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Homely Residential Care: A Contradiction in Terms?

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ABSTRACT
Accommodation and care for older people is commonly thought of in relation to residential care homes: the collective settings with communal lounges and dining rooms, where older people may live what seems to be a fine balance between individual and group routines. Yet, while there have been changes to the living arrangements of people in relatively large collective groups, the ideal put forward as a basis for care settings has remained that of 'home', with the family model still central. With the tensions between public and private, domestic and institutional living, regulated and non-regulated settings, all too obvious, this article uses a pilot study in Bedfordshire, Buckinghamshire and Hertfordshire of registered small homes with less than four residential places, often run by the proprietor and her family, to consider whether residential homes may replicate a homely environment, or whether the model has run its course.

INTRODUCTION: INDIVIDUAL LIVING VERSUS COMMUNAL LIVING

While 'caring about' may exist unbounded by time and place, 'caring for' someone happens in specific places; most commonly the 'ordinary' domestic home. Domestic homes are imbued with their own cultural and personal meanings, which influence the ways in which care is given and received in them. A person who is cared for in their own home – especially a home which they have owned or rented for some time, and which has become a familiar and meaningful part of their life experience – has an understanding of 'ways of doing things' there, and usually, some control over how things are actually done. In contrast, people receiving care in other contexts, for example in the home of a friend or a paid carer, or in a hotel or guest house, may find that 'ways of doing things' there do not always suit their own customary routines or preferences; and their routines may be regulated by others (Peace, 1998).

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In the latter half of the twentieth century Britain became a nation of owner-occupiers – and this included half of all people aged over 60 years (Peace and Johnson, 1997; Peace and Holland, forthcoming 2001). Owning your own home became the 'thing to do', producing a form of capital, security and a means of inheritance for the family. It also has implications for citizenship, and the owner's own view of social relation-ships (Saunders, 1990). This process of 'normalisation' of the ideal of the personal home has tended to reinforce the desire to maintain one's private residence throughout life, and research shows that older people prefer living with their spouse, or on their own, rather than moving in with other family members or into a group setting (Arber and Ginn, 1991). They prefer support to maintain reasonable autonomy within the community, so that they are not excluded from the lives of those around them.

The rhetoric of care policy has also for some time idealised the home, or *domus,* both in unregulated and regulated settings (Peace, Kelleher and Willcocks, 1997). The White Paper 'Caring for People' said that com-munity care should: 'enable people to live as normal a life as possible in their own homes or in a homely environment in the community' (Department of Health, 1989, para 1.8). However, there is a complex pattern of people (paid/unpaid carers), places (domestic/non-domestic) and times (daily, intermittent, continuous) involved in care. Many older people use a combination of support services in which paid and unpaid carers may come into their homes, and they may also go out to a day centre, or spend time in respite care in someone else's home. In the case of younger people with disabilities, it is becoming commonplace for individuals who need support to exercise control over the combination of accommodation and personal assistance which they receive (Morris, 1994). For older people, community care services often fall short of providing what individuals need to be able to stay in their own homes, and the availability of support from various family and non-family members is often critical. This affects the context of caring, both within and between places. Sometimes people need to receive care outside the home in the short term (e.g., respite or day care), but at other times it becomes necessary to make a permanent change. Older people who find that they can only get the support they need by moving to a place where accommodation and care are provided together, are now faced with a range of provision from hostels, to sheltered housing, to nursing homes.

But while some collective living arrangements have changed since Townsend published *Last Refuge* in 1962, most older people still express a reluctance to swap their own home for an Old People's Home. Yet over a

quarter of people aged over 85 years now live in nursing and residential care homes; many other older people live in sheltered housing schemes, and there is a range of new small-scale developments to suit the needs of particular people, from retirement communities to home-sharing (Peace and Johnson, 1997; Laing and Buisson, 1999; Peace and Holland, forthcoming 2001). This range of living arrangements offers a variety of types of communal living and degrees of segregation from the intergenerational life which older people are likely to experience in mainstream housing. But the ability to choose within these arrangements is often dictated by finance, and people who feel that they are in control and paying their own way may find the experience of group/collective living more acceptable than those forced into communal arrangements.

INSTITUTIONS AND THE 'NORMALITY' OF THE FAMILY HOME
From the historical evidence of early workhouses and asylums, and onwards, it can be seen that caring and accommodation were not the only goals of institutions: they also sought to control those seen as 'unfit' for integration with the general public (Peace *et al.*, 1997). In these predominantly 'public' institutions, control could be stark, but it was generally hidden away from the public gaze. From the 1950s onwards, the lifestyle of people within institutions who were old or mentally ill began to be explored (Barton, 1959; Townsend, 1962; Morris, 1969; Miller and Gwynne, 1972), with revelations about the effects of 'institutionalisation'. This concept, perhaps most commonly associated with the work of Irving Goffman (1961), encapsulated certain characteristics of institutions including homogeneity of daily living; lack of choice and personal autonomy; distance between the two worlds of paid workers and residents; and the acceptance of a secondary status by residents.

Have we now moved away from these worlds? In the fields of disability and mental health, debates around institutionalisation and normalisation have been central to the development of 'special needs' housing and of 'ordinary living' (Kings Fund Centre, 1980; BCODP, 1996; Towell, 1988; Morris, 1994; Shaw, Lambert and Clapham, 1998). Research into collective environments for *older* people has critiqued the nature of institutional living (Townsend, 1962; 1986), but it has also discussed alternative environments (Willcocks, Peace and Kelleher, 1987; Davies, 1998), and unpacked the role of the home in policy language (Higgins, 1989). It has looked at how paid and unpaid carers find roles within these different types of accommodation (Allen, 1989; Twigg, 1997), and debated how collective living outside the family may be justified (Dalley, 1996). Authors have also begun to recognise the complexities of places

for care and assistance. This literature has led the current authors to explore further the reality of 'homely non-family environments in the community' and different ways of living in later life. Is a *small residential home* more likely than a large institution to allow people to maintain their sense of self – or does size not matter if individuals have the flexibility of moving in and out of groups? What are the essential features of home life that could be replicated in a small home?

FEATURES OF HOME LIFE

As we have seen over the twentieth century, households have changed and the family now comes in many forms. Nevertheless the notion of home retains many associations. Traditionally it has been seen as a 'woman's place', focused around kin, and associated with domestic work – including housework, looking after children and caring for other family/non-family members.

In addition to unpaid domestic work, some people have always done paid work in or from the home, and as new technology makes easier communications between workplace and home, these roles continue to evolve. It is arguable that leisure activities have also become more focused on the home, a major centre of consumption as well as production of wealth. All of these activities take place in what is regarded as a private rather than a public sphere, though the boundaries between the two may be permeable (Pratt, 1999). Technological advances and social change may alter what is regarded as acceptable home-based activity, allowing people more control, but this will vary according to income, gender, age, social class and culture.

The evolution of domestic housing in this country underpinned a tendency to create private space for the nuclear family rather than the extended family (Matrix, 1984). The privacy of the home may for many continue to be at the level of the household group rather than the individual (Matrix, 1984; National Federation of Housing Associations, 1993; Holland, 1996) and family life is indeed predicated on sharing space. But some people acquire privacy within the household, for example most middle-class children now expect their own bedroom. Older generations may not have had such expectations when young, and many older people will have worked towards acquiring private space in shared or single-occupancy households. For some of them, privacy may be an essential factor in their ability to maintain both their self-identity and their own body; for others it may not be such as issue. How we use our private space demands attention. What do we wish to reveal of ourselves to others? Can we be alone and separate from others? Can we be anonymous and decide

not to join in? How does our age affect our options and choices? (Ittelson *et al.*, 1974; Willcocks *et al.*, 1987).

Beyond the bounds of personal space, people can also make choices within the household. They can light a fire, re-heat yesterday's dinner, re-decorate a room or dig up the garden. They would not expect someone from outside the home to tell them how to do these things – though they might look for advice. And access to privately owned property depends upon the occupier's permission – exceptions, as in the case of planning officers, the gas-man, police, fire or environmental health officers, are specified and limited by legislation. One of these exceptions to domestic privacy has been the regulation of childminding: the Children Act 1989 allows inspection, and childminders have to meet regulations concerning fire and health safety in their homes. At the time of writing, domiciliary care for older people is not yet regulated in this way, except through voluntary provider registration schemes. Following the government White Paper 'Modernising Social Services', and the Care Standards Act, 2000, this sector also became regulated through the new regional Commissions for Care Standards. So, privacy and individual accountability are paramount within the home, but paid caring relationships are seen as one of the exceptions brought about by issues of public interest.

In addition to its privacy, the familiarity of home provides an important context for care. Arber and Ginn (1991, pp. 140–2) have related this to the home's association with life roles, especially for older women. These role include the ability to conceal frailty and maintain competency within your own home; the importance of privacy for acts of intimate care; and the ability to maintain control over levels of dependence without feeling burdensome. This all underlines how important our home can be to personal well-being. For most people the home is more than shelter, it is part of the self (Sixsmith and Sixsmith, 1990; Altman and Low, 1992; Gurney and Means, 1993). It is a place to which people can feel attached; 'be themselves'; a place where safety and security is often reinforced by memories of the past and reminders of the present, perhaps represented in possessions (Low and Altman, 1992). As people grow older and increasingly lose *people* to whom they are attached (Bowlby, 1969; Jerrome, 1996), their attachment to *places* may become more important. But we should also acknowledge that the home is not always so rosy. It can be a place of loneliness or conflict; a poor environment; a place outgrown. One might rather leave, but be unable to because of past history, or a present lack of alternatives. The home can be a contradictory place as time passes, and expectations and opportunities place barriers to choice.

TABLE 1. *Small home places for older people by sector in relation to all residential home places for older people, 1996*

Residential home places for older people:	All Residential Home Places[a]	Small Homes Places[b]	Small homes places as per cent of all residential home places
Local Authority	57,308	–	0
Voluntary	39,277	86	0.2
Private	107,962	3,941	3.7
All Sectors	267,547	4,027	1.5

[a]available places; [b]occupied places – available places not reported.
Statistics from: Department of Health (1996).

The majority of people reach old age after a lifetime of living in their own homes and managing their own affairs, and with little personal experience of paid care. They often come to consider their need for accommodation and care services as they arise and without a vast amount of knowledge about the alternatives. In this context we look at an under-researched setting, small residential homes for older people. Small homes, providing accommodation with care for three or fewer people are arguably the most domestic in scale of residential provision. As such they test the ability of collective and regulated care arrangements truly to provide a homely environment for givers and receivers of care.

SMALL RESIDENTIAL HOMES FOR OLDER PEOPLE – WHAT DO WE KNOW?

The 1980s and 1990s saw a switch in the provision of residential places for older people from local authorities to the private sector, and nursing home provision began to outstrip residential care provision. Until the Registered Homes (Amendment) Act of 1991, small residential homes were not required to register with local authorities. When the Act came into force in 1993, many former adult family placements along with other establishments were reclassified as small homes, becoming 'visible' in government statistics of residential care places. Since March 1997, however, official statistics have tended to aggregate small homes with other provision (see Department of Health, 1997). Table 1 shows the situation in 1996, when small home places formed less than 2 per cent of residential home places for older people nationally (although there were wide geographic variations), but nevertheless were home to more than 4,000 older people.[1] Around 98 per cent of these places were being provided in the private sector.

The Registered Homes (Amendment) Act (1991) gave a right but not a duty for authorities to inspect small homes after registration, and given the cost implications, many authorities inspected small homes infrequently, or never. However under revised legislation (Stationery Office, 1998), small homes will in future be subject to annual inspection.

The comments we make here are based on the first systematic pilot study, carried out in Bedfordshire, Buckinghamshire and Hertfordshire during 1997/98 (Holland and Peace, 1998). In common with most other local authority areas, small residential home places formed a very small proportion (less than 1 per cent) of the total residential care places available in these counties, but the number was increasing year on year. Almost all were provided by the private sector. Our pilot study involved a postal survey of the forty-four homes registered in the three authorities at that time, and we followed this with detailed fieldwork in six homes. This included semi-structured interviews with home owners and residents, and some relatives, concerning their social, physical and psychological well-being, along with observations of daily life in the homes (see Willcocks *et al.*, 1987) and interviews with inspection officers. To get access to these six homes we first had to get the agreement of the owners and then of the residents. As a result we only interviewed small home owners who were confident enough in their homes to let us in. They were quite open with us about the problems and pleasures of running a small home, but given the short time frame and the existing regulatory framework, we did not have access to small homes where things might be going wrong. In all the homes we were able to interview the residents privately, and some of them did voice minor concerns or dissatisfactions with the home. Further details about the methodology of this work can be found in the report of the project (Holland and Peace, 1998).

We followed the pilot project with a national postal survey in 1999 of Registration and Inspection Units (R&I Units), looking at regulatory practice with regard to small homes (see Holland and Peace, 2001). Here we give a brief account of findings from the pilot research, and observations from the national survey of Registration and Inspection Units.

The physical environment of small homes
Data from the pilot study showed that a wide range of building types, sizes and locations could be used for small homes, from a large seven-bedroomed sixteenth-century listed building to converted council houses; but a typical home would be a five-bedroomed detached house with a built extension or some adaptations. On the whole, the small homes

tended to look like the other houses in their neighbourhood rather than having an obvious presence in the local community.

The size, maintenance and heating of homes in the pilot study was good, but bathing and mobility facilities varied from home to home. The control and maintenance of the physical environment in the homes lay very much with the proprietors, who had their own priorities according to their understanding of standards and the finance they had available. The current legislation required Inspection Units to register a small home provided that the proprietor/manager is a 'fit person', without specific regard to the suitability of the premises themselves, and in practice the physical suitability of small homes was addressed through local regulations and by social services contract conditions.

Both of our surveys revealed a distinction between 'extended family homes' which were also the proprietor's own home, and 'mini-residential homes' where the proprietor lived elsewhere. The latter included 'small homes' registered within nursing homes as an alternative or a precursor to dual registration. Where proprietors did live in, the smallest houses had residents occupying spare bedrooms alongside them (and possibly their family), and sharing the living rooms with them. In homes like this the arrangements are similar to adult placement schemes, in that there was an intimate sharing of the proprietor's living space and limited options for residents to spend time alone. Personal space could also be at a premium, and we observed bedrooms of less than 10 square metres – giving residents little opportunity to create their own environment within the home. In larger homes, and homes where the proprietor/manager lived out, there was a separate lounge for residents. In these homes the distinction between residents and carers was clearer, and the nature of the place as a residential care home rather than a family home more obvious.

The small home proprietors that we interviewed were anxious to maintain the domesticity and comfort of their homes for themselves, their families and their residents. At the same time, most of them had views about good care practice, and the physical amenities which are required to ensure the well-being of their residents as well as complying with local regulations on small homes. There were some tensions between regulation requirements and the ideal of a family-like home: including the issue of whether sink units were necessary or desirable in all residents' rooms, and whether freezers and refrigerators needed to be monitored to the same level as in larger residential institutions. All but one of the kitchens was average in size and they were equipped domestically rather than as catering kitchens. The proprietors all said that their

kitchen was run to catering standards of hygiene and regulation, but the fact that in half of the homes their own families used the same kitchens might bring this into question. In two places residents were effectively excluded from the kitchen on the grounds of hygiene; indeed one proprietor had been happy to use advice on hygiene as a reason to discourage residents from using the kitchen at all. Another had come to an arrangement for residents to use the kitchen in specific and limited ways:

We can't allow them into the kitchen because of health and safety regulations. I had great battles with the inspecting officer, who said they should not be allowed into the kitchen because of the contamination. Although our staff have been on the food hygiene course, residents obviously haven't. I said that it was a small home, and if they wanted to go in and take their relatives in to make a coffee, or to do baking under supervision ... my residents weren't going to be stopped from doing that. He's not happy with it but he allowed it. They go in once a week, wash their hands, wear an apron, fasten their hair back or wear a hat, so they are supervised under basic hygiene rules by members of staff. None of them just pop in, because one is very confused and another is too frail. (Male resident) possibly could, but he's not safe. He is registered partially blind, and I wouldn't like him to start using the geyser in case he burns himself.

Other homes had no objection in principle to residents using the kitchen, and a few residents made themselves an early morning cup of tea. Nevertheless it was taken for granted that residents would not cook meals even if they were capable of doing so. Other than the 'therapeutic' supervised baking described above, none of the residents routinely took part in meal preparation and they did not have a direct input into menu planning either. There was usually no choice of dishes for residents, the same meal being prepared for all of them, but proprietors said that they asked residents about individual likes and dislikes and tried to take those preferences into account in preparing the meals. In practical terms residents in small homes may no more be guaranteed their choice of food than are residents in larger homes.

The six homes in our pilot study looked like domestic houses rather than residential establishments in their external appearance, design, internal decoration, and the absence of institutional odours, sounds etc. Furnishing and decoration in the shared areas (e.g., lounges and dining areas) was good and almost entirely domestic in type, although two of the homes also had some specialised chairs and tables for immobile residents. On the whole the furniture and objects such as pictures and ornaments in the day and dining areas belonged to the proprietors, with residents' belongings generally being confined to their own rooms. They looked homely – but the question remains, 'whose home?' Shared areas were clearly dominated by the proprietors, subject to the proprietor's notions of

acceptable behaviour, and marked by the proprietor's taste in furnishings and decor; even in homes with a separate lounge for residents.

Home, the workplace
Control over their environment had been an important motivating factor for the proprietors we interviewed. Their explanations for deciding to open a small home business included personal, family and financial factors; but the chief motives had been financial gain, control over the work environment (e.g., with relation to specific care practices), and a preference to work from home (particularly if there were school-aged children). The proprietors of two of the homes had been working long hours as managers of larger residential homes and came to the conclusion that they would be better off both financially and in terms of job satisfaction by running their own home. In two other cases, there had been problems with a previous family business and the small home allowed available space in the home to be used as another way to finance the mortgage. All six of the proprietors said that they got a great deal of personal satisfaction from running the home, although most of them felt that the work did not leave them enough free time. Half of them felt, with hindsight, that in purely business terms they would have been better off doing something else.

With registration for less than four residents, small homes need to maintain very high occupancy rates, especially if there are mortgage or loan repayments to be financed, and the long-term financial viability of some small homes is questionable. Most of the businesses in our detailed study relied on income earned outside the home by the proprietor's partner, and on casual help from family and friends (a pattern also noted in US board and care homes: Morgan, Eckert and Lyon, 1995). Paid staff were usually untrained women part-time workers. They were very likely to be laid off if finances became tight, further reducing the proprietor's own time off.

In these circumstances, small home proprietors might be expected to seek help, but most of those in our study wanted to be self-reliant and avoid interference: for example one proprietor's attitude to the cost of aids was: 'I prefer to do it myself. You can fit what you like then, and it fits in with what you want to do.'

For most of the proprietors, their workplace was also their home, where understandably they wanted to maintain control and privacy. But it was a workplace which must in some degree be open to official scrutiny because it was home to potentially vulnerable people, and care services were bought and sold. Nippert-Eng has described how,

we see 'work' as a public activity requiring public presentation of a carefully constructed self. Appearance, speech, emotions, and the portrayal of intellect must be attended to in specific, situationally defined ways 'at work'. As a private realm, however 'home' is the place where we can 'be ourselves', 'put up our feet', 'let down our hair', relax among those who see us 'warts and all' but aren't supposed to hold it against us... (Nippert-Eng, 1996, p. 20)

These homes were also workplaces, not just for the proprietors but for also for their paid staff and non-resident family helpers. The proprietors had arrived at various strategies for preserving some privacy. These included: the provision of comfortable bed-sitting rooms and separate bathrooms for themselves and their children; keeping their own rooms strictly off-limits to residents; and the demarcation of 'on-call' from 'on-duty' periods (for example by changing from formal clothes into casual ones). Nevertheless, all the proprietors found that their homes, most of them long-time homes before the arrival of residents, had been radically changed by becoming care settings.

The social life of small homes

Willcocks *et al.* (1987) wrote about 'crossing the threshold' from community to institutional care as an actual and symbolic change of environment. Residents moving into a small home from community care experience a change of this kind, and those interviewed in our study were in no doubt that they were now in 'a Home' rather than a 'home'. Moving into a small home, they entered a social environment which differed in many respects both from their previous domestic life and from their notions (and in some cases their own previous experience) of life in a larger residential institution.

Some people might find the smaller group of new faces in these homes easier to deal with than all the residents and staff in larger residential settings. On the other hand new residents in small homes could feel intimidated at entering a group where personal relationships between existing residents and staff are already well established. Small home life involves the intimate proximity of a group of people who are unrelated to each other and who usually have no mutual history. They must form relationships and establish routines and boundaries of behaviour in order to create a viable home for them all. Proprietors laid a lot of emphasis on the importance of making sure that new residents would be compatible with existing residents, staff, and in particular, any children of the household. Some proprietors conducted a pre-entry interview with the potential resident either at the small home or at the place where the potential resident was living. Most of them had a 'trial' period of up to four weeks before a

long-term decision was expected on either side. However given the financial pressure to fill vacancies, it is clear that in practice some proprietors might find it difficult to refuse a new client.

An individual's social life is inevitably changed by moving into residential care, but the nature of the change varies. Some residents said that they had been more isolated in their previous home, and they liked having people around in the small home and somebody to talk to if they felt like it. They enjoyed the ebb and flow of ordinary life around them as the family, staff, and other visitors dropped in, brought the shopping, or exchanged gossip. Other residents, though, had experienced a shutting down of their previous contacts as their life became more centred on the home. The scale of the small home could be seen either as an opportunity – for rich relationships and individualised care: or as a problem – with limited variety, and possible introspection.

Residents usually sat alongside each other while watching TV or reading, but they did not appear to engage in other activities together, either inside or outside the home, unless staff organised something. The residents tended not to 'visit' each other in their rooms. Their chief point of contact in the day was around mealtimes. They took lunch and dinner together, but not usually with the staff or the proprietor. Proprietors explained that they were too busy serving the residents at mealtimes to eat with them, but one effect of this separation of meals was to reinforce the differences in status and identity between residents and carers. In some homes proprietors had structured mealtimes to be social events, accompanied or followed by conversation, reminiscence, or singing along to records.

Residents who were interviewed said that part of the reason that they liked the small home was because it allowed them to live a secure, quiet life in a place where their needs were met but they did not have to engage with people more than they wanted to. They appeared to protect their privacy by avoiding overmuch intimacy, which might at some point lead to conflict. Some residents described things they found annoying about others, and they tended to deal with these issues by avoidance. But of course, this is not easy to do in a small place. A few residents described real friendships with other residents past or present, but on the whole the atmosphere between residents might best be described as a polite interest or tolerance, rather than close friendship.

Residents inevitably had many interactions with the proprietor's family, especially those who also lived in the small home. In the case of families with school-aged children, part of the *raison d'être* of establishing a small home had been to allow the proprietors to spend more time with

their children, and this inevitably impacted on the residents. Proprietors with children (or visiting grandchildren) tended to take the view that this contact with children was beneficial to residents, who liked having children around. Residents had more mixed feelings: some said that the children could be annoying at times and were too noisy. Residents also came into contact with non-resident relatives and friends of the proprietor; including adult children and their children, siblings, and occasionally parents. Proprietors' extended families and friends were often involved either as regular visitors to the home or as occasional stand-in carers. Over the years residents sometimes got to know some of these people quite well, and took an interest in their lives.

In roughly comparable board and care homes in the USA, Morgan *et al.* (1995) commented on the often intimate social relationships between residents and staff. Owners there described relationships as 'family-like', based on shared activities in common living spaces; while residents often felt closer to the operator of the home than to one another. In our study, residents, with one or two exceptions, said that they had good relationships with staff and proprietors, and in many cases they named a particular person of whom they were especially fond.

Proprietors generally described their relationships with the residents as good, and in many cases they expressed great affection for particular residents. Other relationships were more difficult, but the proprietors regarded these as professional and caring if not affectionate. The proprietors and the staff usually did most of their 'active caring' – helping with bathing, preparing food etc., in the mornings – and many said that they found time after lunch to just sit with residents and chat. Several staff mentioned this as a particularly satisfying aspect of the job, which had not been possible when they worked in larger homes. Because of the small numbers of staff and residents involved, and the personal relationships between staff and the employer, it is also possible for small home residents to experience more continuity of care staff than residents in larger settings. These are potential strengths of small home settings which might be encouraged by sensitive regulation. But given also the potential stresses within small homes, it is important that the proprietors and other carers are not obliged to carry an unreasonable or unsupported burden of physical and emotional work.

Visitors are particularly important to the well-being of residents in small homes, both for emotional reasons and because of the relative lack of surveillance by other outsiders. In common with residents in larger residential care homes, small home residents do not tend to have very much interaction with the outside community, and they are less likely

than larger home residents to go on organised mass outings. A home operating at the margins of profitability, with minimal staffing, and a proprietor with virtually no respite, could be an unsuitable placement for a difficult or very dependent client with no outside visitors. In our pilot study, visits from the residents' own relatives and friends varied from daily visits, to none at all, but most residents saw their visitors weekly or every few weeks. These visitors included the residents' own children and grandchildren, siblings, cousins, and friends with no blood relationship. The location of the small home relative to the visitor's homes probably contributed to the frequency of visits. There were no facilities for overnight stays in most of the homes, although some of the proprietors said that they could accommodate a relative, in an emergency, in their own part of the house.

The proprietors had their own views about visitors, and how they themselves could maintain a social life both within and beyond the home, for example:

We had decided that we couldn't have anybody round for dinner because you had residents in: we didn't have parties and things that you used to have. But then I decided that yes, OK, it's their home, but at the end of the day it's also my home, so we decided that we would carry on as normal ... I think you have to do that. If you can't do that, when you've got children, then you can't have a residential home because it's not fair to your family.

Proprietors saw a lot of their co-resident family, although for most of the time they were, notionally at least, 'at work'. In one home, the pre-school aged grandchildren were also minded for a part of each day alongside the residents. It was much more difficult for proprietors to arrange to spend time with their distant family members and friends. Paradoxically, some of the proprietors therefore had worries about the care of their own parents or other older relatives who lived at a distance.

Most of the proprietors said that they were offering their residents a home for life, but the most common reason given for residents to move out of the homes was that their care needs had become more than the home could reasonably cope with under the terms of registration (i.e., personal care only). On the other hand, many exceptions were made to allow residents to remain in homes in spite of practical problems, including some flexibility in the interpretation of appropriate care to support terminally ill residents. The proprietors' argument in these cases was that the small home was now the resident's home, and they should be allowed to die at home.

But in the case of residents who were asked to leave, proprietors argued that the small home was the other residents' home, and they should not

TABLE 2. *The balance between domestic and institutional influences in small home care settings*

Domesticity	institutionalisation
Privacy	surveillance
Informality	regulation
Risk	security
Normalisation	specialisation
Personal	professional

Source: Taken from 'Homely residential care'; Holland and Peace (1998)

be disrupted by the needs or behaviour of the out-going resident. The proprietor has to balance the interest of individual residents against the needs of the other residents, her own home and family and the health of her business. This involves thinking about occupancy fees, staff morale, and the contentment of residents, as well as her own well-being and ability to cope. The bottom line is that the home belongs to the proprietor and that her needs take priority. If incompatibility arises between their relative needs, a resident is in a weaker position than a proprietor and must go.

HOMELY CARE?

Registered small homes are regarded as homely and domestic settings, but they are domestic settings which are also seen by their proprietors as a business, by residents as a home away from home, and by those who commission care services as small scale residential settings. In the case of proprietors who live in, their business place is also their own home. The 'homeliness' of small homes centres on their scale, informality, and physical appearance, but as a result of the demands of professional caring and public accountability it is constantly under pressure to move towards more formality and 'organised' living. Activities and the division of domestic labour within small homes are more like the pattern in larger residential care settings than in 'normal' domestic homes. In small homes internal and external influences are constantly at work to affect the balance between attributes of *the domestic* and *the institutional*, as outlined in Table 2.

After extensive research in larger residential homes, Willcocks *et al.* (1987, p. 1) argued that: 'In reality, the ideal of providing a "homely" setting is a genteel facade behind which institutional patterns, not domestic ones, persist.' If homeliness can be achieved anywhere within the residential care sector, it is in these very small homes. Asked to characterise 'homeliness', operators of American board and care homes mentioned: sharing activities, showing love and affection to their residents, and the

quality of their caring. The familial style of delivering care made, for those operators, all the difference between 'just giving treatment' and creating a home (Morgan *et al.*, 1995). In our study too, proprietors talked about their feelings of affection for residents. They discussed giving the kind of care which they would like for their own parents or for themselves in later life. They talked about avoiding, or at least disguising, many obvious signs of being an institution, and claimed to listen to their residents more than staff in large homes. Yet at the same time they saw their small homes definitely as businesses which would have to close if they made a loss. For their part, the residents appeared to be in no doubt that they were living in 'a Home', not 'at home', even if it was, as one resident put it, 'more like a guest house'.

The Wagner Report (NISW, 1988) emphasised the importance of allowing people in residential care to take risks and to have a degree of autonomy. Higgins (1989) described social policies for dependent people as being frequently paternalistic and over-protective, providing a level of protection 'which few people would have at home and which many people find stifling' – whereas in their own homes, people are more able to make 'unsuitable' or damaging choices (Higgins, 1989, p. 173). Falling as they do somewhere between domestic homes and formal care settings, small homes are nevertheless in danger of replicating the controlling environment of those larger residential settings where authentic autonomy may be lost. They are in many ways a hybrid with the potential for the best and worst of both worlds.

NOTE

1   Most small homes are registered for people with learning disabilities. In 1996 there were 5,697 places for people with learning disabilities: of these 4,488 were in the private sector and 5,697 were in the voluntary sector (Department of Health, 1996).

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