Citation: Harrad-Hyde, F., Williams, C. & Armstrong, N. (2025). Deteriorating care home residents as 'matter out of place' in both care homes and hospitals: An ethnographic study. Social Science & Medicine, 373, 118012. doi: 10.1016/j.socscimed.2025.118012

Link to published version: https://doi.org/10.1016/j.socscimed.2025.118012

Social Science & Medicine 373 (2025) 118012

Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

Deteriorating care home residents as ‘matter out of place’ in both care homes and hospitals: An ethnographic study

Fawn Harrad-Hyde[a,*], Chris Williams[a], Natalie Armstrong[b]

[a] University of Leicester, Department of Population Health Sciences and LOROS Centre for Excellence, UK
[b] University of Leicester, Department of Population Health Sciences and NIHR Greater Manchester Patient Safety Research Collaboration and City St George’s, University of London, UK

ARTICLE INFO

Handling Editor: Medical Sociology Office

Keywords:
Care home
Nursing home
Transfer
Hospital
Mary Douglas
Risk perception
Matter out of place

ABSTRACT

Older people living in care homes are susceptible to deteriorations in their health. At times of deterioration, care home staff play a crucial role in considering the potential benefits and burdens associated with either caring for the resident in the home or transferring them to hospital. Using data collected through interviews with 30 care home staff and 113 h of ethnographic fieldwork in care homes in England, we consider the ways that care home staff can perceive deteriorating care home residents to be, often simultaneously, vulnerable (or ‘at risk’) and dangerous (or ‘a risk’) in both the hospital and the care home. Drawing on the work of Mary Douglas, we suggest deteriorating care home residents can be considered to be ‘matter out of place’ and can therefore be considered as ‘placeless’ in whichever setting they receive care. Instead of asking whether deteriorating residents are in the ‘right place’ to receive care, we might instead ask whether healthcare services are the ‘right shape’ to support to deteriorating care home residents and their complex needs.

1. Introduction

How risks are assessed, understood and perceived has received much sociological attention. Scholars across social science disciplines have sought to explore risk in a number of ways. Some have emphasised risk as a central feature of modern life (Giddens, 1990; Beck, 1992); others have explored how organisations and institutions govern individuals’ actions (Foucault, 1991) and studied the motivations of individuals engaging voluntarily in risk-taking (Lyng). In addition, scholars have considered how risks are socially constructed (Douglas and Wildavsky, 1982) and examined how everyday risk practices are enacted (Brown and Gale, 2018; Horlick-Jones, 2005). Each of these approaches provides a different lens through which risk can be explored and understood.

In the early twentieth century, Giddens (1990) and Beck (1992) shaped sociological discourses on risk with their ‘risk society thesis’, arguing that industrialisation in Western societies had created ‘new’ risks that were too complex for traditional insurance models used for managing risk. However, following criticism that their work could not account for variation in how individuals assess and respond to risk, attention moved towards exploring risk as socially constructed within particular social and temporal contexts. For anthropologist Mary Douglas (1966), and sociocultural theorists who drew upon her work, culture was central to understanding how risks are understood and communicated across contexts. Whilst risks can be ‘real’ and present objective danger, the framing of risk is always embedded in a broader social context (Douglas, 1966). From this tenet, Douglas suggested that to understand how certain risks come to be known and prioritised in different cultures, whilst others are ignored, one must be attuned to context (Douglas and Wildavsky, 1982).

In this paper, we apply the work of Mary Douglas to the context of care home staff making decisions about how best to manage residents whose health is deteriorating. We demonstrate the ways care home staff perceived deteriorating residents to be, often simultaneously, vulnerable (‘at risk’) and dangerous (‘a risk’) in both the care home and hospital setting. This in turn led to them being perceived as ‘matter out place’ in whichever setting they received care.

1.1. *Hospital transfers from care homes: weighing-up risk*

Older people who live in care homes have uncertain health trajectories, significantly shorter life expectancies than age-matched people living elsewhere in the community (Office for National Statistics, 2022), and are vulnerable to becoming acutely unwell and experiencing

---

* Corresponding author. University of Leicester, Department of Population Health Sciences, George Davies Centre, University Road, Leicester, LE1 7RH, UK.
E-mail address: fawn.harradhyde@leicester.ac.uk (F. Harrad-Hyde).

https://doi.org/10.1016/j.socscimed.2025.118012
Received 22 April 2024; Received in revised form 5 February 2025; Accepted 20 March 2025

deteriorations in their health (Hodge et al., 2023). Both the speed at which deteriorations occur and the severity of these can vary (Barclay et al., 2014). Care home staff play a crucial role in monitoring and managing residents' health and in identifying and responding to potential deteriorations. When deterioration occurs, staff make complex decisions, in which they weigh-up the potential benefits and burdens of different courses of action, including related whether to provide care within the care home or to transfer the resident to hospital (Harrad-Hyde et al., 2022a).

Whilst care home staff may prefer to care for deteriorating residents in the care home, at times, residents may be transferred to hospital. This can occur for a multitude of reasons. A hospital transfer may be initiated due to a clinical need - for example, if a resident (potentially) requires tests, treatments or healthcare support that are not available within the care home setting. A hospital transfer may also be initiated due to non-clinical factors, for example, if staff are concerned that failure to transfer the resident to hospital could leave them personally and professionally vulnerable to accusations they have failed in their duty of care (Harrad (2021))(Arendts).

For care home residents, particularly those with frailty and/or cognitive impairment, hospital transfers and admissions can be associated with declines in physical health and psychological well-being (Fogg et al., 2018; Calnan et al., 2013). Once in hospital, residents may experience invasive interventions, perhaps with limited benefit, and face a higher risk of inpatient mortality (Dwyer et al., 2014). In addition to being potentially burdensome for residents, hospital transfers from care homes have financial and resource implications for healthcare services. As a result, a substantial body of research has sought to identify emergency care use which could be considered 'avoidable' (Ouslander; Marincowitz et al., 2022).

Whilst there have been attempts to differentiate between terms such as 'avoidable' and 'inappropriate', (Parkinson et al., 2021), these terms are often used interchangeably. Although there is no agreed definition of what constitutes an 'inappropriate' hospital transfer and/or admission (Harrison et al., 2016; Lemoyne et al., 2019), this term is usually rooted in an assumption that the underlying medical condition or issue could have been prevented or managed outside of a hospital setting (Parkinson et al., 2021).

The data presented in this paper were collected as part of a study exploring the decision-making of care home staff when faced with situations in which residents potentially required a hospital transfer (Harrad (2021)). The findings from this study highlighted the complexity of staff decision-making processes and the centrality of risk to these. During decision-making, staff 'weighed-up' a variety of risks, including risks to: residents; staff (as decision-makers) and their social relationships with others; care home organisations; and wider health and social care services (Harrad-Hyde et al., 2022a and Harrad-Hyde et al., 2022b).

Given that balancing different forms of risk was identified as a central tenet in staff decision-making, in this paper we turn to the work of Mary Douglas, to further explore the ways care home staff perceived deteriorating care home residents to be potentially vulnerable ('at risk'), dangerous ('a risk') or both in care home and hospital settings. We draw on Douglas' notion of 'matter out of place' in order to further explore and interrogate ideas around hospital transfers from care homes and to provide alternative ways of thinking about this phenomenon.

1.2. Mary Douglas on 'matter out of place' and risk

Despite being a highly influential author within the field of risk studies, Douglas' early work (Douglas, 1966) did not use the term 'risk' and instead referred to 'danger'. Nonetheless, throughout her career, Douglas studied the ways that risks are culturally framed around notions of purity and danger (Douglas, 1966; Douglas and Wildavsky, 1982). Douglas believed that shared ideas about danger were influenced by both a concern for hygiene and a concern for convention and shared societal norms. As such, Douglas suggested that ideas about risk could reflect the social order of the society in which they existed. Drawing on psychological research that suggested humans tend to perceive patterns in the world and interpret the world as stable and ordered (Bartlett, 1932), Douglas suggested that through our attempts to categorise and order the social world, we identify things that either do not fit or that exist within the margins of our pre-existing schemas. These anomalous objects are subsequently categorised as 'matter out of place'.

Douglas used the notion of 'dirt' to refer to things that are considered 'matter out of place'. She stated: *"As we know it, dirt is essentially disorder. There is no such thing as absolute dirt: it exists in the eye of the beholder"* (1966, p36), emphasising that notions of dirt were socially constructed within particular social, historical, cultural, political and economic contexts. Douglas suggested that people, as well as objects, could be considered 'matter out of place'. Discussing the ways that individuals can be bound to, and thus belong or not belong to places, Douglas argued that such anomalous persons - that exist within the margins or outside of pre-existing categorisation - are perceived to be 'matter out of place' and are therefore in a 'marginal state'. Douglas suggested that such persons are *"treated as both vulnerable and dangerous" (1966, p95),* and constructed as simultaneously presenting as 'a risk' (or dangerous) to others whilst also being 'at risk' (or vulnerable) themselves.

Scholars have drawn on Douglas' work to interpret a wide range of phenomena, including to examine the experiences of people providing and receiving healthcare. Murphy and Philpin (2010) outlined ways that Douglas' notion of 'matter out of place' could be applicable to early-miscarriages, because these represent an ambiguous loss and atypical bereavement. Watermeyer et al. (2022) used Douglas' work to suggest that although children with visual impairment are increasingly receiving their education in 'inclusive schools', staff anxieties around visual impairment may lead them to perceive such children as 'matter out of place' within these settings. More recently, Douglas' work has been used to provide critical insights into how risks related to the Covid-19 pandemic have been understood. In an editorial published during an early phase of the pandemic, Brown (2020) called for a greater engagement with Douglas' work to study shared understandings of risk related to Covid-19. In particular, Brown suggested that investigating the evolution of local practices and use of objects, such as face masks, could provide insight into the organisation of social categories and the ways risk was understood and culturally framed. Indeed, Davy (2021) drew upon Douglas' work to investigate obedience to government guidance related to the Covid-19 pandemic, suggesting that social distancing rules shaped shared understandings of personal space and that for some people the transgression of these rules were associated with being 'dirty' or at risk of being 'polluted' by the virus.

Drawing on data collected as part of a study which aimed to understand care home staff decision-making during potential resident hospital transfers (Harrad (2021)), in this paper we focus particularly on staff's perceptions of deteriorating residents and their 'fit' in different potential care locations. We explore the ways deteriorating care home residents can, often simultaneously, be perceived as both vulnerable ('at risk') and 'dangerous' ('a risk') in both care home and hospital settings, to demonstrate how deteriorating care home residents can be understood as 'out of place' in whichever setting they receive care. In doing so, we draw on Douglas' notion of 'matter out of place' in order to further explore ideas around hospital transfers from care homes and to provide alternative ways of thinking about this phenomenon.

2. Methodology

The data presented here were collected as part of a study seeking to understand care home staff decision-making during potential resident hospital transfers (Harrad (2021)). Guided by the philosophical paradigm of critical realism, which ascribes to a realist ontological position and an interpretivist epistemological position (Bhaskar), data collection occurred in two phases. Care homes are complex environments, made up of a range of staff and residents, with their own staffing structures, operational policies and procedures. Therefore, in line with the recommendation by Goodman et al. (2011) that when preparing to undertake research in a care home, researchers need to understand the formal and informal staff hierarchy and the ways in which staff view their role, interviews were first undertaken with care home staff, to develop an understanding of the transfer process in each home, before further ethnographic data collection took place.

In total, 28 face-to-face, semi-structured interviews were undertaken with 30 members of staff across six care homes. Semi-structured interviews enabled questions to be ground within existing literature, whilst also allowing new topics of conversation to emerge (Braun and Clarke, 2013). On two occasions, participants requested that they be interviewed in pairs. In both cases participants were employed in the same role. Interviews took place between May 2018 and February 2019 and were conducted in a private area of the participants' workplaces during their working hours. Participation was voluntary and written informed consent was obtained. Care home sites were sampled purposively to reflect factors that influence transfer rates (Graverholt; Hancock et al., 2017; Wolters et al., 2019). This included: whether or not the home provided nursing care; whether or not the home was registered to provide specialist care for people living with dementia; the size of the care home (determined by the number of beds); the size (determined by the number of homes the company owned) and type of provider (for-profit or not-for-profit); and homes with different regulatory ratings. Individual participants were also sampled purposively based on their role to ensure a range of different voices were heard in each home (for more information see Table 1).

Once permission had been obtained from the care home manager, individual staff were invited to participate by a member of the research team. It was made clear to staff and managers that participation was voluntary and staff were not obliged to participate. The interview schedule included questions about personal experiences of being involved in transfer decisions and a number of vignettes which were designed to reflect situations that could occur in care homes. Interviews and vignettes were piloted with a care home manager and another member of care home staff prior to the commencement of data collection. Data from pilot interviews were not included in analysis. Each interview was audio-recorded and transcribed verbatim. During transcription, all identifiable data were removed, and each transcript was allocated a transcript number. Ethical approval for this phase was obtained from the University of Leicester's Research Ethics Committee for Medicine and Biological Sciences (reference: 15340).

The second phase of data collection consisted of 113 h of ethnographic fieldwork at three of the care homes that had taken part in the first phase. Ethnographic studies can illuminate factors that influence behaviour, including behaviours that, at face-value, may appear illogical (Barbour, 2014). This was relevant to the phenomenon of interest as studies have suggested care home staff initiate hospital transfers without the expectation of better clinical outcomes for the resident (Arendts). A short-term theoretically informed approach to ethnography was adopted (Pink and Morgan, 2013). Fieldwork was conducted between April 2019 and November 2019, for a period of approximately six to 8 weeks at each care home. Data were collected via observations focused on staff activity and interactions. This included observations of: i) the ways in which staff managed residents' health conditions, ii) interactions between members of staff, residents, family carers and visiting healthcare professionals, iii) the decision-making processes that care home staff undertook when initiating or avoiding a transfer to hospital and iv) the work that care home staff undertook to maintain residents' health and to prevent hospital transfers. Observations occurred at different times of the day (mornings, afternoons, evenings and nights) across all days of the week. Observation and interview data were supplemented by data collected via documentary analysis and through informal, unstructured conversations with care home staff, residents, family carers and visiting healthcare professionals.

Detailed descriptions were recorded using a pen and paper during each visit. In addition, at the end of each visit, an audio-recording was created to summarise thoughts, experiences and the events that had occurred. Both hand-written notes and the content of audio-recordings were later typed. The ethnographic-theory dialogue, described by Pink and Morgan (2013) as a process of searching for and re-examining data in light of relevant theories and concepts that could be potentially applicable, continued beyond the duration of fieldwork. Ethical approval for this phase was obtained from the Social Care Research Ethics Committee (reference: 18/IEC08/0033).

Data analysis involved intensive engagement across the range of data sources. In line with a Straussian approach to grounded theory, analysis was based on the constant comparative method (Bryant and Charmaz, 2007; Singh and Estefan, 2018). This involved coding segments of data and comparing each segment with other segments, both within the same source and across sources, in order to identify similarities and differences. Codes developed during analysis of the interview transcripts (collected during the first phase of data collection) were used as 'sensitising concepts' to inform the second, ethnographic phase.

Data were analysed in three steps. Firstly, each section of each transcript was coded according to the phenomenon or concept that was being discussed, thus identifying a number of 'open codes'. Secondly, an exploration of relationships between codes produced 'axial' codes, before 'selective codes' - core categories to which all data related – were identified. Coding was initially carried out by hand before using NVivo12. Data collection and analysis occurred concurrently and analysis was an inductive process. The first author (FHH) carried out all interviews and initially coded transcripts. The remaining authors (CW,

Table 1
A table to describe the characteristics and number of participants recruited at each care home.

Name	Care home type		Provider size	Number of beds	CQC rating	Participants recruited				
						Manager	Deputy Manager	Registered nurse	Senior Carer	Carer
Cedar Court	Care home with nursing	Private for profit	5	35	Good	1	1	1	1	1
Cheery Tree House *	Care home without nursing	Private for profit	1	15	Good	2	**	**	**	2
Goldfinch Lodge *	Care home with and without nursing	Private for profit	120	60	Good	1	1	3	2	0
Starling Manor	Care home with nursing	Private for profit	300	35	Requires Improvement	1	0	2	**	1
Sycamore Gardens *	Care home without nursing	Charitable not for profit	5	45	Good	1	1	**	3	2
Wren Grange	Care home with nursing	Private for profit	1	40	Outstanding	1	0	1	1	0

* Took part in both phases of data collection.
** Indicates this job role did not exist within specific home.

NA) independently reviewed five transcripts. This provided an opportunity to: compare coding across team members; discuss differences within coding; identify preliminary findings and; reflect on whether the style and content of the questions could be improved. Themes were continually reviewed, validated and refined until theoretical saturation was achieved.

3. Findings

In what follows, we use our data to explore the ways that deteriorating care home residents can be positioned as being both 'vulnerable' and 'dangerous' in both hospital and care home settings. We also highlight the ways in which the prioritisation of different forms of risk and vulnerability could change across different times and situations. In doing so, we highlight the double bind problem that care home staff face when deciding how to respond to such a deterioration, as residents can potentially be perceived as 'matter out of place' in whichever setting they receive care.

3.1. Deteriorating care home residents as vulnerable in hospital

In the majority of situations, staff across all care homes described a strong preference for caring for deteriorating residents in the care home where possible. This preference was influenced by concerns that residents would be 'at risk' in hospital. During interviews and ethnographic fieldwork, participants repeatedly discussed the possibility that residents might experience poor quality care or poor outcomes as a result of being transferred to hospital. Staff discussed the possibility that residents might not receive the high level of support they required or might develop iatrogenic illnesses, or spend long periods of time in bed which may later affect their mobility. As a result of these concerns, across interviews and ethnographic data staff repeatedly referred to hospital as "the wrong environment" (Manager, Sycamore Gardens)' or 'not the right place' for deteriorating residents. The perception that a hospital environment may not always be the 'right' place for residents to receive care appeared to be shared by some healthcare professionals who visited the care homes and, albeit to a lesser extent, by families.

> "You send someone with dementia into hospital and it makes them a million times worse … they don't recognise anybody, they're scared. And they are restricted a lot in the hospital … It's not like they would be able to get up and walk." (Carer, Cedar Court)

> "A GP visited the home today as part of a regular weekly visit. She said 'acute is not the best place for them', noting that residents often 'sit around and 'pick stuff up' … Also when I spoke to a resident's daughter she said that the hospital was the 'right place' for her mum because when she was in an unfamiliar environment she become more confused." (Fieldnote, Sycamore Gardens)

Staff frequently said they believed healthcare professionals (such as hospital staff and ambulance staff) felt that deteriorating residents often visited the hospital 'unnecessarily', particularly if the transfer was related to a chronic health condition that might have been potentially 'manageable' in the community and that this could lead to residents being returned from the hospital without adequate investigation. They also raised concerns about the potential for residents to experience a poor discharge when returning to the care home and the potential risks this could have to residents' physical health and well-being.

> "I have concerns with them coming home … I always feel there's a bit of neglect … Coming home in a nighty, no blankets. It could be 10 o'clock at night and it's like, 'hold on a minute, this is a vulnerable lady'." (Carer 1, Cherry Tree House)

> "They go into hospital and they are not looked into properly. They just send them back with a UTI or chest infection diagnosis. They don't do any further checks." (Nurse, Cedar Court)

3.2. Deteriorating care home residents as dangerous in hospital

As well as acknowledging the risks residents may face in hospital, care home staff also discussed the potential impact that transferring residents to hospital may have on the hospital and wider healthcare services. Concerns about residents being 'dangerous' or presenting a risk when in hospital were mentioned less frequently and less explicitly than concerns about residents being 'at risk' in hospital. However, throughout ethnographic fieldwork, staff repeatedly acknowledged that hospitals were "busy" and "struggling to meet demand". They were aware that when they requested healthcare support for the residents, for example from a GP or ambulance, this had a knock-on effect elsewhere in the system. Occasionally, family members also discussed the possibility that, in the event a resident was transferred to hospital, there may be subsequent effects on the wider healthcare system.

> 'I don't want to waste people's time because I know people call [999] for really silly things.' (Carer 2, Cherry Tree House)

> "Today I spoke with the wife of a gentleman who has slowly been deteriorating over several months. She said: 'That [hospital transfer] is what we are trying to avoid where possible, we don't want to be taking a place from somebody else who might need it'." (Fieldnotes, Goldfinch Lodge).

3.3. Deteriorating care home residents as vulnerable in the care home

Despite often stating that hospital was 'not the right place' for residents, there were occasions when staff did not feel able to meet residents' needs on site. At these times, deteriorating residents could be seen as 'at risk' when remaining in the care home, especially when staff were not able to obtain access to adequate healthcare support.

> "Although we have got nurses here, we haven't got x-ray eyes, so it is just to make sure that the resident is OK." (Manager, Starling Manor)

> During a handover, a carer reported that they had contacted the GP practice at 8am to request either an antibiotic or a visit from a GP for a resident who they suspected had a chest infection. It was now 3pm and they had had no subsequent contact with the GP practice. The carer said "we just need help – if anything happens we don't have oxygen or anything and we would have to call 999". (Fieldnote, Cherry Tree House)

> "When we call the Out-of-Hours and they will say 'we're not coming out' … it gives the staff no assurance at all." (Manager, Sycamore Gardens)

3.4. Deteriorating care home residents as dangerous in the care home

Whilst staff were concerned about the health and well-being of the deteriorating resident, they were also concerned about potential for the resident to be dangerous and pose a risk to others in the care home. For example, when a resident experienced a deterioration in their health, they often required additional support or monitoring to ensure they did not deteriorate further. This could create additional work for staff, which could detract attention from other residents. Staff also discussed occasions where other residents may be directly at risk as a result of a deterioration – for example, if a resident were to become uncharacteristically aggressive – and occasions when other residents found it distressing to witness a deterioration.

> "If a resident becomes unwell and became very violent towards others it would be a 999 call." (Nurse 2, Starling Manor)

> "A lady in the home has been screaming for long periods of time. Staff are going out of their way to keep her in the home but it feels like the situation is reaching boiling point because the screaming is

> distressing for her, for staff and for other residents." (Fieldnote, Sycamore Gardens)

In addition, staff frequently raised concerns that keeping a deteriorating resident in the care home could be potentially risky for both themselves (as decision-makers) and for the care home in which they worked, especially if it was later decided that a hospital transfer would have been a more appropriate course of action.

> "You can be suspended and scrutinised … You have to bear that in … if I were going to be reprimanded, would I be able to justify?" (Manager, Goldfinch Lodge)

> "Today, a member of care staff reflected on an occasion in which a resident fell. Believing the resident was uninjured, she had not called external services or initiated a transfer. The following day it was clear the resident had fractured their hip. The staff member said: 'And you think about the fear and the blame –whatever happens you blame yourself, because you are supposed to be looking after them … I felt awful and then I got a bollocking [telling off] from the managers'." (Fieldnote, Cherry Tree House)

3.5. *Risk configurations as fluid*

Despite the acknowledgment that residents could always be viewed as potentially vulnerable or dangerous in each setting, the degree to which an individual resident could be viewed as either in each setting could change over time. As a result, the different risk configurations that were foregrounded and called upon at times of decision-making could change. Staff were more likely to emphasise the possibility that residents might be vulnerable in hospital when they suspected the resident was approaching the end of their life. For example, one participant said:

> "A person can have a choice to die in hospital … but … you will get much better care here than in the hospital due to the fact that hospital is a busy place …" (Manager, Wren Grange)

During a conversation with a daughter of a resident who lived with advanced dementia, the daughter described a conversation with care home staff in which she and staff decided to move away from prioritising curative hospital treatment and instead to move towards supportive and palliative care that could be provided on site. Doing so encouraged staff to deprioritise the notion that the resident could be vulnerable in the care home, yet prioritised and foregrounded the ways in which the resident could be vulnerable in a hospital setting.

> The daughter stated that when her mother first joined the care home, two years previous, she had experienced numerous admissions. She said that staff were doing "their best" for her mother and treating her "more like family". However, as her mother's dementia progressed she was concerned about the impact a hospital admission might have on her mother's health and well-being. As a result, she asked about putting a written plan in place, which led to a discussion about her mother's health status, prognosis and the desire to prioritise comfort over the extension of life. She felt this had helped staff to keep her mother out of hospital. (Fieldnote, Sycamore Gardens)

Conversely, during interviews and ethnographic observations, staff were more likely to emphasise the potential for residents to be vulnerable in the care home during instances when residents exhibited life-threatening symptoms and (potentially) needed tests, treatment or equipment that were not available in the care home. In these instances, staff described decision-making as more *'straight-forward'* (Deputy Manager, Goldfinch Lodge) and there appeared to be less emphasis on the possibility that residents might be considered 'out of place' in the hospital environment. In addition, staff were also more likely to emphasise the potential that residents may be vulnerable in the care home at times when they were concerned that by not transferring a resident to hospital, they or their organisations may be accused of being neglectful. Staff felt this was particularly important when residents had dementia and other forms of cognitive impairment which reduced their ability to report symptoms such as pain.

> "The resident isn't able to tell us that something is wrong … today it is all about covering yourself … With people with advanced dementia, you just never know. If you've got people with an injury, you can have safeguarding involved and all sorts. (Nurse 1, Starling Manor)

> A GP had been called because there was uncertainty about whether the mark on the arm of a resident living with advanced dementia was a bruise or a rash. The GP prescribed antibiotics (for a possible skin infection) and scheduled an x-ray for two days later (to rule out injury). The care home manager referred to the home's policy which stated all residents should be transferred to hospital immediately in the event of a suspected fracture. She said she would struggle to provide justification, to family members and regulatory bodies, for waiting two days if the x-ray identified a fracture. An ambulance was called and the resident was taken to hospital. (Fieldnote, Goldfinch Lodge)

3.6. *Risk configurations as socially mediated*

The (de)prioritisation of different forms of vulnerability and risk were socially mediated. Staff perceptions of what represented a 'change' in a resident's health, the degree to which changes were a cause for concern and what an appropriate course of action might be, were often negotiated with family carers, care home staff colleagues, healthcare professionals and, to a lesser extent, individual residents. The prioritisation of particular risk configurations could be influenced by the ways hospital transfers were socially constructed in different care homes. Staff discussed how *their* care home was 'good' at avoiding hospital transfers in comparison to *other* care homes. However, the discussion of 'other' homes was seldom related to a concrete example of a specific home. Instead, staff appeared to be attempting to position themselves as separate from an abstract concept of 'other' care home staff, who were imagined to be making thoughtless decisions.

> "It is not just that the nurse feels 'oh I can't cope with this, phone 999 and send the resident' we don't do things like that." (Deputy Manager, Wren Grange)

Organisational thought styles that shaped risk configurations appeared to be influenced strongly by the care home manager's views. At Wren Grange, the decision to *not* transfer residents was framed as reducing the potential dangers of a hospital admission for residents by providing care in the home. During interview, the manager emphasised the risks that deteriorating residents may face in hospital settings. This was echoed by other staff, who also referenced such harms. In contrast, at Starling Manor, the decision to *not* transfer residents was framed in terms of potential harms that might occur as a result. During interview, the manager highlighted risks to staff, other residents and the organisation. Although staff at Starling Manor discussed a preference for caring for residents in the home where possible, they also frequently referenced concerns about being accused of 'not doing enough'. Organisational differences between the two homes may also have influenced the prioritisation of different risk configurations. Both homes provided nursing services, yet staff at Starling Manor cared for people with advanced dementia, and therefore their decision-making may have involved more uncertainty, as residents were less able to report their symptoms. In addition, at the time of data collection, Wren Grange had a higher quality rating from the regulatory body, which may have increased staff's confidence in their approach to providing care, reducing fears about being accused of 'not doing enough'.

4. Discussion

4.1. Summary

We have suggested that at times of deterioration, care home residents can be perceived, often simultaneously, as 'vulnerable' and 'dangerous' in both care home and hospitals settings. Based on this tenet, in line with the work of Mary Douglas, we argue that deteriorating care home residents can thus be conceptualised as 'matter out of place' in which ever setting they receive care. On one hand, care home staff perceived deteriorating residents to be 'vulnerable' in a busy hospital environment due to the possibility they may experience poor care, poor outcomes and, a poor discharge process. However, whilst staff often preferred to care for residents in the care home, they recognised that doing so could lead to residents being 'vulnerable' to the risks associated with being unable to obtain tests, treatment, equipment and healthcare support that are not routinely available in care homes. On the other hand, staff recognised that when residents are transferred to hospital, the care they receive has implications for wider healthcare services and therefore they may represent a danger to hospital settings. However, caring for a deteriorating resident in the care home introduced new dangers to other people within the home. Caring for a deteriorating resident could create additional work for staff, which could detract attention from other residents, and staff were concerned that they or the wider organisation might be held responsible if it was later decided a hospital transfer had been required. Therefore, whilst previous research has drawn on the work of Douglas to demonstrate the ways people can be constructed as belonging within particular spaces, yet 'matter out of place' in others (Watermeyer; Groves and O'Connor, 2020; Murphy and Philpin, 2010), through our analysis, we demonstrate that people – in this instance deteriorating care home residents - can be perceived as both vulnerable and dangerous and therefore be 'matter out of place' in all settings available to them.

Furthermore, whilst staff acknowledged that residents could always be viewed as potentially vulnerable or dangerous in either setting, different forms of vulnerability and danger were prioritised and foregrounded in different contexts. However, by providing examples of occasions in which staff perceived a resident to be more or less 'out of place' in either the care home or hospital setting over time, we have demonstrated that different forms of vulnerability and danger are (de) prioritised under different circumstances. Therefore, our findings support the work of Boholm and Corvellec (2011) who argued that risk identities are fluid.

For an object to be considered 'at risk', it must be ascribed value that is considered to be 'at stake' (BoholmCorvellec). In our work, we identified various things care home staff considered to be 'at stake' when making decisions about deteriorating residents including: residents' health and well-being; the care home's reputation; and staff's own reputation; conscience; professional relationships; employment and professional registration (Harrad (2021)). Further research could examine the ways different perceptions of value influence how different forms of vulnerability and danger are emphasised. The analysis we present extends our empirical work (Harrad-Hyde et al., 2022a), providing a theoretical lens through which to reconsider the experiences of care home staff. At times of potential deterioration, care home staff make complex decisions in which they weigh-up a variety of risks, including to: residents; staff (as decision-makers) and their social relationships with others; care home organisations and wider health and social care services. Care home staff report feeling "in between a rock and a hard place", using phrases such as "damned if you do and damned if you don't" to convey the potential risks associated with whichever option they choose (Harrad (2021)). Explicitly framing deteriorating residents as 'matter out of place' in whichever setting they receive care enables us to unpick these experiences further, casting new light onto the double bind problem that care home staff face.

4.2. Reconsidering concerns about hospital transfers from care homes in light of Douglas' notion of matter out of place

Using Douglas' notion of 'matter out of place' provides a theoretical lens through which to further interrogate and critically assess current framings of risk within policy and practice surrounding hospital transfers from care homes. Drawing on Douglas' work provides a different vantage point from which to question why the emergency healthcare use of care home residents (and the impact of this use on the healthcare system) has come to be selected for such policy and research attention, whilst comparatively less attention has focussed on the well-documented and long-standing lack of healthcare support available in care homes and the impact this has on care homeresidents (NHS England, 2016).

Douglas suggested it is crucial to attend to issues of power and status within society in order to understand why some risks are prioritised or selected for attention whilst others are ignored, and in turn to understand why some people are considered to either belong or to be 'matter out of place' in particular contexts. By reconsidering our data based on these tenets we suggest that the policy and research attention afforded to reducing hospital transfers from care homes may reflect the low levels of power and status that care home residents (and perhaps more broadly older people living with multiple long-term conditions) are perceived to hold within society. To further illustrate this point, we may also consider that other groups of individuals who are routinely over-represented in using emergency healthcare services, such as young children (Blunt, 2013), are not the focus of such level of attention, perhaps due to the highly-valued position of children within many modern societies (Zelizer). People may be more likely to be constructed as 'matter out of place' at times of social, political or economic uncertainty (Douglas and Wildavsky, 1982). It is perhaps unsurprising that much of the concern about the 'risks' associated with the emergency healthcare use of care home residents is occurring at a time when, internationally, healthcare services are underfunded and are therefore struggling to meet the demands of the population (World Health Organisation, 2015). It is important to locate concerns about residents' emergency care use within this specific context.

4.3. Deteriorating care home residents as 'placeless' in 'out of shape' health and social care services

It is widely acknowledged that care home residents have complex and co-morbid health and social care needs. Furthermore, residents' needs may not align with the design of health and social care services, which are often fragmented and disease-specific. This lack of alignment can lead to residents being perceived as existing between the margins of health and social care systems, which in turn contributes to deteriorating residents being framed as being simultaneously 'vulnerable' and 'dangerous' - therefore as 'matter out of place' - in whichever setting they receive care. At times of deterioration, care home residents become "*persons in a marginal state … who are somehow left out of the patterning of society … who are placeless*" (Douglas, 1966, p95).

The notion that deteriorating care home residents are perceived as 'matter out of place' – and that they are therefore 'placeless' in whichever setting they receive care has important implications for considering current service provision. Empirical studies suggest hospital services do not adequately support older people with complex needs (Fogg et al., 2018; Calnan et al., 2013). Additionally, policy documents often acknowledge the potential burdens for residents, alongside resource and financial implications for hospital services. To date, attempts to address the 'problem(s)' associated with emergency care use amongst care home residents have largely aimed at reducing 'inappropriate' hospital transfers from care homes. The evidence base is strongest for approaches which: encourage integrated working between health and social care services; introduce quality improvement programmes to develop skills and expertise within the care home; and provide additional healthcare support in care homes. Simpler approaches, focussing on or providing training about specific issues (such as medication management or the identification and management of delirium) provided less-promising results (Chambers et al., 2023).

The aforementioned approaches offer promise in moving towards improving healthcare support for deteriorating care home residents, however, we perceive three limitations. First, since deteriorating residents are perceived as 'matter out of place' in both settings, it may be naïve to assume that encouraging closer, more 'integrated' working across health and social care will enable services to adequately meet residents' needs. However, closer working may encourage better understandings of residents' complex needs, which may in turn shift individual and group perceptions of the degree to which deteriorating residents are 'out of place' in either setting. Second, attempts to reduce hospital care use amongst residents relies on over-simplistic, dichotomous categories – for example, of 'appropriate' or 'inappropriate' healthcare, which lack agreed definitions (Harrison et al., 2016) (Harrad-Hyde and Burton, 2025), including who decides and on what basis. Third, strengthening healthcare support in care homes may be challenging in the context of sector level issues, such as staffing shortages and complex funding arrangements between health and social care.

In their relational theory of risk, Boholm and Corvellec (2011, p181) suggest that that "scientific evidence … has a privileged position in the creation of risk accounts" in that it "establishes a plot" or narrative. Based on our findings, we offer an alternative plot to dominant media, policy and academic discourse by presenting the double bind problem care home staff face when deciding how to respond to a deteriorating resident, situated within a system in which they can be considered 'out of place' in either setting they receive care. Instead of asking whether deteriorating residents are in the 'right place' to receive care, we might instead ask whether healthcare services are the 'right shape' to meet the needs of the care home population and their complex health and social care needs. Strauss, Schatzman, Bucher, Ehrlich and Sabshin (1964) noted that healthcare services have their own unique 'shape' in terms of the tasks and routines undertaken and the population they support. Later Strauss, Fagerhaugh, Suczek and Wiener (1985, p25) discussed the implications of placing patients into services not aligned to their needs, arguing: "if a patient is placed on a ward into whose shape, he (sic) does not fit at all" then routine healthcare issues can become highly "problematic under these 'out of shape' conditions". Instead of seeking to reduce 'inappropriate' transfers from care homes, an alternative, theoretically-informed, approach to address this 'problem' is to develop appropriate services which are the 'right shape' to adequately support deteriorating care home residents and their complex needs.

As the health and care needs of those living in care homes become increasingly complex (Barker et al., 2020), finding new ways to support residents is crucial. Shifting the focus from the 'appropriateness' of a transfer to the appropriateness of a service could provide an approach which refrains from unintentionally stigmatising residents who use emergency care services and the health and social care professionals involved in decisions about their care. (Harrad-Hyde and Burton, 2025). Care home residents have a right to timely healthcare support. Developing services that are responsive to residents' needs is likely to require the input of various stakeholders including care home staff, residents, their families and health care professionals who provide support at times of deterioration (Harrad-Hyde and Burton, 2025). However, continuing to focus on the degree to which deteriorating residents are 'out of place' will perpetuate the positioning of residents in such a way that inadequately supports deteriorating residents and the people who care for them.

4.4. *Strengths and weaknesses*

Data were collected using multiple methods including semi-structured interviews with care home staff, observations, informal conversations and documentary analysis. This triangulation of data allowed for a more in-depth exploration of the ways ideas about risk were understood within the social context(s) in which staff were operating and to compare work as reported with work as done. It was unclear whether the process of gaining consent from managers first, before inviting staff to participate, influenced the way the researcher was perceived by staff. Whilst the results of this paper and the wider study focused on the views of care home staff, it is widely acknowledged that a range of stakeholders contribute towards transfer decisions. Therefore, future work could build on the findings presented by exploring the ways other stakeholders understand risk(s) associated with the (non)transfer of residents to hospital. Furthermore, future research could build on existing literature related to multi-disciplinary decision-making, by exploring the ways risk is negotiated by those working across health and social care organisations.

As has been stated elsewhere (Harrad-Hyde et al., 2022b), although this study did not intentionally focus on risk, 'risk' was identified as an important overarching theme. An *a priori* focus on risk may have led to an earlier and more in-depth engagement with the notion of deteriorating residents being conceptualised as 'matter out of place'. However, the inductive identification of risk ensured the application of the concept was grounded in participants' lived experiences. Data presented were collected prior to the Covid-19 pandemic, which impacted care homes globally (Comas-Herrera and Fernandez, 2020; Gordon et al., 2020). The notion of deteriorating care home residents being 'out of place' in both hospital and the care home may have been heightened during and after the pandemic, at a time staff were concerned that residents might contract Covid-19 in the hospital or have Covid-19 in the care home.

5. Conclusion

At times of deterioration, care home residents are perceived, often simultaneously, as both 'vulnerable' and 'dangerous' in both care home and hospital settings. The degree to which different forms of vulnerability and danger were prioritised and foregrounded could change over time. Drawing on Douglas' notion of 'matter out of place' provides insights into the decision-making processes of care home staff, highlighting the double bind problem that care home staff face when deciding how best to respond to a deteriorating resident. In addition, by drawing on Douglas' notion of 'matter out of place', we suggest that the lack of alignment between deteriorating residents' needs and current health and social care provision leads to deteriorating care home residents being perceived as 'out of place', or 'placeless', in whichever setting they receive care. Therefore, we propose a shift in focus, which moves away from considering the degree to which a resident is in the 'right place' to receive care and towards the degree to which a healthcare service are the 'right shape' to provide appropriate support to deteriorating care home residents and their complex needs.

Funding

The analysis presented in this paper was supported by a Mildred Blaxter postdoctoral fellowship from the Foundation for the Sociology of Health and Illness held by Fawn Harrad-Hyde. Fawn Harrad-Hyde's doctoral work was funded by a University of Leicester College of Life Sciences studentship. Fawn Harrad-Hyde and Chris Williams are supported by funding from LOROS Centre for Excellence. Natalie Armstrong is supported the National Institute for Health and Care Research (NIHR) Applied Research Collaboration East Midlands (ARC EM) and by the NIHR Greater Manchester Patient Safety Research Collaboration (GM PSRC). The views expressed are those of the authors and not necessarily those of the aforementioned funding bodies.

CRediT authorship contribution statement

Fawn Harrad-Hyde: Writing – review & editing, Writing – original draft, Project administration, Methodology, Investigation, Formal

analysis, Data curation, Conceptualization. **Chris Williams:** Writing – review & editing, Supervision, Funding acquisition, Formal analysis, Conceptualization. **Natalie Armstrong:** Writing – review & editing, Supervision, Methodology, Formal analysis, Conceptualization.

Ethical approval statement

Ethical approval for the first phase of data collection (interviews with care home staff) was obtained from the University of Leicester's Research Ethics Committee for Medicine and Biological Sciences (reference: 15340). Ethical approval for the second phase of data collection (ethnographic fieldwork) was obtained from the Social Care Research Ethics Committee (reference: 18/IEC08/0033).

Acknowledgments

With thanks to the ENRICH East Midlands and ENRICH West Midlands teams for their support in identifying care homes to participate in the study and to the care home staff, residents, relatives and visiting healthcare professionals who took part.

Data availability

Data will be made available on request.

References

Arendts, G., Howard, K., 2010. The interface between residential aged care and the emergency department: a systematic review. Age Ageing 39, 306–312.

Arendts, G., Quine, S., Howard, K., 2013. Decision to transfer to an emergency department from residential aged care: a systematic review of qualitative research. Geriatr. Gerontol. Int. 13, 825–833.

Barbour, R., 2014. Introducing Qualitative Research. SAGE, London.

Barclay, S., Froggatt, K., Crang, C., Mathie, E., Handley, M.J., Iliffe, S.R., Manthorpe, J., Gage, H., Goodman, C., 2014. Living in uncertain times: trajectories to death in residential care homes. Br. J. Gen. Pract. e576–e583.

Barker, R.O., Hanratty, B., Kingston, A., Ramsay, S., Matthews, F.E., 2020. Changes in health and functioning of care home residents over two decades: what can we learn from population based studies? Age Ageing afaa227, 2020.08.05.20168740.

Bartlett, F.C., 1932. Remembering: A Study in Experimental and Social Psychology. Cambridge University Press, Cambridge, UK.

Beck, U., 1992. Risk Society: towards a New Modernity. SAGE, London.

Bhaskar, R., 1978. *A Realist Theory in Science,* Hassocks. Harvester Press.

Blunt, I., 2013. Quality Watch: Focus on Preventable Admissions; Trends in Emergency Admissions for Ambulatory Care Sensitive Conditions, 2001 to 2013. The Health Foundation and Nuffield Trust, London.

Boholm, Å., Corvellec, H., 2011. A relational theory of risk. J. Risk Res. 14, 175–190.

Braun, V., Clarke, V., 2013. Successful Qualitative Research: a Practical Guide for Beginners. SAGE, London.

Brown, P., 2020. Studying COVID-19 in light of critical approaches to risk and uncertainty: research pathways, conceptual tools, and some magic from Mary Douglas. Health Risk Soc. 22, 1–14.

Brown, P., Gale, N., 2018. Developing a sociology of risk work in client-facing contexts: an editorial. Health Risk Soc. 20, 1–12.

Bryant, A., Charmaz, K., 2007. Grounded Theory research: methods and practices. In: BRYANT, A., CHARMAZ, K. (Eds.), The SAGE Handbook of Grounded Theory. SAGE, Thousand Oaks, CA.

Calnan, M., Tadd, W., Calnan, S., Hillman, A., Read, S., Bayer, A., 2013. 'I often worry about the older person being in that system': exploring the key influences on the provision of dignified care for older people in acute hospitals. Ageing Soc. 33, 465–485.

Chambers, D., Cantrell, A., Preston, L., Marincowitz, C., Wright, L., Conroy, S., Lee Gordon, A., 2023. Reducing unplanned hospital admissions from care homes: a systematic review. Health Soc. Care Deliv. Res. 11, 1–130.

Comas-Herrera, A., Fernandez, J.-L., 2020. England: Estimates of Mortality of Care Home Residents Linked to the COVID-19 Pandemic. International Long-Term Care Policy Network, CPEC-LSE. https://ltccovid.org/wp-content/uploads/2020/05/England-mortality-among-care-home-residents-report-12-May-2.pdf.

Davy, B., 2021. Social distancing and cultural bias on the spatiality of COVID-19. J. Am. Plann. Assoc. 87, 159–166.

Douglas, M., Wildavsky, A., 1982. Risk and Culture : an Essay on the Selection of Technological and Environmental Dangers. University of California Press, Berkeley.

Douglas, P.M., 1966. Purity and Danger: an Analysis of Concepts of Pollution and Taboo. Routledge and Kegan Paul, London.

Dwyer, R., Gabbe, B., Stoelwinder, J.U., Lowthian, J., 2014. A systematic review of outcomes following emergency transfer to hospital for residents of aged care facilities. Age Ageing 43, 759–766.

Fogg, C., Griffiths, P., Meredith, P., Bridges, J., 2018. Hospital outcomes of older people with cognitive impairment: an integrative review. Int. J. Geriatr. Psychiatr. 33, 1177–1197.

Foucault, M., 1991. The Foucault Effect: Studies in Governmentality. University of Chicago Press, Chicago.

Giddens, A., 1990. The Consequences of Modernity. Polity, Cambridge.

Goodman, C., Baron, N.L., Machen, I., Stevenson, E., Evans, C., Davies, S.L., Iliffe, S.R., 2011. Culture, consent, costs and care homes: enabling older people with dementia to participate in research. Aging Ment. Health 15, 475–481.

Gordon, A.L., Goodman, C., Achterberg, W., Barker, R.O., Burns, E., Hanratty, B., Martin, F.C., Meyer, J., O'Neill, D., Schols, J., Spilsbury, K., 2020. Commentary: COVID in care homes: challenges and dilemmas in healthcare delivery. Age Ageing 49, 701–705.

Graverholt, B., Riise, T., Jamtvedt, G., Husebo, B.S., Nortvedt, M.W., 2013. Acute hospital admissions from nursing homes: predictors of unwarranted variation? Scand. J. Publ. Health 41, 359–365.

Groves, J.M., O'Connor, P., 2020. Whiteness out of place: white parents' encounters with local Chinese schooling in post-colonial Hong Kong. Sociol. Rev. 68, 209–224.

Hancock, J., Matthews, J., Ukoumunne, O.C., Lang, I., Somerfield, D., Wenman, J., Dickens, C., 2017. Variation in ambulance call rates for care homes in Torbay, UK. Health Soc. Care Community 25, 932–937.

Harrad-Hyde, F., Armstrong, N., Williams, C.D., 2022a. 'Weighing up risks': a model of care home staff decision-making about potential resident hospital transfers. Age Ageing 51.

Harrad, F., 2021. Understanding hospital transfers from care homes in England: an ethnographic study of care home staff decision-making. PhD. University of Leicester.

Harrad-Hyde, F., Williams, C., Armstrong, N., 2022b. Hospital transfers from care homes: conceptualising staff decision-making as a form of risk work. Health, Risk Soc. 24, 317–335.

Harrad-Hyde, F., Burton, J.K., 2025. Care home quality and 'inappropriate' emergency healthcare use - failing to engage with complexity. Age Ageing 54 (2) afaf030.

Harrison, J.K., Mckay, I.K., Grant, P., Hannah, J., Quinn, T.J., 2016. Appropriateness of unscheduled hospital admissions from care homes. Clin. Med. 16, 103–108.

Hodge, S.Y., Ali, M.R., Hui, A., Logan, P., Gordon, A.L., 2023. Recognising and responding to acute deterioration in care home residents: a scoping review. BMC Geriatr. 23, 399.

Horlick-Jones, T., 2005. On 'risk work': professional discourse, accountability, and everyday action. Health Risk Soc. 7, 293–307.

Lemoyne, S.E., Herbots, H.H., De Blick, D., Remmen, R., Monsieurs, K.G., Van Bogaert, P., 2019. Appropriateness of transferring nursing home residents to emergency departments: a systematic review. BMC Geriatr. 19, 17.

Lyng, S., 2005. Edgework: the Sociology of Risk Taking. Routledge, New York.

Marincowitz, C., Preston, L., Cantrell, A., Tonkins, M., Sabir, L., Mason, S., 2022. Factors associated with increased Emergency Department transfer in older long-term care residents: a systematic review. Lancet Health. Longev. 3, e437–e447.

Murphy, F., Philpin, S., 2010. Early miscarriage as 'matter out of place': an ethnographic study of nursing practice in a hospital gynaecological unit. Int. J. Nurs. Stud. 47, 534–541.

NHS ENGLAND, 2016. New Care Models: the Framework for Enhanced Healthcare in Care Homes. NHS England.

OFFICE FOR NATIONAL STATISTICS, 2022. Life expectancy in care homes, England and Wales, 2021 to 2022 [Online]. Retrieved from. https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/lifeexpectancies/articles/lifeexpectancyincarehomesenglandandwales/2021to2022#cite-this-article/. (Accessed 3 August 2023).

Ouslander, J., 2019. Strategies to reduce potentially avoidable hospitalisations among long-term care facility residents. BMJ Qual. Saf. 28, 515–519.

Parkinson, B., Meacock, R., Checkland, K., Sutton, M., 2021. Clarifying the concept of avoidable emergency department attendance. J. Health Serv. Res. Policy 26, 68–73.

Pink, S., Morgan, J., 2013. Short-term ethnography: intense routes to knowing. Symb. Interact. 36, 351–361.

Singh, S., Estefan, A., 2018. Selecting a grounded theory approach for nursing research. Global Qual. Nurs. Res. 5, 2333393618799571.

Strauss, A., Schatzman, L., Bucher, R., Ehrlich, D., Sabshin, M., 1964. Psychiatric Ideologies and Institutions. The Free Press of Glencoe, London.

Strauss, A.L., Fagerhaugh, S., Suczek, B., Wiener, C., 1985. Social Organization of Medical Work. University of Chicago Press, Chicago and London.

Watermeyer, B., Mckenzie, J., Kelly, J., 2022. Dealing with disability as 'matter out of place': emotional issues in the education of learners with visual impairment. Int. J. Incl. Educ. 1–16.

Wolters, A., Santos, F., Lloyd, T., Lilburne, C., Steventon, A., 2019. Emergency Admissions to Hospital from Care Homes: How Many and what for? The Health Foundation.

WORLD HEALTH ORGANISATION, 2015. World Report on Ageing and Health. Switzerland.

Zelizer, V.A., 1994. Pricing the Priceless Child: the Changing Social Value of Children. Princeton University Press.