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Making a “home” into a home: How design of aged-care homes impacts residents

Alethea Blackler [a,*], Claire Craig [b], Claire Brophy [a], Fatima Kamali [a]

[a] QUT Design Lab, Queensland University of Technology, Brisbane, Australia
[b] Lab for Living, Sheffield Hallam University, UK

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ABSTRACT

The move into residential aged care is a difficult transition for many people. The place may be called an aged-care or nursing “home”, but for many residents it does not feel like a home at all. This paper explores issues experienced by older people who are trying to make themselves at home in aged care. The authors present two studies examining residents’ perceptions of the aged-care environment. The findings suggest that residents experience significant challenges. Residents’ identities are influenced by their ability to keep treasured objects and personalise their rooms, and the design and accessibility of communal areas influences residents’ willingness to spend time in them. For many residents, their private spaces are more appealing than communal areas, resulting in extended time alone in their rooms. However, personal items have to be discarded due to space issues and/or private rooms can become cluttered with personal items and become difficult to use. The authors suggest that much can be done to improve the design of aged-care homes and enable residents to feel more at home. Of particular importance is providing ways for residents to personalise their living space and make it feel homelike.

Introduction

Much of an individual’s sense of self is invested in the places they live. Heliker and Scholler-Jaquish (2006) described the concept of home as related to a “sense of self-meaning and purpose” (p. 37) that cannot be separated from identity. Holmes and Rahe (1967) rated the act of moving house high on their scale of stressful life events. Moving into an aged-care home is no exception and has been conceptualised as one of the most difficult transitions of later life (Ekerdt, 2020; Kellett, 1999; Lee, Woo, & Mackenzie, 2002; Nay, 1995; Tobin & Lieberman, 1976).

This paper reports on two studies, one undertaken in Australia and the other in the United Kingdom (UK), both completed in 2016, examining the issues older people experience when trying to make themselves at home in aged care. The research considers how design influences the ability of older people to experience a sense of home within their new environment. It highlights the key role of design in promoting quality of life, particularly in supporting the transitions older people make when moving into the aged-care residential environment and trying to retain their sense of self.

Background

A growing need for aged-care homes

Globally, the population is ageing. The fastest growing demographic is individuals aged 65 and over. The number of people aged 80 and over is expected to triple by 2050, from 143 million in 2019 to over 420 million (United Nations, 2019). It is projected that the number of Australians aged 85 years and over will increase from 515,700 in 2018–19 (2.0% of the Australian population) to more than 1.5 million by 2058 (3.7% of the population) (Commonwealth of Australia, 2021). In England and Wales’ 2021 census, almost one fifth (18.6% or 11.1 million) of the population was aged 65 years and over, up from 16.4% (9.2 million) in 2011. The number of people aged 90 years and over (527,900 or 0.9%) has also increased since 2011 (429,017, 0.8%) (Office for National Statistics, 2022).

An increase in older cohorts leads to higher demand for care services. Although ageing in place is the current preferred policy in both countries, inevitably there are frail older people whose social and physical needs cannot be met by existing community services and, as a consequence, require the level of support offered by residential aged-care

* Corresponding author at: QUT Design Lab, Queensland University of Technology, GPO Box 2434, Brisbane QLD 400, Australia.
E-mail addresses: a.blackler@qut.edu.au (A. Blackler), C.Craig@shu.ac.uk (C. Craig), cj.brophy@qut.edu.au (C. Brophy), f.kamali@qut.edu.au (F. Kamali).

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environments.

Aged-care homes as contested spaces

Care homes (UK) or residential aged-care (Australia) can be defined as settings that “provide accommodation, together with nursing or personal care for [individuals who] are or have been ill, persons who have or who have had a mental disorder, persons who are disabled or infirm” (Department of Health, 2000, p. 3). This perspective places aged-care homes firmly in the health and social care realm, with the care home fulfilling the function previously performed by long-term hospital settings. This shift has not happened without criticism. Townsend (1957, 1962, 1965), for instance, argued that growth of residential aged care would contribute to “institutionalised ageism” and reinforce the view that older people are fragile and dependent. While Goffman (1961) did not specifically address the experiences of aged-care residents as part of his critique of “total institutions”, his work has become synonymous with a body of literature that emphasises the dehumanising effect of institutional processes and the marginalisation and mistreatment of older people within institutional settings (Barton, 1959; Illich, 1971; Robb, 1967).

It would appear that these problems continue to hound us. In late 2019, the Australian Royal Commission released its interim report on aged care. It was simply titled *Neglect*. The report argued that Australia’s aged-care system “… does not deliver uniformly safe and quality care for older people. It is unkind and uncaring towards them. In too many instances, it simply neglects them” (Commonwealth of Australia, 2019, p1). The report pointed to significant over-reliance on chemical restraint and a system that “minimises the voices of people receiving care and their loved ones” (Commonwealth of Australia, 2019, p. 2). The final Royal Commission report was released in 2021 and backed up the findings of the interim report (Commonwealth of Australia, 2021).

However, an alternative picture is presented by aged care providers. Froggatt (2001) noted that the concept of “being at home” was an important part of the culture and ideology of the aged-care homes she studied. Promotional literature and the prevalence of statements such as “… we’re opening up new lives ... our residents too can look forward to a new lease of life” (Froggatt, 2001, p. 323) clearly aimed to advance a notion of aged-care homes as homelike. The visual material produced by care homes reinforces this perspective, since, as businesses, it is in the interest of providers to present an image of a place where older people want to live (e.g. AR Care, 2020; Caring Homes, 2020; Carinity, 2020).

Most aged-care providers in Australia are owned by community, charity or religious organisations or ‘not-for-profits’, though many are run like a business. Others are privately owned organisations run as commercial businesses. There is also a smaller group of government and local government providers. There has been a shift towards consolidation of the aged care sector in the hands of a few large non-government operators. In 2009–10, there were two very large providers of residential care operating 16% of all places. By 2018–19, this had grown to 10 very large providers operating 39% of all places (Commonwealth of Australia, 2021). Meanwhile, in England, there are now very few council-run aged care homes, and private operators own and operate 84% of all aged care places, although only around 13% are large operators (Campbell, 2019).

Conceptualisations of the home-as-hospital (the “nursing” side of the nursing home) and the home-as-home (the home side of the nursing home) can conflict. Froggatt (2001) reflected on the home-as-home, noting that “this emphasis did not openly acknowledge the limited duration of the future and inevitability that the majority of residents would die in the care of the nursing home” (p. 323). This is underlined by Tuckett (2007) study and the comment made by one staff member: “we know that the only way these people are going to leave here 99.5% of the time is in a plastic bag ... they’re just waiting to go up to St. Peter” (Tuckett, 2007, p. 127). The ways that operators talk about and market care homes do not openly acknowledge that they are places to die, emphasising the “home” aspect so they are instead seen as places to live. This tends to downplay the enormity of the transition that resident have to make when they move in.

Froggatt (2001) and Tuckett (2007) were not alone in highlighting these tensions. Moss, Davies, and Brown-Wilson (2021), for instance, challenged the appropriateness of naming long-term care settings as “homes” as they do not have the long term security and autonomy of a real home, and instead suggested they be seen as communities Their concerns relate to how associations with “home” can raise older people’s expectations, leading to confusion anddisappointment. This is reflected in the findings of Gubrium (1997) classic ethnographic study, *Living and Dying at Murray Manor*.

Research undertaken by Nakrem, Vinsnes, Harkless, Paulsen, and Seim (2012) further highlighted the tensions and ambiguities that can exist as older people seek to make sense of living in a place that is called “home” but requires them to adapt to often-rigid institutional routines. An “identity crisis”, as described by Vladeck (1980), can arise as care homes try to balance their dual role of attending to the technical dimensions of care while ensuring they create a home-like environment (Gubrium, 1997; Steinhauser, 1998).

Personal possessions

For some decades, the literature has highlighted the importance of personal possessions in the aged-care environment. Belk initiated the concept of possessions as part of the “extended self” and mentioned that they help older people achieve a sense of continuity and preparation for death. Possessions are a way to store the memories and feelings that attach to a sense of the past (Belk, 1988). Personal possessions, particularly objects to which people have an emotional attachment, can help people maintain links between their past journey and who they are now, and can be used to help them achieve their desired identity (Ekerdt, 2020; Kleine, Kleine III, & Allen, 1995) .

Vlosky (1979) found that well-functioning adults report significant emotional attachment to special possessions. Sable (1995) and Schouten and McAlexander (1995) suggested that people can derive psychological security from objects and other non-human targets, including deities, media personalities, pets, places and objects. In addition, Fedorikhin, Park, and Thomson (2008) showed that objects and non-human targets can fulfil the roles of providing a safe haven and secure base traditionally thought to be filled only by other people. Related experimental research has shown that people seek security from objects, particularly when they perceive a lack of social support (Keefer, Landau, Rothschild, & Sullivan, 2012). This may make personal possessions and objects particularly pertinent in the aged-care context.

Research has suggested that personal possessions and objects are particularly important because they provide links to memories (Csikszentmihalyi & Rochberg-Halton, 1981; Savaş, 2004; Schifferstein & Zwartkruis-Pelgrim, 2008), connections to family and friends, and reflections of identity and social status. In a study of families across three generations, Csikszentmihalyi and Rochberg-Halton (1981) found a distinct pattern between individuals of different ages. While the favourite objects of children and younger participants were action-oriented and self-oriented, adults were attached to objects because of memories and contemplation-orientation reasons representing family. Rubinstein (1987) claimed that valued possessions have an important role in late adulthood and could help individuals to signify their personal identity. Many of the objects that people keep for the long term are those that relate to their spouse or other close family members (Rubinstein, 1987). Personal objects can help older adults feel grounded in their identity as they transition into aged care, including changes in social connectedness.

Holzapfel (1982) and Csikszentmihalyi and Rochberg-Halton (1981) explored the significance of people’s possessions, specifically in the context of moving into long-term care. They highlighted the challenges of downsizing and the difficult decisions that arise in relation to

choosing what to keep and what to discard. Marcoux (2001) conceptualised this as an existential process. The belongings are seen as an extension of self, so the act of selecting and disposing of items becomes a way of deconstructing and reconstructing identity. As self-identity changes, a person decides to keep certain possessions as symbols of life stories (Kleine et al., 1995). This process helps individuals to distance themselves from past events. At some point in the predisposal stage, individuals slowly separate themselves from the object. They then persuade themselves of a mismatch between their current self-identity and the owned object or confirm that it cannot satisfy their current needs or social position. As a result, they can justify disposal.

However, Marcoux (2001) assumed that this process occurs in a systematic way before a move, with the individual investing time in the process. For people moving into aged care, this is not always the case. In fact, many people are transferred directly from hospital after a fall, illness, or injury. Many others are moved rapidly from their home following the illness, injury, or death of a spouse or other carer (International Longevity Centre, 2012). Even when older people do get the opportunity to do their own “decluttering”, the research relating to older people letting go of possessions to move into aged care does not show a trend of relief and lightness as the current decluttering movement claims. In fact, it is possible that the decluttering movement is inaccurate in its claims when applied to older adults. Li and Belk (2020) claimed that “The societal obsession with home order and organization is similar to our obsession with slim and well-kept bodies. A cluttered home is seen as synonymous with an overweight body. In both cases programmatic dietary restriction is promoted as one way to achieve societal ideals” (p. 988). Therefore, the decluttering movement may in fact be heaping yet more unachievable expectations upon people of all ages.

Holzapfel (1982) highlighted that, for aged-care residents, special possessions provide a link with their past and an opportunity for older owners to review and remember their life with pleasure. Tobin (1996) noted that older adults’ favourite possessions usually present their personal history through different stages of life. Possessions help them to preserve their unique identity, which has been shaped by their life’s events, and facilitate them in reviewing their lives (Kamptner, 1989). Several researchers have suggested that strong attachment with objects may develop over a long period (Kleine & Baker, 2004; Strahilevitz & Loewenstein, 1998). Schifferstein and Zwartkruis-Pelgrim (2008) found that, while the average degree of product attachment decreases after the first year of ownership, attachment is significantly higher for objects owned for longer than 20 years. Objects that are owned and used for a long time tend to have significantly increased attachment and emotions (Ball & Tasaki, 1992). It is also possible that women become more attached than men to possessions that are related to their past experiences (Dyl & Wapner, 1996) and reinforce their sense of identity through relations with their family and friends and their role in their household (Csikszentmihalyi & Rochberg-Halton, 1981; Kroger & Adair, 2008). Studies suggest that men favour possessions that have more emphasis on their personal identity (Dyl & Wapner, 1996), or objects that are action-oriented, like vehicles, equipment and tools (Csikszentmihalyi & Rochberg-Halton, 1981).

It is possible that attachments to personal possessions and objects can help individuals to adapt more easily to a new environment or situation. In a study about the role of cherished possessions and adaptation to the aged-care environment, Wapner, Demick, and Redondo (1990) noted that possessions help older people in five ways: (a) serving as comforters until they fit into the new environment, (b) providing a sense of control, (c) serving as an anchor point which helps a person to explore their new environment, (d) helping them to represent their identity to others and (e) preserving a sense of historical continuity.

In conclusion, the extant literature on personal possessions shows that older people have attachment to objects and that being able to retain special possessions may help them to maintain their sense of identity and to reflect on their lives and relationships while in aged-care. This may provide comfort and also enable them to use that secure base to form new relationships and continue to build or adjust their identity, especially in the absence of a spouse or other family member.

Methodology

This research examines the aged-care environment through two studies, one in Australia and one in the UK. Both studies explored the role of personal possessions and environmental design in relation to quality of life. Study 1 (Australia) focused mostly on chairs and seating, while Study 2 (UK) considered furniture and personal possessions more generally.

Study 1: Australia

Study 1 involved semi-structured interviews with aged-care residents, carers and therapists in four aged-care homes in Australia. The homes covered a range of price points – one at the higher end of the price range, two mid-priced and one at the lower end. The lower-priced one was a secure dementia care facility. Study 1 was designed to understand how residents and staff related to chairs in private rooms, lounge rooms, dining rooms, “breakout” spaces and multifunctional places used for concerts and other group activities. Participants were 19 aged care residents (6 male, 13 female), five staff members (3 Facility Managers, 1 Assistant in Nursing, 1 Clinical Manager) and two experts (1 Occupational Therapist, 1 Physiotherapist). The participants were representative of the gender balance of aged care residents in Australia, which is 65% female . The staff and experts were from five different organisations, with representatives from four aged care homes and one specialist service for independent living and assistive technology. For residents, inclusion criteria were that participants lived in the accommodation full time, were capable of giving informed consent and were recommended by staff who knew them. The researchers were not permitted by participating residential care organisations to approach potential participants directly. The research received ethical approval from the Queensland University of Technology Human Research Ethics committee and each organization involved. All participants signed a consent form and image-release form and received an AU$25 gift card in return for their participation.

The primary research method used in Study 1 was video-recorded, semi-structured interviews. This allowed for detailed analysis at a later date (Goodwin, 1994). In addition, still photos were taken by the researcher to show the context of the participants’ environments (some of which are included in this paper). Sometimes interviews took place in private rooms and other times in a more communal space, depending on preferences of the aged-care provider and the participants. During the interviews, participants (some alone, some in groups or pairs/couples) answered 10–15 questions about their experiences of chairs in aged care, with different questions for residents and staff.

The questions were initially designed to elicit information about chair comfort and utility and, therefore, related almost entirely to the physical aspects of chairs and sitting, for example: Are you happy with the height of the chairs you use - When you are sitting; When you are getting up and down; Do you use footrests; Which parts of the lounge chair do you find most/least comfortable; Are you happy with the comfort when you are sitting for a long time; If you fall asleep in the chair, does that cause pain or discomfort; What would be the highest number of hours you spend sitting in the same chair; Do you prefer a firm or soft lounge chair; What are the key grab points or hand supports you look for; If you could adjust the pressure in any part of the chair, which would you think most critical; If your chair could recline how far back would you prefer it to go?

However, some questions were more open, such as the following: What would be your ideal lounge chair; Do you have a favourite and least favourite chair; What kinds of things do you do whilst sitting in lounge chairs – i.e. activities such as reading, knitting, watching telly, playing games; Do you have any comments about other types of chairs?

Due to the open nature of some of the questions and the fact that we did not force participants to stay strictly on topic and instead let them talk as they chose about their environment, we found that people wanted to talk about their other possessions. We therefore collected a lot of data about other possessions, rooms and communal spaces as well as about attachment to chairs that we decided to analyse, as the importance of both chairs and other possessions goes far beyond their utility or comfort. We used Noldus Observer video data analysis software to interrogate the data. Our findings relating to the ergonomics of aged-care seating and its effect on residents have been published elsewhere (Blackler, Brophy, O'Reilly, & Chamorro-Koc, 2018). In this paper, we consider attachment to chairs and other possessions, the process of selecting what to keep when moving into care and how the design of chairs and other aspects of the home affected resident behaviour and quality of life.

Study 2: UK

Study 2 used photography to elicit the views of six older people living in three aged-care homes in the north of England. The research sought to identify facets of the environment that promoted engagement and enhanced quality of life. It used a photo-elicitation technique (Collier & Collier, 1986) to promote engagement, initiate conversation, stimulate memory and structure discussion. Photo-elicitation is effective in studies that include participants with complex needs and communication difficulties, including memory problems or difficulties with verbal expression (Levin et al., 2007). Miller and colleagues discuss this method (which they call "Photovoice") and its use in aged care, along with details of how they have used it (Donoghue, Miller, & Buys, 2017; Miller, Donoghue, Buys, & Holland-Batt, 2017).

Ethical approval for the study was obtained from Sheffield Hallam University ethics committee and the three care homes involved. Older people living in the care homes who expressed a wish to be included in the research consented to the study. They were given cameras and invited to take photographs that 1. captured their day-to-day life and 2. that they identified as being important. The photographs formed the basis of an interview with each person.

The interviews took place in the privacy of the individual's own room. Participants were invited to select and talk about each photograph in turn. The order of discussion was left to the participant. Two questions were used to prompt discussion: 1. Please tell me about the photograph, and 2. Can you tell me about why you chose to take this picture? The interviews were audio recorded and transcribed.

Thematic analysis

In Study 1, a lot of the data were coded for a range of behaviours and modifiers relating largely to comfort, safety and ergonomics of chairs, and these results were published elsewhere (Blackler, Brophy, O'Reilly, & Chamorro-Koc, 2018). During that process of coding, three further key themes related to attachment to chairs and other possessions were elicited from the data and used to create a new coding scheme (Table 1). This new coding schemewas then used for analysing Studies 1 and 2 and also to structure the reporting of results in the following sections.

Table 1
Coding scheme for Studies 1 and 2.

Theme	Sub-themes
Possessions and home-making	Emotional attachment to objects Using objects for home-making Clutter
Communal vs. private spaces	Impact of design of care environments on residents' use of different spaces Medicalisation of the home and objects within it
Access and accessibility	Getting to outside spaces Getting around within the home.

Results: Study 1

Study 1 revealed that residents were attached to their personal possessions and objects. They appreciated retaining their objects when they moved into a care home, in order to maintain and communicate their sense of identity. However, many residents had issues with clutter and storage space, which impacted the ways they could use their rooms. Residents tended not to use communal areas and often found outdoor spaces difficult to access. They may therefore have spent more time alone in their rooms than is necessary or healthy. In this section, we cite residents and care staff by the number assigned during data collection, but experts by their profession.

Possessions and home-making

The four aged-care homes involved in Study 1 acknowledged their effort to create a home-like atmosphere. Staff recognised the role of personal possessions in easing the transition into care, and said they encouraged residents to bring their own furniture where possible, particularly items such as bedding and chairs.

> *"I think that's the main thing ... the homely aspect of making it home, and that's part and parcel about why we promote being able to bring in items from home."(*Staff3).

> *"... I'd encourage them to bring in their own lounge chair, something that was familiar to them. I'd encourage them to bring in their own bed spread ... because if that's going to be your home, you want some of you there ..." (*Staff 6).

The literature suggests that the appropriateness of chairs for older people is heavily influenced by ergonomic measures (Blackler, Brophy, O'Reilly, & Chamorro-Koc, 2018). In this study, however, participants rated their own chairs highly, whether they were "appropriately" designed or not. Residents referred to "my chair" as in the following:

> *"Ohh ... my chair is not the best, it's my own [from home] it's like a wicker chair ... all these threaded through ... it's got a little cushion on it ... it's the hardest to sit on, it's so hard ... and I have little glass-top table to match it."* (Resident 17).

Residents' own chairs varied widely and all seemed to come with a story. The stories connected the residents to other people, to other personal items and to important experiences or occasions in their life. For one couple, a question about the furniture that was already provided in their room led to a conversation about the leafy suburb they had raised their family in and the chairs they had received as a wedding gift but had to leave behind:

> *" ... the big wing chairs ... we had them since we were married, my boss made them. He said you gotta have them lasting a lifetime. Well, that's true, it did, it did ... all our married life there. *Sigh* Oh, never mind ..."* (Resident 8).

> *"I don't even know where they are now ... whether we did the right or wrong thing I don't know ... but um ... I had records and books and ... they're all gone ... we just moved out of the house didn't we? Poor old R* had to [pack it up]. I don't know what he's done with lots of stuff. But! We had a clean break and I think that's the best thing we could have done."* (Resident 9).

While talking, Resident 9 looked at his wife, not at the researcher, as though he was trying to reassure her. For another resident, who was interviewed sitting in an office chair, his chair was an important conduit to the identity wrapped up in his life-long legal career: *"Well this is my [office] chair from when I was at the bar. I've kept it all these years ..."* (Resident 11).

The aged-care homes encouraged connection between residents and their possessions. Overall, we found that aged-care staff understood and implemented these model-of-care principles to some extent: *"… I think that's what they ultimately want, they want in-home-care. For these residents, this is their home …."* (Physiotherapist).

Participants who worked in the care homes understood the importance of personal possessions to the wellbeing of residents. However, everyday application could be difficult. In reality, care homes need to balance the desire for personal possessions, such as chairs, against the various risks the possessions pose. For example, deep vein thrombosis (DVT) risk can be an issue for older people who sit for long periods. While DVT risk can be alleviated with footrests, which are recommended for older people, in aged-care homes footrests are little used due to perceived falls risks, especially in common areas. Only one separate footrest was observed in use in a private room. For example,

"… they'd be a trip hazard for our residents" (Staff 6) and:

> *"only for residents that have their own recliner chairs, they have footrests, but not in the main facility areas. A lot of the time it can be more of a falls risk, they'll try and get out with the footrest up."* (Staff 5).

Risk considerations meant that personal chairs to be brought into care homes were all assessed by physiotherapists to ensure safety for both residents and staff. If the chair did not meet basic requirements, particularly related to sit-to-stand transfer, the chair would be removed:

> *"we encourage residents to bring in their own furniture, basically whatever it takes to make the room more comfortable for them; [the] more appealing and more home-like the better. As long as it's safe for the residents and safe for the staff. So, if a resident wants to bring in an arm chair from home ... we'll do an assessment with our physio on whether or not it's acceptable"* (Staff 1).

> *"... we never modify. If the physio feels that there is a risk element there, both for the staff who would be manual handling, and the resident themselves, through a fall risk or not being able to get up, or not being able to reach the call bell because the chair is too low ... those aspects we take into consideration. So it's not just the resident but maybe those who assist the resident as well."* (Staff 3).

Many residents had recliner chairs in their own rooms, which enabled them to raise their feet while sitting. However, we observed that chairs were frequently positioned against the wall or covered with belongings, making it difficult to take full advantage of them (Figs. 1 and 3). Residents often said they did not have enough space to properly recline their chairs:

> *"… my one, my chair in my room is [a recliner], but there's no space in my room [to recline it]… because I've got too much stuff in my room"* (Resident 4).

The small spaces dictated what furniture and other possessions residents had in their rooms (Fig. 2) and how they use the space and the furniture. We regularly observed chairs stacked full of items, such as books, activities and laundry (Figs. 1 and 3).

Often there was only room for some of the furniture residents would have preferred to bring:

> *"… I don't even have enough room on it because I've got it full of books … It was two chairs and the table ... I kept one chair. I sent the other one back"* (Resident 17).

For most residents, the solution to lack of space was "getting rid of stuff" and not "needing that here," rather than seeking more storage space. The concept of "stuff" depended on the context and the individual. Rather than "stuff" as clutter that should be given away, when seen from the resident's perspective "stuff" was tied to many things, including convenience, their daily activities, their past and their identity:

> *"They say to me, get away with the clutter and you'll have more room and you can do things better. And I say, 'no leave it, it's my clutter'… cause there's things I want and I can't do with getting up every five minutes … they're right there … Prayer books, my Bible … because I use them all day, daily … all the time. Because when things get too much I turn to them, they're my only sanity."* (Resident 17).

> *"... I've had that years ... y'know. Just things that you hate parting with. ... I have some dresses up there that I [wore] at my children's weddings you know?! ... and christenings. And they don't fit me now, but I don't want to give them away. Now, is that wrong?! ... it's just horrible. Because we don't have much left when we come into places like this so we [like] to … you know, keep such things."* (Resident 17).

Communal vs. private spaces

In the communal areas of aged-care homes, chairs were often high-back lounge chairs or a type of dining or café chair. In residents' private rooms, chairs ranged from occasional chairs provided by the care home to office chairs, recliners and other chairs brought in by the resident.

Communal areas varied depending on the style and cost bracket of

Fig. 1. Chair as storage.

Fig. 2. Storage of personal items in a private room.

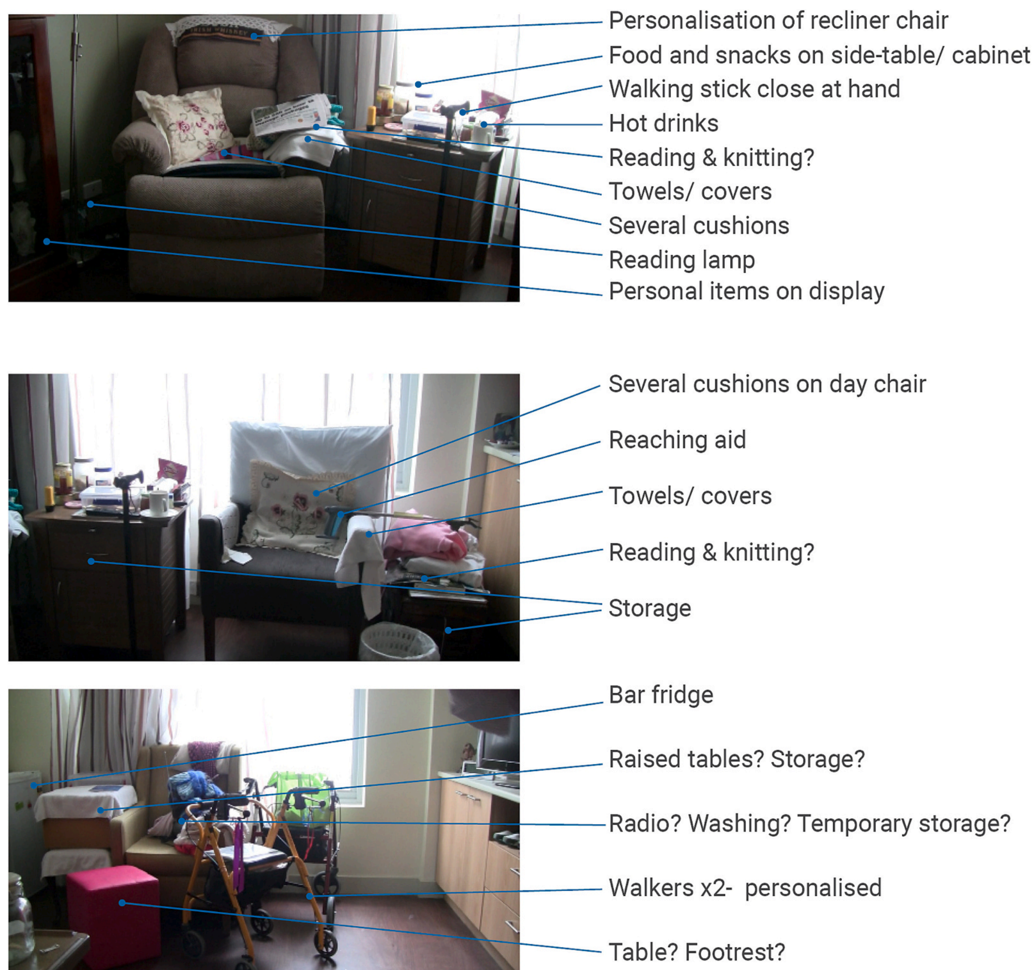

Fig. 3. Small private rooms filled with functional and personal items.

the care home. In a secure dementia care home (at the lower end of the cost continuum), communal areas were multi-purpose. The priority was a home-like appearance and cleanliness. The furniture was mobile and flexible. In higher- and mid-priced care homes, seating was relatively fixed and designed for a dedicated purpose (e.g. for the lounge room, cinema, café or activities areas). The higher- and mid-priced care homes had several communal spaces where maintaining a uniform appearance seemed to take priority. Seating was carefully lined up side-by-side, with a lot of space in front enabling residents to place wheelie walkers in front of their seats or manoeuvre past in their wheelchairs (Fig. 4). This arrangement was practical and tidy but served to leave the communal areas lacking in "life". They had an appearance like a club or hotel, rather than a home. This suggests tensions in balancing the needs of residents with the needs of the care home: "*We're a club site so, having uniform chairs, this sort of height ... so as you can see, same height same structure the whole way round*" (Staff 3).

Participants often said they only used communal areas for scheduled activities or events, such as daily exercise programs or weekly concerts. In the higher-priced care home, the communal areas were generally empty during our visits and appeared only to be used for scheduled events and activities:

> *"Do you spend much time in the common areas?"* (Researcher).

Fig. 4. Carefully lined up chairs in a communal area.

"Not very much, no, no I don't go down there ... if there's something on I'll go."(Resident 14).

In the mid-priced care home, there was more activity in the "recreation hall", with the television on most of the time and residents coming and going frequently. This activity increased in the lead-up to a concert and decreased substantially afterwards. When residents wanted to relax, they would return to their rooms, where they may spend several hours a day sitting or lying in a chair or on a bed. We observed participants resting on the beds in their rooms during the day:

"I really don't use the chairs in the common areas." (Resident 11).

"What kind of chair would you sit in when you're watching telly then?" (Researcher).

"Oh, I'd probably lie down." (Resident 11).

In the higher- and mid-priced care homes, residents were observed spending time with friends or family members in their rooms or in the publicly accessible café located within the reception area. In contrast, the secure dementia care home had substantially more activity in the communal area and passageways. Some residents suggested it was physical limitations that stopped them coming to the communal areas:

"… I don't come down [to the lounge room] very often now. I used to … I've lost a part … of the things I used to do a couple of years ago. I'm trying to get back into what I was used to doing …." (Resident 7).

For some participants, cleanliness was a major deterrent to spending time in the communal areas. This is a significant challenge for aged-care homes: *"The biggest thing for all furniture in aged care is basically keeping it clean and being stain resistant"* (Staff 1).

Residents did not want to sit in seats they perceived as dirty and smelly due to the incontinence of other residents. Some had strategies in place for choosing which chair they would use in those areas:

"... they're not very nice, and they're very dirty. And they do get fleas, and they get ants ... and you go back to your room and you always feel you're scratching ... And you've got some patients here that they bring down, and sometimes they have accidents in them ... they're always having accidents in them ... no they're not very pleasant to have to come and sit in." (Resident 17).

".... and all you have to do is smell it. And the ones that have material on them are all stained. They're never clean ... and I don't want to sit on that. I try to pick the same chair, I do, because it's the cleanest. I watch the people that sit in there ... and they look like they've had showers" (Resident 17).

Both residents and staff suggested that residents preferred to relax and spend time in their rooms, where they may spend several hours a day sitting or lying in a chair or on a bed: *"… if they want to rest they'll usually ask to go back to their rooms, or go back to their rooms and lie on the bed and elevate their legs"* (Staff 4). While there were clear attempts by staff to get residents involved in activities, such as crafts for festive events, residents expressed a sense of obligation to attend rather than a genuine interest in taking part:

"*Look if you really want these I'll do them [Christmas decorations], but if you don't, then don't just have me doing them to pass my time away because I could be doing other things …."* (Resident 17).

In fact whether related to creativity or activities of daily living, some residents expressed a loss of autonomy or control with all of the planning and organised activities: *"... things are planned out for me"* (Resident 7) and *"… we're not cooking for ourselves no more, we just gotta take what's given"* (Resident 6).

These findings suggest that residents were not making the best use of communal areas and that design issues within those areas resulted in them being alone in their rooms far more than necessary.

Access and accessibility

In the secure dementia care home, home-like characteristics extended beyond the style of furniture to include fabric choice and soft furnishings. The choices were designed to address the limitations experienced by people with dementia, the importance of personalities and past life in managing potential behavioural issues and allow residents some contact with the outside world. For example, *"… the curtains were floral because I wanted to bring the outside in because these people weren't mobile"* (Staff 6) and:

"… [in regards to behavioural issues from one resident] … she was a lady from the West… A Lady from the West. You know what they had in her bedroom? Abstract curtains. So I got the staff to go check what other curtains we had" (Staff 6).

When the resident was given curtains with a more nature-based pattern, she became calmer. Some care homes attempted to provide outdoor space, but the spaces were limited, lacking a meaningful connection and were often not easy to access or use:

"It was two chairs and the table. I used to have them out on a patio. I thought when I moved in here, I was gonna get a little verandah I could sit them on, but they won't fit out there, it's only a little tiny verandah. It isn't worth even getting out on to." (Resident 17).

"I miss my land … it was my parents' … we had the back half, it was nice and high. The lady next to us she sold her land just before we left…. Living next to people for a long time … I miss the grounds, my dad used to have gardens up there … I put a – well I call it a mini-forest – in … all trees, rainforest trees, 40 ft high … but anyhow…." (Resident 8).

Results: Study 2

Study 2 also revealed issues around attachment to possessions, loss of possessions on entry into care, accessibility within the "home", access to outside spaces and interpreting the purpose of and feeling comfortable in communal spaces.

Possessions and home-making

Objects were important to the six participants involved in Study 2. Emotional attachment to objects and the meanings of objects became a significant theme across the interviews. Objects often represented the only link individuals had to their previous lives. For instance, Jean photographed a cabinet (Fig. 5):

"I chose this picture, well because it is the only link I have to my life before. Everything else was sold to pay for me to come in here. I went into hospital, and they said 'we'd like you to visit a place where you'll be looked after, but you'll have to make your mind up quick'. I left hospital and came here and never saw my house again …. I sometimes wonder what happened to all my things …." (Jean).

At times, objects were symbolic reminders of facets of lives and relationships. For instance, Olive photographed two small ornaments of Westmorland terriers. When she described them, she became animated, moving between her memory of her pet and the ornament in front of her:

"… she's like her but hadn't got a tail because she had bit it off when she were little … they're like anchors, they give you a sense of who you are … these are grounding points … these dogs, my ornaments … these are the things that keep it ok."

Often the meaning of the objects was metaphorical. For instance, Marie took photographs of soft toys in her room – one photograph of two stuffed bears and a stuffed moose on her bed and another of a tiger

Fig. 5. A link to my life before.

sitting on the bedside table. She referred to these images as *My Family*:

> *"… this is my family: these are my children [pointing to the bears and moose] who I care for, and this is my heart, my courage [pointing to the tiger] watching over us, keeping guard at night."*

These soft toys were treasured objects that kept her grounded. They reminded her of good times but were also poignant in terms of what she missed.

Communal vs. private spaces

For participants, the physical layout of the aged-care home, the loss of their connectivity with family and their new location reinforced a loss of identity. The overwhelming experience described by participants was a sense of loneliness. The care home offered communal living, but individuals described how the disconnection they felt between themselves and other residents simply served to reinforce their feelings of isolation. In part, this was because of the varied needs experienced by individuals in the care setting. For example, for residents who had never met a person with dementia, the experience could be frightening. Joan described this in the following way:

> *"It's quite lonely really. Some of them can answer you, but a lot don't bother. It can be difficult ... we've a lady who tears up her pads, so we've been giving her newspaper to tear up instead ... and they don't always know what time it is ... they sit for hour and hour in that lounge with the blaring out of the television ... some of them have got dementia."*

As a consequence, some residents, like Olive, chose to isolate themselves, spending time in their rooms rather than sitting in the communal lounge:

> *"Mostly they watch television out there and talking and falling out and I think I can go up and watch my own television without all this going on because if it is anything interesting, you miss it because you can't hear it properly."*

The most significant issue that arose was the sense of being "betwixt place and space". For residents, the physical environment was confusing. Individuals struggled to navigate a place that was called "home" but resembled a hospital. For Olive, it was impossible to make sense of the design of the care home, which compounded her feelings of confusion. She reflected the views of other participants when she said:

> *"It's an unusual place in that it's a home but it's not a home. Sometimes I think it's a trick and it's just another hospital. I don't know what is happening. They don't tell you nothing … it's like a game where no-one tells you the rules, like finding your way through a labyrinth … I don't know, I don't know what it feels like. It doesn't feel like there's [any] warmth. I don't know. I can't explain it."*

Residents used different coping mechanisms to try to make sense of the environment, which was designed to look like a home but, in reality, presented as a hybrid space between hospital and home (see Fig. 6). Betty, for instance, separated out different parts of the home, deeming some as public and some private. She described the entrance and the reception area of the care home:

> *"Downstairs … it feels like you are going somewhere else. It's where we go for hairdressing, and they have staff meetings there. You know it's where staff go to those things like that."*

To others, the care home had qualities of both a prison and a hotel. This created tensions, and some residents resisted the notion that it could ever be a home. For instance, Ray described how not having photographs in his room was one of the ways he coped with being there. The act of putting photographs in the space would have been tantamount to accepting that the space was home, which to Ray, for example, it was not: "*Why would I have photographs here*?" he asked. "*It's not home is it*?"

Access and accessibility

Accessibility to outside space was a challenge for participants. While the care homes offered opportunities to engage in social activities, residents missed the freedom of being outdoors and being close to nature. Marie summed this up: *"You stop being able to feel … every day, everything here is the same. Every day warm, no cold, no rain."*

However, accessibility to outdoor spaces was not the only issue.

Fig. 6. Confused spaces: The communal sitting room doubled as a storage space, adding to confusion about what type of place the care home is.

Many of the residents were living with long-term neurological and musculoskeletal conditions, which significantly limited their mobility. The care home environments where the study was undertaken were all built over multiple floors. This posed significant challenges for residents, with access and accessibility a clear issue. Jean articulated this in the following way:

> *You see when you get into your 90s you … can't walk about anymore. I can stand up just a bit but I can't without that (points to frame) – it's old age you know, it wears you out."* Olive echoed these sentiments: *"… what I miss is being independent. Just being able to get where you want to …. I've got two new knee replacements and a hip replacement. The trouble is if I go down on the floor, I can't get up."*

For Ray, the physical limitations he faced as a result of a stroke were compounded by the design of the environment. He described frustration at not even being able to enter his own room without help. Health and safety regulations meant the door needed to close automatically, but the weight of the door meant he was unable to open it himself. On numerous occasions, he had been forced to sit in his wheelchair outside the door to his room, waiting for a staff member to open the door for him. The physical limitations resulting from Ray's stroke dominated much of his life. He frequently contrasted the freedom of his life prior to the stroke with the limitations he now experienced:

> *"When I was younger, I swam down the Suez Canal ... since the stroke, well that's finished. Even now this thing they put outside your door. To push the button to get in ... I can't do that so I take this [walking stick]. I have to use my walking stick to push the thing so I can get into my room. … Sometimes it'll work … most of the times it doesn't. So I've had to wait until someone comes past and I say 'can you open the door?'."*

Feelings of helplessness were the consequence of both the building's architectural features and the design of much of the care home's furniture. For instance, the height of tables in communal areas made it difficult to accommodate wheelchairs. Wardrobes and drawers in individuals' rooms were designed in a way that made it impossible for residents who used wheelchairs to access and choose their clothing independently. In the communal sitting room, chairs were positioned around the outside of the room (as also seen in Study 1, Fig. 4), making it difficult for individuals with hearing problems to interact with each other but allowing wheelchair and wheelie walker access.

Discussion

This paper brings together two separate studies completed at opposite sides of the world, yet their findings were remarkably similar. The two studies showed that personal possessions, environmental features, and furniture design impacted the ways individuals experience aged-care homes.

Personal possessions support the transition into aged care and influence the extent to which aged care becomes home. Our studies confirm the value of personal possessions and their use as mechanisms through which individuals feel anchored in the space and develop a sense of ownership or belonging (Holzapfel (1982) Kamptner, 1989). For participants, objects had multi-faceted layers of meaning that often transcended their original purpose and came to represent something quite different. For some, they appeared to be their major source of comfort.

The most striking finding of the studies was the magnitude of the upheaval experienced by participants and the multiple transitions they were attempting to navigate. Downsizing to move into an aged-care home was problematic, and many expressed regrets about the possessions they had lost. Previous studies have also described the challenges facing individuals as they adapt to life in aged care (Davies & Nolan, 2003; Reuss, Dupuis, & Whitfield, 2005; Sussman & Dupuis, 2014).

The studies revealed that participants' negotiation of the new physical space occurred as they were simultaneously adapting to and managing a range of physical changes and life events that had, in some way, precipitated the decision to move. Potential support networks provided by family and friends were, for reasons of geography, often compromised, and existing routines were disrupted or subsumed by the rhythm of the aged-care home. As a consequence, the move into aged care represented a significant threat to identity, suggesting they represent what Goffman (1961) would call a "total institution". Participants' questions about the nature of the care home and the meaning of the space they now inhabited were linked to a more fundamental question of *who they were* within this space. The sense of being "betwixt and between" related as much to participants' understanding of self as it did to the aged-care environment. The ability to keep special possessions may help residents to maintain or build their identity (Gulerce, 1991; Kleine et al., 1995), as revealed by Olive's dogs (Study 2) or the barrister's chair (Study 1). In many cases, though, keeping larger special possessions, such as chairs, was not possible due to space constraints. And other possessions often resulted in clutter and trip hazards within private rooms as shown in Study 1.

Participants spent a lot of time in their own rooms, retreating from common areas. They discussed reasons for this, including an inability to relate to other residents (whether due to hearing difficulties, the placement of seating or cognitive issues such as dementia), the need to elevate their legs, perceptions that the chairs in communal areas were dirty and a lack of choice and flexibility in seating in communal areas.

Both studies revealed that participants felt more relaxed, comfortable and "at home" in their own rooms. In their rooms, residents felt able to make decisions on how to spend their time and, to some extent, how they arranged their possessions. In contrast, the design of communal areas did not support autonomy and did not encourage residents to spend time there. This, in turn, limited residents' social and physical interactions, leading to hours spent needlessly in or on the bed rather than interacting and being active. "Home", in these cases, seems to mean often being alone in a tiny room and unnecessarily in bed.

Spending so much time in their small rooms can make people more isolated and less mobile, especially if they are lying in or on the bed due to clutter on their chairs or an inability to recline chairs in the small space. Most were also unable to access the outdoors directly from their rooms. Mobility is closely linked with people's health and their quality of life, and models of care (e.g. NHS England, 2017) posit that residents should remain as active as possible. However, the Aged Care Royal Commission "heard numerous examples of aged care providers not supporting people to maintain and improve their mobility. Poor mobility increases the risk of falls and fall-related injuries due to deconditioning and reduced muscle strength" (Commonwealth of Australia, 2021, p. 70). Our studies suggest that residents spend time in their rooms and due to the design issues of communal areas, and on their beds due to the design of the rooms, leading to relatively well individuals spending a large part of each day lying in or on the bed, which will not support their mobility.

The potential of design reaches far beyond its ability to provide older people with physical access to and around the building. As these studies show, design can act as both an enabler and a barrier to developing and maintaining relationships with others, to engaging in valued activities, to staying active and independent and to building a sense of self at a time when identity is most under threat. Older people participating in the studies did not regard the physical environment of the care home as their "home". Based on Gifford (2007) definition of home, this is not surprising: "A house is not a home. A house ... is a physical structure. Home is the rich set of evolving cultural, demographic and psychological meanings we attach to that physical structure" (p. 194).

Current design practice of residential care homes in the UK (Study 2) emphasises the need to incorporate generic features into the environment that seek to convey feelings of home (e.g. fire-places and décor emulating living room furniture). However, as this study highlights, these very elements that seek to offer support can add to the confusion a

person experiences as they seek to navigate the multiple transitions of moving to a care home.

Generic features intended to convey a meaning of "home" are also apparent in Australia (Study 1) but can be quite different. Instead of aiming for a traditional "homelike" aesthetic, care homes work to maintain a particular design aesthetic that offers the desired "look" for various market segments. This often leads to aged care homes appearing like hotels or clubs. However, this study suggests that the aesthetic may come at the expense of personality and a feeling of being at home in both the public and private spaces. This "club" look may appeal to families and even potential residents when they are making decisions on where to live, but it can be rigid and preclude residents from making efforts to feel at home (at least in communal areas).

There is no obvious reason why residents should not be encouraged to display or use their own possessions in communal areas. Chairs, pictures, photos, ornaments, etc. belonging to residents could replace the bland and standardised decoration that make shared spaces look so hotel-like and make them more welcoming for residents, as well as providing opportunities for them to share their stories. However, this would be antithetical to the "brand" that some aged-care providers are trying to build for the purpose of selling their services by presenting a smart but soulless club- or hotel-like environment (Blackler, Brophy, O'Reilly, & Chamorro-Koc, 2018). Providers should prioritise the needs of their own existing residents, how to support them in feeling at home, over the perceived preferences of the families of potential future residents. Indeed, the Royal Commission final report highlights that there is a need for more homelike settings and suggests a focus on a small household model of care (Commonwealth of Australia, 2021).

Limitations

These studies both contained fairly small samples that were feasibility driven, and a more comprehensive study that was constructed specifically to include a representative range of aged-care residents would be ideal to confirm and extend these findings.

The two studies used somewhat different methods, although both were interview-based. Study 1 focussed on discussing chairs and other objects, which were in the room where the interview took place or in the participants' private room or even in their memories. Study 2 used photovoice to elicit ideas for discussion during the interviews. The strength of this paper is that, despite these differences in methods and in cultural backgrounds and life experiences, the findings were so similar. This indicates that these issues could be widespread.

The focus on chairs in Study 1 is a limitation, as we did not ask people directly about other types of possessions. However, the fact that they spontaneously discussed all sorts of possessions without being asked indicates the importance of treasured possessions to people and the issues they face in attempting to fit the richness of their whole lives into a small room.

Both studies were based on self-report, and no rules were set about what types of possessions were eligible for discussion. This means that there is little direct comparison between types of possessions (apart from chairs to some extent), but what people choose to discuss tell us something about what was most pertinent to them.

Recommendations and further work

Care homes are contested spaces that seek to fulfil the dual roles of hospital and home. Rather than contributing to the blurring of these boundaries, design must continue to highlight and grapple with the complexity and the challenges these spaces present. It must respect residents and seek to increase rather than erode their autonomy, while enabling them both to move freely around the space and feel comfortable in their own home environment. Poorly designed or maintained features, such as doors that do not allow easy access to resident's own rooms and clutter-filled living spaces, should be urgently addressed.

The two studies discussed in this paper reveal opportunities for improvement in the design of current and future models of aged care. Most importantly, the studies illustrate the need to recognise the importance personal possessions have on quality of life in aged-care environments. The stories told by residents in our studies demonstrated an important attachment to objects, such as furniture, clothing, decorative items and craft activities. These objects and artefacts reinforce self-identity and offer a conduit to memories and past lives. The design of aged-care homes should include increased effort to accommodate this type of attachment.

The studies reveal that personalisation is often confined to the small and cluttered space of residents' private rooms. Therefore, for many residents, most personal possessions are simply left behind or lost when they move in. Care homes need to work to improve the balance between brand image and actually enabling residents to feel at home. They could do this by encouraging placement and use of residents' personal possessions in communal spaces, whether pictures or photos, craft supplies, finished craftwork or chairs and other furniture. Currently, many schools do a far better job of this than most so-called "homes".

The role of design in improving quality of life of older people living in care homes is an area that warrants further research. This could include investigating attitudes to the concepts designers create for residential aged care homes, how better consideration of residents' needs can be built into the design process and the level and source of resistance of designers and operators to more personalisation in communal spaces. It could also include investigation into the success of the small household model as suggested by the Royal Commissioner and whether it allows more personalisation of the home.

Conclusion

Despite improvements on perspectives of ageing and the provision of care, our research indicates that many residents do not feel at home in their aged-care homes, and there is still work to be done on ensuring that aged-care homes do, in fact, feel like *homes* rather than "total institutions". Work must be done to improve the homelike atmosphere of communal areas so that residents feel that they identify with them and want to be in them, as well as removing physical barriers to comfort and communication such as insistence on a standardised "look", dirty chair fabrics and poor layout of furniture. Work must also be done to improve private room design to allow people to comfortably spend time in their rooms but not in bed (unless needed). Finally, work must be done to allow residents to personalise both private and communal spaces much more than is currently accepted so that they can retain their sense of identity and feel "at home" in the home. Unless and until these three inter-related issues are addressed, aged-care homes will continue to be – at best – a hybrid that falls short of a home and – at worst – reminiscent of a prison or mental asylum that completely fails to support older adults through the challenging transition from home to not-quite-home.

Statement of ethical approval

Both studies were granted ethical approval as stated in the paper.
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Declaration of contribution of authors

Blackler worked on conception and leading of the paper as well as designing and leading Study 1, and the lit review and discussion. Brophy worked on data collection and analysis for Study 1, the lit review and discussion. Craig worked on the lit review, Study 2 and discussion. Kamali worked on the lit review.

Declaration of Competing Interest

No conflicts.

Data availability

The authors do not have permission to share data.

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