

COMMENTARY

Enforced relocation of older people when Care Homes close: a question of life and death?

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Abstract

Care Homes are usually seen as the last refuge for older people but residents are sometimes required to move between homes for administrative purposes. There is concern that such moves threaten their well-being and survival. Relocations have been contested repeatedly in court. A recent ruling and its review of case-law and literature provides guidance for practitioners who may be consulted for advice in this demanding situation.

Keywords: relocation, Care Homes, older people, elderly

Introduction

This commentary draws attention to a recent European Court of Human Rights (ECHR) ruling on a Care Home resident who was reluctant to be moved. The court's considerations and thinking are presented and welcomed. The implications are that relocation cannot and should not always be avoided, but there is a professional burden on practitioners to identify hazards and minimise risks by adopting best practice in preparing residents and their families.

Hazards of relocation

What responsibilities do organisations and professionals carry when it is proposed that old people be moved from one institution to another? To what extent does the law protect such individuals? The recent ECHR ruling in the case of Louisa Watts [1] provides an important reference point in this evolving story.

In spite of public outrage about the quality of institutional care for the elderly and mentally ill in the 1960s, which led to the formation of the Hospital (later Health) Advisory Service [2], further scandals followed. One was at Fairfield Hospital in Bury. Fifteen elderly women with

dementia were moved from ward 17 to cold, ill-suited Musberry House at Rossendale General Hospital December 1973. Seven died within the next month and nine within the first 3 months. Only four survived a year [3]. The Bury-Rossendale Inquiry drew attention to the hazards and responsibilities associated with movement of older people for administrative or economic convenience. It concluded prophetically that 'transfers of groups of patients are likely to become more common, particularly in the fields of psychiatry and geriatrics'.

Since that time there have been serial reconfigurations of services. Much of the care of very frail old people is now provided in the community or in Care Homes rather than in hospitals. Enabling individuals to retain a degree of independence at home or in sheltered accommodation is promoted as the preferred option [4]. Changes occur in the Care Home sector in England, in response to fierce market forces, shifts in political ideology and pressures to reduce costs yet improve standards. Despite increasing numbers of the very old, the Care Home sector shrank from 214,130 beds in 2004 to 177,605 beds in 2009. The most marked reduction has been among local Authority-managed homes, where 40% of beds have been lost [5]. Total bed numbers are likely to shrink further in response to forthcoming public expenditure cuts.

It is generally accepted that moving home is a stressful life event for individuals of any age even when the move is planned and anticipated as a positive step [6]. Relocation of older people from one care setting to another is recognised to be particularly stressful and to have adverse effects on health and even on survival. We now know which elements of a move produce the greatest stress, which individuals are most vulnerable to adverse effects and which procedures minimise stress and improve outcome [7–12] (Boxes 1 and 2).

Box 1.

Vulnerabilities, stresses and approaches to best practice

Characteristics of residents most vulnerable to adverse effects

- Gender: males do less well
- Age: adverse effects more likely with greater age
- Dementia
- Depression
- Anxiety
- Regression or withdrawal in the face of relocation (expressed anger is protective)
- Impaired eyesight and/or hearing
- Reduced mobility
- Incontinence
- Multiple problems summate

Elements of relocation which are most stressful

- Sudden or unplanned moves
- Failure to assess and meet medical and psycho-social needs
- Multiple moves including temporary interim placements
- Discontinuity of care
- Lack of consultation with residents and families
- Lack of information and explanation of rights and options
- Highest risk in the first 3 months after relocation

Box 2.

Good practice towards reduced stress and better outcomes

Pre-relocation

- Inform residents and families individually and as soon as possible when relocation becomes a probable option
- Make careful plans for individual residents, groups of individuals and staff. Make written records of discussions and share these with all parties
- Facilitate discussions and counseling with individuals and groups in anticipation of the move
- Undertake comprehensive medical and psycho-social needs assessment for every individual in association with their family and current health and social care staff. Make any adjustments to care and therapy indicated by the findings

- Identify suitable alternative placements in association with the family and resident. Factors to take into account include: site, accessibility for family and friends, physical attributes (layout, space, furniture, temperature, etc.), number and mix of residents, staffing, management style and activities. Reports from inspecting authorities should be scrutinised and made available: factors such as rates of catheterisation, use of tranquillisers, physical restraint, pressure sores and contractures are informative
- Prepare handover notes so that continuity of health and psycho-social care can be ensured. Share these with staff of the receiver home in advance
- Arrange for familiarisation visits if this is feasible so that the resident and their family gain a feel for the receiver home and the staff and vice versa
- Arrange for staff of the donor home to be available to or within the receiver home during the first weeks of the placement

Relocation

- Be sure that all parties are aware of the date and the details
- Ensure adequate physical and staffing arrangements are achieved within the donor and receiver homes and that suitable transport is provided
- Ensure appropriate health checks at departure and arrival
- Ensure that a familiar and responsible person travels with the resident and carries with them documentation required for continued care, including health care, medication and equipment
- Relocation of groups of three to four residents together may have advantages
- The introduction of large groups within a short time-scale may produce additional stress for residents and staff
- Ensure that each individual is welcomed and made to feel safe, comfortable and wanted
- Let family and the donor home know of the safe arrival

Post-relocation

- Organise a review of progress and current health and psycho-social care needs within 1 week and at 4 weeks and 3 months. These reviews to include the resident, their family and contributions from all relevant care groups. Act to rectify any problems as far as possible
- Provide orientation within the new environment
- Maximise stability and continuation of good practices from the previous home
- Provide opportunity to discuss and come to terms with the experience
- Facilitate an environment in which the resident and family know that their values and preferences are heard and will inform activities
- Keep records of key communications and monitor physical health, mood, cognition, participation and integration, quality of life and the views of family and friends who visit

Relocation and the law

In the decade following implementation of the Human Rights Act (HRA) 1998 in October 2000 a series of challenges were mounted in the Family Division of the High Court in England, on behalf of individual Care Home residents, seeking to prevent or delay Home closure (largely unreported because of confidentiality). It was argued that relocation posed a threat to their well-being or survival and infringed upon their human rights. Expert medical evidence was provided (by the present authors among others), relying on clinical experience and on published evidence from ill-planned closure programmes. It was established that local authorities had a duty to assess the risk to individuals prior to finalising closure or transfer, and best practice guidance followed [11]. Following a split House of Lords decision on whether HRA protection extended to those in privately owned Care Homes (*YL v Birmingham City Council and others* [2007] UKHL 27), the government changed the law to include them.

Other agendas may fuel resistance to Care Home closure. Many homes attract loyalty from families of current and past residents and staff. Holding on to what we have and what we know is a strong instinct. Not everyone is convinced that the proposed alternatives will deliver better care. There is often deeply held suspicion that the elderly are systematically disadvantaged by changes purporting to benefit them but in fact intended to save costs. The spectre of vulnerable old people—who established our Welfare State >60 years ago—being exposed to unnecessary upheaval and suffering at the very end of their lives is understandably abhorrent.

The key argument put forward on behalf of Louisa Watts was that: ‘her involuntary transfer to another care home resulted in a threat to her life, her health and her right to respect for her private and family life and in particular her right to respect for her physical and psychological integrity’.

This argument (summarised below together with the court’s conclusions) relies on Articles 2, 3 and 8 of the European Convention of Human Rights:

Article 2: Everyone’s right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction for a crime for which this penalty is provided by law.

This imposes both a ‘negative obligation’ on agents of the state not to take life, and a ‘positive obligation’ to safeguard the lives of those within their jurisdiction.

The court found that in this case there was no intention to take life (the negative obligation). Relying on expert medical evidence from earlier cases as well as medical opinion on her specific risk, the court accepted that ‘badly managed transfer... could well have a negative impact on life expectancy’. Relocation of elderly frail residents does therefore carry risk to health and life though it is difficult

to quantify. The court further accepted that adverse effects can be reduced by careful planning and other measures but worded its findings on the obligation to protect Louisa Watts from risk cautiously: Although not all risk was (or could have been) eliminated, the local authority had taken ‘all reasonable steps’ to reduce risks. It had therefore met its positive obligations under Article 2. The Article 2 complaint was rejected as ‘manifestly ill-founded’.

Article 3: No one shall be subjected to torture or to inhuman or degrading treatment or punishment.

The court judged that the probability of stress and distress associated with relocation did not reach the (very high) threshold required for a positive obligation required within Article 3—i.e. it did not consider relocation to amount to inhuman or degrading treatment and there was no failure by the local authority to prevent such occurrence.

Article 8: (1) Everyone has the right to respect for his private and family life, his home and his correspondence and (2) There shall be no interference by a public authority with the exercise of this right except such as in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

While accepting that involuntary relocation did constitute an interference with her private and family life, the court found that it was pursued with a view to providing a better standard of care to Mrs Watts and others, at lesser cost and that: ‘every effort was made to minimise the impact of the move on the applicant and to avert risks to her health and well-being’. It was therefore not an illegal act. The transfer was ‘proportionate and justified under Article 8’. The court also quoted Sedley LJ ‘that to involve them [vulnerable residents] in litigation might contribute to the stress of relocation’ [13].

These matters have now been explored exhaustively in law. Unless there is evidence that parties clearly depart from accepted good practice in their preparations, consultations and implementation of the relocation of an individual or group of residents, there is unlikely to be justification for further recourse to the courts. The legal process carries an attendant risk of adding to the stress for the residents, their families and care staff involved. Although the health, well-being and interests of individuals should never be overlooked, residents should not be used as pawns in negotiations.

The current position

Practitioners must remain vigilant to prevent irresponsible relocation of vulnerable old people such as occurred in *Bury-Rossendale 1973*. Examples now exist of remodelled

services where good overall outcomes have been achieved with the active involvement of residents and their families [9–15]. Life contains risk at every stage. The very old and frail, and people with dementia, are particularly vulnerable as well as being less able to act effectively as their own advocates. They must therefore be protected. Expert medical advice should be sought when revision of services and movement of groups of older people are contemplated. When professionals are involved in service redesign or when they are asked to advise on relocation they should ensure that they thoroughly understand the issues involved in relation to the individuals who may be moved. Although clinicians will always have the best interests of individuals at heart, not all risks can or should be avoided and responsible progress should not be vetoed.

Key points

- Being a resident in a Care Home is not a status which conveys the right to live in a particular home for the duration of life. There are several eventualities that may require that individuals move on.
- Relocation is stressful and carries an associated risk of morbidity and mortality.
- Most residents of Care Homes are very old. Many are disabled as a consequence of multiple pathologies including dementia, depressive illness, impairment of mobility and reduced sensory function. Most have experienced multiple losses leading to their need for care. These characteristics render them vulnerable to any stress including that associated with relocation.
- When an individual is acutely unwell with additional symptoms but not so severe as to need transfer to hospital, there may be absolute arguments against a move at that time. Active medical input will be required in such instances in the care home setting.
- Where the vulnerability is longstanding and a move can be carefully anticipated and planned, there are accepted practices that will ameliorate the stress and its possible consequences. This includes expert medical advice to identify individuals who require additional help in planning their move, as well as sharing information about hazards and ways of minimising consequential stress with individuals, their families and care professionals.

Conflicts of interest

All four authors have contributed expert advice to court proceedings in related matters. No copyright issues.

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