home. The majority of the individuals (n=14) were living alone at the time of admission (hospital/care home) while the remaining nine participants lived with spouse/family members. Of the nine that were living with spouse/family, five reported that community care services could no longer meet their needs.

The main reasons cited for prompting the relocation to a care home was deterioration in physical health (n=17), recent bereavement (n=3) and no-one to take care of me/changing family circumstances (n=3). Only four of the Individuals had made the decision to move to a care home, and of these four, only two were able to move to the care home of their choice.

1. **Findings**

This paper reports key findings pertaining to the experiences of older people at the pre- placement and immediate post-placement phase of the relocation to care home. Identified categories were 1): Inevitability of the Move ‘*I had to come here’*, 2) Making the Move ‘*Abrupt Departures’*, 3) Decision Making and Exercising Choice: ‘*What can I do, I have no choice’* 4) Maintaining Identity, ‘*Holding on to self’*, and 5) Maintaining Connections. ‘*I like my family to be near’*. The concept ‘*You’re at their Mercy’* links the identified five categories and encapsulates the experiences of the older people in the study who perceived a sense of disempowerment and being at the mercy of a health and social care system and professionals as well as their family throughout the admission process. Moreover, on arrival to the home they were at the mercy of others to maintain independence and connections to their own identity, sense of self, family and home.

**Insert Table 2**

*From Concepts to Categories:*

*Inevitability of the Move: ‘I had to come here’*

The admission to a care home was a unique experience. For a minority, it was a planned process with active participation and for others it was challenging and complex. Health care professionals, especially GPs, social workers, hospital staff and care home managers, were frequently described by individuals as very influential in the decision-making process. Moreover, the data conveyed a sense of the inevitability of the move.

Changes in health, social circumstances such as a carer becoming unwell or dying, and an increased vulnerability to living alone were predictors of the move to a care home.

***“Well to tell you the truth I wasn’t going to do another winter on my own at home.*** ***Well I said to Dr X that I wasn’t great, and he got me in here. I used to be able to walk anywhere 7 days a week do you know how much I can walk now …. about 10 minutes then I am done” (Francis)***

***“I had to come here as I have been on my own a long time since my husband died and I suppose finding things more difficult. My sister would be worried about me you see, her and my daughter. They convinced me that maybe a residential home would be a good place for me as I could come and go as I please” (Philomena)***

The move took on a sense of inevitability as care and “hands on support” needs increased in tandem with decreasing health and physical capabilities.

***“Well I had a bad fall a few months ago and I wasn’t really myself after that. I lost my confidence and of course they worried away about me and wanted to make sure nothing happened to me. You know you can’t do this on your own. You have to have help. So that’s where I am” (Tracey)***

***“So, I knew then after this fall that I would not be able to go back again. You know with the stairs and all and different things like that. I think that it was a good decision that I made you know” (Kevin).***

The circumstances surrounding an individual’s admission to a care home were rarely ideal. The person may have had several previous hospital visits, and perhaps a more recent deterioration in their health that left them unable to care for themselves at home. When combined with little or no family support, a care home was seen as the only choice.

***“I have really bad arthritis now and I would have bother getting about you know on my own with no family. You feel as you get older everything starts to fail…it gets worse” (Jane)***

***“Well I had sicknesses, two operations on my hip, and that's why I can't walk very well, and I had this thing with falling. They came and took me to Hospital and that was it no more going home for me on my own the social worker said, I am here now” (Ellen)***

 *‘Making the Move: ‘Abrupt Departures’*

Many individuals in the study reported that the move to the care home was often a rushed and a hasty affair regardless if it was from the hospital or their own home.

***“Well the same day the nurse in the hospital told me I was not going home the carers from the home came and got me from the hospital and took me here” (James)***

***“I came from home as an emergency the day my wife took sick, she had a stroke and died in hospital. I had to come here. I had no choice about coming here and the social worker said that staying on my own was not an option………. I was put in a taxi with no shoes on my feet and brought here” (Charles)***

Many individuals in the study spoke about how care managers/hospital staff are the key people making the decisions about moving to care home, often very quickly once they received confirmation of bed availability.

***‘When the bed becomes available well that’s it, apparently you have to grab it. The sad thing for me about moving to the care home tomorrow is that I'm walking in a dead man’s shoes!’(David)***

***“So really you are at the mercy of other people and the health care system, aren’t you?” (Sean)***

During the recruitment process the researchers took cognisance of care managers who reported that once financial funding became available for a care home placement, the transfer of older people to a care home very quickly thereafter. This had repercussions for undertaking the first interview prior too admission to the care home. The following theoretical memo offers insight into the experiences of care home managers.

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| --- |
| 24.04.17Care home managers have reported that on frequent occasions they were asked to undertake a patient care assessment in the morning and due to the pressures of freeing up hospital beds were asked to accommodate having the older person move to the care home that very evening. This left managers feeling pressurised and frustrated that individuals were not getting time to prepare for the relocation to a care home.  |

*Decision Making and Exercising Choice*: ‘*What can I do, I have no choice’*

The data conveyed that only three individuals had been able to exercise some choice in the care home they moved to:

David explained that *“I chose this nursing home for my wife. She is here, and I liked what I saw”.*

Tracey related “*I got a social worker through the G.P. They ask you what you think of all the different ones you know. So, you tell them what you think and that’s it. I just looked at two homes that was the choice. I think it’s very good here*”, and

Therese stated “*Well I wanted to come here as I was here a few years ago for a couple of weeks when I had surgery (pause)…. but it was good then, I liked it, but it is not the same now*”.

For some individuals there was no offer or choice to stay at home with increased support. Personal control and level of engagement in decision making processes appear to have been guided by healthcare staff and family.

***“I didn’t really have a say in where I would go, it was the social worker talking to my family, they arranged it all (Ann)***

***“The doctor said I needed to come in here. What can I do, I have no choice? I couldn’t go home unless I was able to go home, like if I was fit or had proper care at home” (Therese)***

***“My brother had left instructions that I was to be looked after…. but it didn’t work out like that…… How would you like to be put in a home against your will?” (Sophie)***

 ***“Well the family arranged all this…. not my choice “(Martina)***

The small ‘window of opportunity’ to obtain a care home ‘bed’ when one became available, further restricted choice. Individuals conveyed an understanding of having to “*take the next one available*”.

***“My niece was responsible for me coming here, that’s the way it was, the pressure was put on her to get me a home quickly so that is why I am here. All these places are all filled up you see”. (Hugh)***

For individuals that were receiving care in acute hospital services, there were additional pressures to ‘move on’ and ‘free up beds’.

***“I didn’t know about this place at all. In the hospital they were looking to get the bed released and we had to start looking for a care home, but they were all filled up. The pressure was put on us you see so under the circumstances I had to come here and take the first place that came up” (Jane).***

***“You don’t have much choice, most of them are full, that's the problem, and this was the only one I could get.*** ***I never heard of it and I never got to see it. I wanted to live in sheltered housing” (Ellen).***

Another factor that appeared to influence the choice of care home was ‘age’. After admission to hospital for an extended period following the development of sepsis and paralysis, Sean needed 24-hour care upon transfer to the care home. In Sean’s locality, there was only one care home that accommodated residents under the age of 65 years.

***“I came here because there was nowhere for me to go. This is the only home that takes people like me under 65 in this area. I had no choice*** ***I couldn’t comprehend any of this, on me and on my family and it took a while for us to get used to what had happened. I’m still not 100% about coming here. (Sean)***

*Maintaining identity: ‘Holding on to self’*

The importance of maintaining continuity between past and present roles and relationships was seen as an important element of future adaptation to life within a care home, encouraging the individual’s self-esteem and personal identity. A major challenge associated with the transition into a care home was the perceived loss of the individual's home life, therefore threatening identity, belonging and sense of self.

***“I wouldn’t feel like myself here. The farm is my life so that is where I want to be every day. You never retire being a farmer you know it is in your blood ……. a way of living” (Joseph)***

Another individual spoke about her feelings of sadness at moving into a care home but worried about expressing this anxiety about the move to others.

***“It’s a very sad time for me just now you know. But I mean other people are just getting on with it…. people don’t talk about their own bothers…. they help everybody else instead. So, I don’t know whether I’m right or wrong staying quiet” (Tracey)***

Despite the unsettling nature and anxiety provoking contexts of getting to know residents and staff, efforts were utilised to project self-agency and resilience.

***“The future……you don’t have much choice being in here but I’m holding on, I’m trying to fit in” (Andrew)***

***“Look love I am here now, I’ve arrived. There is no going back home. I have to put up with it so there is no point in me talking about it anymore. I just need to get on with it now”. I don’t want to talk about it” (Martina)***

The importance of supporting independence for sense of identity was emphasised. There was frustration expressed that care home staff were preventing them from doing the things they wanted to or were taking their independence away by doing things for them that they were able to manage themselves.

***“I’m trying to get my power assisted wheelchair here, so I can get about myself. This is not a big thing…but once they hoist you into that chair, you’re at their mercy for them to take you somewhere” (Sean)***

***I am not angry I am just annoyed that they can’t get it right. The hospital told them that I needed to have physio to get me walking more and nothing has happened since I have arrived…. apparently, it all takes time to organise…. Not much good if you have had a stroke and you have to keep moving……they don’t tell me what to expect or what is happening (Andrew).***

On arrival at the care home, some individuals felt that they were incorrectly placed in their particular care home. For these individuals the care home environment and care provided were perceived as not meeting their needs. For one individual, this sense of mismatch, prompted her to discuss other options with the social worker. In her case, this action prompted a rapid move from the nursing home, to a residential home.

***“I couldn’t sit in a big room with a whole lot of people looking at TV all day and no-one talking. I didn’t want to be like that or turn into something that I wasn’t. And even in that big room the poor souls would all fall asleep. And I thought you know I’m just not suited to this at all. Restriction, it’s a big thing isn’t it? When I came around to saying to the social worker that the home wasn’t for me, she agreed this residential home was more suitable and here I am” (Ann)***

*Maintaining Connections: ‘I like my family to be near’*

Individuals talked about the positive contribution family visits and old friendships would make towards maintaining a sense of connectedness between their past life at home and life in a care home.

***“My family come in and that makes a difference” (Joseph)***

***“There’s not much to look forward to now I’m here. I mean I look forward to seeing people belonging to me coming in” (Isobel)***

***“I'm too old to be thinking of things. I know that I like peace and I like my family to be near” (Jane)***

It was important for individuals to maintain their role as father, mother, sister and brother. One individual Andrew had a schedule of family visits lined up from children who were living in other countries.

***“My children are all away. They have made a pact that one of them will come over every month to see me for a few days. My son is coming this week” (Andrew)***

Although some participants had just moved to the care home, they reported being dependent upon care home staff and family to get outdoors and maintain continuity with home and the community. Getting a care home near to home was important in maintaining a sense of well-being. If participants were able to continue corresponding with friends and families it gave them a sense of control and enabled them to maintain the relationships. One individual spoke about her “delight” at getting a care home placement which was near to her family and one where she had previously visited friends and had undertaken some social and recreational activities with them and where she felt “at home”.

***“When I came here, they were all throwing their arms round me here because they all knew me from visiting other residents, so I felt so welcome.*** ***I hope to be going out with my cousin to Mass fairly soon when the weather improves. She wants to take me up home afterwards and it would be nice to go you see I will miss that every week now.” (Ann)***

1. **Discussion**

This study set out to explore older peoples’ experiences of the pre-move or immediate post-move transition to a care home. Nine males and fourteen females aged between 60 and 94 years were interviewed at their respective home, hospital environment or within three days of arrival at the care home. Given the paucity of research concerning such a transition (e.g. Armstrong, Hamilton & Shenkin,2014; Davies & Nolan, 2006; Sussman & Dupuis, 2012), the aim was to gain insights into the nature of the relocation and to discover more about the experiences of older people before and immediately after the move to a care home.

Five distinct categories captured the experience of the pre-placement and immediate post-placement period: Inevitability of the Move, Making the Move, Decision Making and Exercising Choice, Maintaining Identity, and Maintaining Connections. The concept ‘*You’re at their mercy’* encapsulates the experiences of the older people within the study. Participants perceived that the move to a care home was out of their control*;* they felt *‘at the mercy’* of others in the decision-making process. Being at the mercy of someone is defined by the Cambridge Dictionary (2019) as *‘to be in a situation where someone or something has complete power over you’*. The older people in this study appeared to see themselves as being powerless as a result of others, for example, family members, social workers, community care managers and care home staff, making decisions on their behalf. Closely linked to their feelings of being at the mercy of others was the strong sense of disempowerment that permeated the experiences of most of the older people in this study. In the absence of any opportunity or encouragement to have their voice and choice heard, they appeared to display a resigned acceptance to their fate. These findings concur with international literature that reports moving to a care home as being a traumatic and life-changing experience for older people. Often the importance of moving to a care home is not recognised or supported by formal services (Brownie & Horstmanshof 2012; Cooney, 2011; Thein et al., 2011). Moreover, international studies show that poor communication and a lack of voice, choice and control can adversely affected transition experiences (Dossa et al,2012; Fuji et al,2012; Hanratty et al, 2012; Toles et al,2012).

*Management of the Move*

It is evident from the literature that a more successful transition or adjustment to a care home is associated with a planned admission rather than unplanned admission. (Gilbert, Amella, Edlund & Nemeth, 2015; Walker and McNamara, 2013). In terms of choice, collaboration, or the actual move itself, there was little or no pre-planning. Neither was there a planned process of admission in which individuals were an active participant. Such was the extent of unpreparedness, Charles reported being ‘put in a taxi ‘unaccompanied late at night, whilst his wife who was his main carer, was under transfer to hospital as an emergency, (she died shortly afterwards). For many individuals, there was little opportunity to plan or consider which possessions they could be taking into the home. As a result, personal belongings were brought in by family/ friends /neighbours or indeed from social workers under the instruction of the individual either from a hospital bed or within the first few days of arrival to the care home. In the case of Charles, he had no opportunity) to bring “clothes, money and a few bits and pieces of sentimental value”. In adapting to new surroundings, the importance of bringing a sense of home and possessions to the care home environment is highlighted, as leaving behind the previous home and possessions can have a significant psychological and emotional impact (Marshall and McKenzie, 2008; Cooney, 2012; Falk, Wijk, Persson & Falk, 2013). This lack of involvement in decision making was borne out of a service driven necessity ‘to free up hospital beds’, placing individuals irrespective if they were at home or in hospital in ‘the next available’ care home bed no matter where the location. Both Ellen and Philomena identified a wish to move to sheltered housing accommodation but were placed into a nursing home, and Ann requested to be moved from nursing to residential care as ‘*I wasn’t that ill’*. Due in part to the ‘urgent nature’ of the moves and lack of preparation and planning, those participants interviewed within three days of arrival to care home reported comparable responses to those participants interviewed in hospital or in their own home. Relinquishing control and not being involved in the decision-making process leads to feelings of fear and anxiety, while having greater involvement could have helped to ease the negative feelings surrounding the move (Nwe et al., 2011; Sury et al., 2013). The management of the move is contrary to the recommendations of Sussman & Dupuis (2014), who highlighted the ideal stages of planned admission to a care home environment as: the decision to move, pre-move preparation and moving day circumstances. In this study, the expeditiousness of admission is driven by several factors including, changes in health, social circumstances and increased vulnerability to living alone. The reasons for moving into a care home were challenging and complex and indeed often fraught with difficulties, not least because of the lack of involvement in decision making about care home entry and individual care home placement or location.

*Decision Making and Autonomy*

While it is recognised that decisions about long-term care should not have to be made by people in crisis (National Institute for Health and Care Excellence, 2015), (NICE). The findings suggest that lack of participation in decision making and choice about the move created a negative experience for some individuals causing emotional disturbance and personal loss, and these findings are acknowledged internationally (Fraher & Coffey 2011 (Ireland); Johnson et al., 2010 (USA); Lee et al., 2013 (UK) & Zamanzadeh, Rahmani, Pakpour, Chenoweth & Mohammadi, 2016 (Iran)). Imposing an unplanned or emergency admission left individuals feeling “lost” and isolated leading them to feel anxious and uncertain as they entered a new environment (Koopitz et al., 2017).

Notwithstanding the complexity of care home admissions, this study has found that for some individuals an increased sense of self was evident if they initiated the decision to move on their own terms. While there were those who felt that the decision to move to a care home was out of their control or made on their behalf, a few individuals did acknowledge the realisation that perhaps the move was necessary and again this is endorsed previously within the literature (Graneheim et al., 2014 & Nwe et al., 2011). There is evidence to suggest that a person will perceive their relocation more positively when introduced to a care home prior to the move (Sury et al., 2013; Graneheim et al., 2014; Sussman & Dupuis, 2014). This is supported by Ryan and McKenna (2013) who found that ‘familiarity’ emerged as the core category influencing rural family carers experience of the nursing home placement of an older relative.

International research literature (Cooney, 2011; Thein et al., 2011 Brownie & Horstmanshof 2012, McKenna & Staniforth, 2017) shows the importance to older people of retaining autonomy in their lives and of feeling valued and purposeful. Our study has uncovered the lack of autonomy that older people experience pre- and post-relocating to a care home. A human rights approach to decision making would respect older people’s autonomy by genuinely involving them in defining their own care needs. The world Health Organisation advocate that international health systems should be organized around older people’s needs and preferences, designed to enhance older peoples’ intrinsic capacity, and integrated across settings and care providers (WHO, 2015). Commissioning bodies have significant scope to influence the way care services are organised and delivered and can stipulate specific practice and outcomes aimed at protecting and promoting human rights. Nursing and health care staff must follow policy directives, guidelines and recommendations for best practice in relation to respecting autonomy and choice for older people. By implementing a human rights-based approach health care professional can empower older people to know and claim their health and social care rights, therefore increasing the accountability of individuals and institutions responsible for respecting, protecting and fulfilling the rights of older people. These core elements of advocacy underpin person-centred approaches to care (McCormack & McCance 2017; Phelan et al., 2017). From an educational perspective, the findings suggest the need for nurse educators to equip future nurses and health care professionals with the knowledge, skills and attitudes to work in partnership with older people, promoting autonomy and choice and challenging systems and approaches that are system focussed, ageist and disempowering to older people.

*Ageism and stereotypical views of older people:*

Despite the growing numbers of people who present with complex health and social care needs, internationally, health care systems continue to deliver care that is medically orientated (Kuluski, Ho, Hans & Nelson, 2017). A service-led approach to health and social care has meant that individuals are expected to fit in with the services provided. The findings from this study clearly show that there was a lack of autonomy for many individuals in their decision to move to a care home, nor in having a choice of the care home. This study is unique because the data is collected in the pre-relocation time period, or the early post relocation phase. The authors have not identified any previous studies on transition to care homes that have collected qualitative data that explored experiences and perspectives of older people at this important tight time frame. Globally, moving home is known to be a major stressor in the lives of adults (Cheek et al., 2007; Brandburg et al., 2013; Ellis 2010; Ryan & McKenna, 2015), and even more so, when people’s views and perspectives are not informing the change (Thein et al., 2011; Brownie et al., 2014). Disregard for people’s views and opinions can predicate towards maladaptation to new social circumstances (Bradshaw et al., 2012; Brownie et al., 2014; Krizaj et al., 2016).

It is very disconcerting to find that in the 21st century most older people within this study had such negative experiences of making the move to a care home. These findings indicate a health care system that cannot cope with meeting individual acute health care needs causing disempowerment and depersonalisation of the older person through system pressures. Moreover, this finding may also identify an ageist attitude towards older people who felt ‘left out’ of the decision-making process thus minimalizing the most significant move in that persons’ life. Ageism is accepted as an inevitable outcome of growing old, and stereotypical views of older people being dependent and incompetent reinforce healthcare professionals’ acceptance and internalisation of negative attitudes towards old age (Swift et al, 2017). Several research studies have focused on attitudes toward older adults among health care providers including Liu, Norman & While (2015), who identified negative, neutral and positive attitudes toward ageing among nurses’ evaluations of older adults. Moreover, it is related that ageism is embedded in the professional culture of nurses in the form of a preference for working with younger patients (Kagan and Melendez Torres, 2015) and this needs to change. In 2016, the World Health Organization adopted the first global strategy and plan of action on ageing and health. The program mandates changes in societal attitudes, more accessible environments, and changes to health care systems that align with the needs of older people.

*Planning for the future:*

Although global policy asserts that care provision should enable self-expression and identity, the ability to make choices, and to maintain connections with social networks (World Health Organisation, 2015) this study’s findings would not support this global directive. Providing care for an ageing population is, an ongoing challenge for healthcare systems around the world. This study adds to the body of evidence available which highlights a lack of service provision for older people undertaking this move representing a global political and health care failure to address older peoples’ social and health care needs during the transition process. The implications and recommendations emerging from the findings are important as they may help to inform and enlighten all those involved in the care of older people, families, social workers, community care workers and those in the caring professions. Firstly, while there is recognition that sometimes others *have* to make decisions about the care of older people particularly those in crisis, (NICE, 2015); the recommendations of Sussman & Dupuis (2014) are significant. Core to the process is planning, decision-making and careful consideration/explanation of the move itself. There is a clear need to involve or include those whose future it is, rather than excluding them to the point where they have little choice or no say.

Considering the implications, recommendations concerning the health and well-being of older people who for whatever reason need to be moved into residential care, include:

* Formulate a policy/model of transfer around decision-making, planning and moving to a care home with emphasis on the rights of individuals to autonomy and choice. Strive to involve prospective residents rather than exclude them.
* Develop a clear care home induction process to be instigated pre-move which should include a visit to proposed care home, moving day plan, welcome orientation to home, planned meeting with residents and staff, information on facilities, services, identified staff member to ‘ease transition’ by facilitating caring conversations and upholding links to the older person’s home and family.
* Support and empower older people to plan for the future when deciding on their own long-term care needs.
* Consider involving advocacy services who may positively facilitate the transition to a care home and help to maximise the quality of life and wellbeing of individuals.
* Future research should include the perspective of health care professionals involved in relocation of older people to care homes.
* Best practice policy directives on moving to a care home should include the development of auditable guidelines to include equal access to health and social care services post transition.
1. **Limitations**

This study was conducted in one geographical area in the UK and the authors acknowledge that this may have a bearing on the findings. Reliance on ‘gatekeepers’ for recruitment was a reality for this study and it may have been the case that this introduced an element of bias into the sample selection. It could also be argued that the study may have benefitted from interviews with other key stakeholders involved in the transition process (e.g. hospital staff, community care managers, care home staff and families) and this could form the basis of a future study in this field.

1. **Conclusion**

This study offers novel insight from the person's perspective on how they perceive moving into a care home to be at ‘the mercy’ of others: families, social workers, hospital nursing staff, community care managers and care home staff. People who are unwell and vulnerable are moving, as it were, into the unknown, a new environment, new surroundings, new people, new ways of doing things and a new form of care. In essence, the move to a care home involves complex changes and losses that can affect an individual’s well-being and identity.

Hospital nursing staff, community care managers and care home managers play a significant role in influencing the experiences of the individual and the transition experience, when older people first move to the care home. The importance of involving ‘the person’ in making the decision to move and having a choice of care home is vital and has a hugely significant impact on their experience of transition. Perceptions of choice may be one mechanism by which to maintain residents’ sense of autonomy and improve overall satisfaction with care received. Moreover, maintaining continuity between the persons past and present roles, providing opportunities to form new relationships with other residents and staff are also important factors which contribute to the person’s adaption process.

We recommend research from the perspective of health care professionals involved in the relocation of older people to care homes. Only with rigorous nursing research can we inform policy makers and service providers on how to meet older person’s physical, emotional and social needs prior to, during and following relocation to a care home.

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