EXPLORING RELATIONSHIPS IN CARE HOMES:

A CONSTRUCTIVIST INQUIRY

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Exploring relationships in care homes: A constructivist inquiry

Summary

Relationships are an integral part of living, working and visiting in care homes. However, few studies have considered relationships as their main focus of enquiry, and there has been a relative dearth of work that has included the perspectives of residents, staff and families. This study sought to redress this imbalance.

Using a constructivist approach the nature and types of relationships between residents, staff and families were explored in three homes through a combination of methods including participation, observation, interviews and focus groups. Data collection and analysis occurred concurrently and three types of relationships were identified: pragmatic relationships, which had as their primary focus the instrumental aspects of care; personal and responsive relationships that engaged more fully with the wider needs of individual residents; and reciprocal relationships that sought to recognise the contribution of residents, staff and families to creating a sense of community within the homes. More detailed analysis revealed a number of factors that helped to shape the relationships with each home including: the personal motivations and values of staff; leadership style; teamwork, and the input of residents and families.

Findings from the thesis enhance our understanding of the importance of, and dynamics contributing to, relationships within a care home setting. These insights are considered with reference to current notions of person centred and relationship centred care and a framework for promoting a relationship centred approach is

presented. Implications for policy, practice and education are considered and recommendations made.

'We delight in the beauty of the butterfly,

but rarely admit the changes it has gone

through to achieve that beauty.'

Maya Angelou

Acknowledgements

When I began the journey that was to culminate in this thesis, I did not really appreciate where that journey would take me or in fact, how I would get there. It has taken some time and much effort, involving both laughter and tears. However, the older people, their families and the staff who agreed to participate have made it all worthwhile. I have been touched by the stories shared with me and I hope I have done justice to these. I thank them for sharing lives with me and teaching me so much; without them, I would not have come so far.

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CHAPTER 1- INTRODUCTION

Personal context and rationale for the research

Long Term Care for older people has been a contested area of policy and practice for some time with consecutive governments attempting to meet the needs of increasingly frail older people within finite resources (Netten et al 2003). As a result, 'care' of older people is often considered primarily in financial terms potentially ignoring the less tangible relational components of care provision (Daly 2002). Although, there is a growing body of literature suggesting that the nature and quality of the relationships between care givers and care-receivers are an important determinant of both the experiences and outcomes of care (Minkler 1996, Nolan et al 1996, Brechin 1998), little seems to be known about the relationships that may exist within the communal environments of care homes. My own experience of working in care homes over several years, suggested that such relationships are often complex and subtle. It was my personal interest in the relationships that exist between all those involved in care homes that stimulated the study reported in this thesis.

When working as a Registered Nurse in care homes, I became concerned that the needs of older people, families and staff were often largely invisible in the context of the community care reforms. Over the years, I had contact with a range of professionals external to each home I worked in and was left with impression that once an older person entered a care home they fell off the 'radar' of other services. This meant that not only were older people and their carers marginalised but the staff who cared for them could become very isolated.

In spite of the primarily negative views of care homes I encountered in the wider community, I often observed positive relationships between staff, residents and families. My experience suggested that many residents were able to live fulfilling lives, maintaining relationships with family and friends in the wider community in spite of their failing abilities. These observations suggested that residents and their families could actively maintain their relationships as well as developing relationships with staff. I felt that understanding how such relationships contribute to care was crucial in improving the experience of all who live, visit and work in care homes. At this point in my career, I entered the world of higher education as an undergraduate student and became aware that there were others who also saw the potential of improving the overall experience of all those in a care home setting.

As I moved into Higher Education as a lecturer, I began to realise how difficult it was to implement research findings in the practice environments in which I had worked in. There were a range of factors I experienced as a practitioner that were rarely considered within the research studies I read. My motivation to undertake a post graduate degree was influenced by this realisation. To make research more meaningful to practice, complex issues need to be better understood and addressed, and I believed that care homes were poorly represented in the limited literature that was available. Therefore, I decided to focus on care homes in an attempt to make a positive contribution to the evidence base for practice in what continues to be a relatively neglected area for nursing research in the UK. Given my focus on relationships, I felt any research I undertook needed to include the perspectives of all those involved in the care home environment: residents, staff and families.

When I first began considering this area of research, the relevance of maintaining 'independence' as the most desirable goal for very frail older people was starting to be called into question with the notion of 'interdependence' emerging as an increasingly important construct (Baldwin et al 1993, Evans 1999, Nolan et al 2001). Such interdependence involves reciprocity and mutual exchange in social relationships, combined with feeling a sense of belonging to the social life of the wider community and pursuing interests that provide pleasure (Godfery et al 2004).

However, promoting interdependence and relationships within a care home setting provides a considerable challenge due to the increasing frailty of the resident population. For example, Bebbington et al (2001) found that 79% of all older people admitted to care homes have high levels of physical frailty, and 44% have a degree of cognitive frailty. To compound difficulties, people are becoming ever frailer by the time they enter a care home and the length of residency is decreasing (Beringeer and Crawford 2003).

The above factors pose several challenges to the formation of relationships within care homes, a situation not helped by the apparently differing priorities of residents and staff.

For example, when asked about quality of care in residential environments, older people identify areas of interpersonal exchange as having great relevance to their experience (Wilde et al 1995) whereas professionals highlight the importance of technical care (Bartlett and Burnip 1998a). The perspectives of staff also reflect a

relative lack of recognition of the social relationships residents develop (Reed and Payton 1997). Consequently, when considering quality improvements in residential care, the providers' or organisational perspective is often different to what the residents themselves see as important priorities (Raynes 1998, Mitchell and Koch 1997, Reed et al 1999).

This raises a number of key questions about the difficulty of involving frail older people in decisions that affect them (Mitchell and Koch 1997, Barnes and Bennett 1998, Raynes 1998, Reed et al 1999). Despite these difficulties, residents have been found to be capable of evaluating nursing care quality (Simmons and Schnelle 2001, Kane et al 2003, Tester et al 2004). Focus groups with residents, their families and staff, for example, have been used to inform the development of quality indicators (Rantz et al 1999, Rantz et al 2002, Saliba and Schelle 2002). This reflects the move away from traditional views of expertise in nursing, to a more equal relationship that respects the knowledge and expertise of service users and carers (Reed et al 2004a).

Despite the above there remains limited evidence on the impact of involving older people in care and service planning (Cook and Klein 2005). But older people are more likely to become involved in policy and planning initiatives if: their expertise and skills are recognised; they feel the process is supportive and fair; and they feel the outcome is likely to make a difference (Reed and McCormack 2005). Involvement of older people, their carers and staff in the identification of priorities for quality has supported the movement of quality away from purely instrumental tasks to consider the value of interpersonal interactions between staff, residents and families in the delivery of care (Rantz et al 1999, Bowers et al 2000, Bowers et al 2001a, Bowers et

al 2001b). In this way, the influence of relationships between staff, residents and families are beginning to be seen as relevant to the quality of care from the resident and families' perspective in care homes.

It was the desire to explore and better understand such relationships that was the main motivation for undertaking the study reported in this thesis.

I have a firm belief that entering a care home should be seen as a positive move rather than the 'Last Resort' (Oldman and Quilgars 1999). For this to be realised older people, families and staff need to believe that care homes are able to provide them with a positive experience of living, visiting and working there. An implicit personal assumption underlying this research is that for this to happen, different ways of working will need to be developed that take into consideration the views of staff, residents and families. The emphasis on providing care in the community for even the most frail older people, suggests that many people will enter care homes at a crisis point in their lives, when they are less able to adapt to a changing pattern of living. Therefore, staff will need to be enabled to work with older people and their families in a different way if the move is to be a positive one. From my personal experience, I believe that developing relationships between staff, residents and family, may be a way forward. With this in mind, the following broad objectives informed my thinking at the start of the study:

- To understand how relationships in care homes influence the experiences of residents, families and staff

- To identify the contribution of residents, families and staff to promoting these relationships

It is from this position that I started my journey with the view of making a difference to the lives of those who live in, work in and visit care homes. This thesis is the first product of this journey and is arranged as follows:

Chapter Two provides an analysis of the themes from the literature that reflect the resident, family and staff perspectives in care homes. When I commenced my review of the literature, there seemed limited research that considered the issue of relationships in care homes as a main focus. I initially reviewed literature that highlighted the nature of relationships within care homes to provide a context for the study. As my literature review progressed, different approaches to care were emerging that recognised the value of relationships in long term care. These included person centred care, relationship centred care and care homes as communities. Each of these approaches was influential in identifying the sensitising concepts that informed the study. A contemporaneous view of the literature was adopted that highlighted the key sensitising concepts from the literature which existed prior to data collection.

Chapter Three describes the methodology for the study. This chapter explains why I chose a constructivist research methodology and the philosophical assumptions that underpinned this. The principles of constructivist research are outlined, and the relevance of this approach to the exploration of relationships in care homes is considered. Methods and techniques for data collection and analysis are described.

Chapter Four presents the initial findings from within case analysis of data from three nursing homes. Each case study home is described according to the key features of the environment, the staff, residents and families and my first impressions of the relationships that I observed. Following these descriptions, key themes emerging from the preliminary data analysis are presented and a typology of relationships is proposed.

Chapter Five presents the findings from the cross case analysis and describes how relationships were developed between staff, residents and families within each home. A key finding in this chapter was how the approach to care adopted by staff appeared to influence the type of relationships that developed. The differing approaches to care are described and the processes that encouraged staff, residents and families to develop different types of relationships are highlighted.

Chapter Six considers other influences observed in each care home that supported or constrained the development of relationships between staff, residents and families. These factors included the personal motivations and values of staff; leadership style; teamwork, and the input of residents and families.

Chapter Seven begins with a reflective account on the methodology used within the study. This chapter then considers each of the relationships from the typology and integrates the findings from previous chapters with the substantive literature in the field, including recent literature as well as that reviewed in Chapter Two. As the different approaches to care appeared to influence the relationships that developed

within each care home, the findings are then considered in respect of frameworks for practice, notably care homes as communites, person centred care and relationship centred care, I suggest how these frameworks may be further developed with the findings from my study.

Chapter Eight considers the implications of the study for policy, practice, education and research in care homes. These are discussed in relation to the themes that emerged from the findings and include promoting effective leadership; sharing information; ensuring continuity of care and developing a learning culture in care homes.

It is hoped that the findings and implications of this research will be of value to residents, staff and families involved in care homes as well as to those responsible for making decisions that affect the lives of these people.

CHAPTER 2 – REVIEW OF THE RELEVANT LITERATURE

Introduction

From the outset of this study, my interest in the experiences, thoughts and feelings of older people, their families and staff in Care Homes, suggested that the methodology used would be qualitative. The use of literature within qualitative research remains a contested area. Some authors, (for example, Glaser and Strauss 1965) argue that knowing what has already gone before may unduly influence the study, resulting in bias. Others, such as Morse (1994), argue that literature should be used to sensitise the researcher to concepts in the field of study rather than leading data collection. While each of these positions holds merit, I felt it was most important to ensure that my study built upon and developed existing knowledge rather than simply replicating it. From this perspective, I felt it would be useful to follow the suggestion of Morse (1994) and use the literature to sensitise me to the concepts within nursing home research. Therefore the purpose of my review of the literature would be:

- to gain a sense of the issues that had emerged from research within care homes, to provide a context for the study;
- to identify key issues about relationships in care homes to provide sensitising concepts that would inform data collection.

In identifying my initial focus, I found the extensive literature review undertaken by Nolan et al (2001) particularly useful. Within this review, Davies' (2001b) considered the experience of older people and their families moving into and living in a care home. An underpinning theme throughout the literature was the value of relationships between staff, residents and their families in enhancing the experience of

older people and their families. This was described in terms of creating a sense of community within a care home where residents needed to be seen in the context of their life development having both rights and responsibilities within the home environment (Davies 2001b).

I decided that following on from Davies (2001b), the purpose of my literature review would be to explore, contemporaneously, the following questions:

- What is known about relationships between older people, their families and staff within care homes
- What effects do the relationships between residents, families and staff have on their experiences within care homes.

Methods and boundaries

I began a focussed search using electronic databases (Figure 2.1) examining the period 1987 – 2002. This time period was chosen to focus the literature on the issues emerging following the regulation of continuing care as it moved into the independent sector within the UK. I decided that a contemporaneous approach to the literature review was most appropriate in order to describe what was known in the literature at the time data collection commenced. As well as the UK, articles were retrieved from North America, Australia and the Scandinavian countries.

Search terms included the following key words in combination: relationships, nursing homes, aged, aged care, older people, quality, residential care, care homes. This process initially identified 343 items. Full bibliographic details were entered into an

Endnote Library (Version 7.0). Endnote is an electronic referencing tool combining the functions of data base management and bibliography creation. The search was then widened incrementally by identifying potentially useful references within these articles, which were retrieved and entered into Endnote.

Table 2.1 Electronic databases consulted for the review

• CINAHL, • EMBASE, • MedLine • Social Science Bibliography, • Age Info and • PsychInfo.

Initially, the title and abstract for each reference was examined. References were then identified and selected on the basis of the following criterion: that the findings discussed relationships between older people, families or staff in care homes. This process resulted in the identification of 115 empirical items from which I extracted the following information:

- Aims of the study
- Methods used within the study
- Key findings of the study

This process revealed the wide range of issues affecting experiences within care homes, which included quality of life and quality of care, relationships between staff and families, relationships between staff and residents, how staff approached their work, job satisfaction and organisational culture. Many of the issues that emerged with the findings of what was a very broad range of studies were also reflected in the

annotated bibliography edited by Bartlett and Burnip (1998b). This bibliography provided an overview of the literature from 1980-1998 in continuing care settings identifying the challenges to improving the quality of care and quality of life for residents. The themes within this bibliography suggested that the literature to that date tended to revolve around the physical aspects of care giving in care homes. Therefore, many of these issues did not immediately present themselves as relevant to relationships within care homes. As I considered the literature I had selected for this review, I was surprised at the dearth of studies that considered the perspectives of residents, families and staff at the same time.

In all, six items of literature were located that considered the perspectives of residents, families and staff within the same study. These six studies primarily aimed to identify issues that impacted on the quality of care, with relationships emerging as a pivotal influence on the experience of residents, families, and staff in care homes (Grau and Wellin 1992, Gjerberg 1995, Meister and Boyle 1996, Jackson 1997, Deutschmann 2001a, Duffy et al 2001). However, there were few studies located that considered these relationships as the main focus (Grau and Wellin 1992, Jackson 1997 were the exceptions). These studies were initially reviewed to identify what was known about relationships when the views of residents, families and staff were considered within the same study.

What is important about relationships in Care Homes?

Given that the main goal of care homes is to provide care for residents, it is not surprising that studies which focus on caring have found that residents, families and staff all identify how relationships between residents and staff were integral to this process (Grau and Wellin 1992, Gjerberg 1995, Meister and Boyle 1996, Jackson 1997, Deutschmann 2001a). While each of these studies had a different focus, a common theme was that the emotional aspect of caring was vital to caring relationships, leading to feelings of being 'connected' (Jackson 1997) and 'not being forgotten' (Deutchsmann 2001a). Another aspect of the relationships between staff and residents was the giving of time. This included time to attend to small details or having the time to talk or walk with someone (Gjergberg 1995, Jackson 1997). However, while there were common threads between these studies, there were also differences in the priorities identified by residents, families and staff both within and across studies. For example, organisational issues such as continuity of staff and a team approach were more important to staff than other groups in most studies (Gjergberg 1995; Duffy et al 2001; Deutschmann 2001a). Meister and Boyle (1996) also found limited consensus between staff, residents and families on how well technical or interpersonal care was being delivered although reasons for this were not explored.

The heterogeneity within care homes was succinctly captured by Grau and Wellin (1992) who, in two case studies, found two culturally distinct homes where relationships between residents, staff and families were enacted very differently. They found a range of factors that affected the development of these relationships, which included:

- the social economic and cultural background of staff and residents, which influenced the type of relationships developed between them
- expectations of families, which impacted on the management of risk and subsequent relationships between staff and families
- shared job understandings and traditions which impacted on the relationships between staff.

(Grau and Wellin 1992)

These six studies were also considered in the light of key ethnographic literature that had captured the lived experience of living, working and visiting care homes (Savishinsky 1991, Henderson and Vesperi 1995). Savishinsky (1991) for example provided an insight into the lives of those who lived and worked in one care home through a volunteer pet visiting project. In describing how residents and staff adjusted to losses and created new meaning in their lives, Savishinsky revealed the significance of relationships in care homes. The role which memories, symbols and developing relationships play in people's lives were recounted through the stories of residents, staff and volunteers in this project as each adjusted to the challenges of living, visiting and working in a care home (Savishinsky 1991).

In another US based ethnographic study, Timothy Diamond (1992) worked as a nurses' aide (NA) in three nursing homes and presented a poignant account of the experiences of living and working within these environments. Diamond (1992) recounted stories that described the value of relationships between residents, families and staff within their everyday experience. While this account was punctuated with

the personal stories of those he cared for and worked with, he revealed the continued 'batch treatment' of residents, resonant of the early works of Goffman (1962) and Townsend (1962). Diamond (1992) suggested this was due to the emphasis on the physical aspects of care often to the exclusion of deeper emotional needs expressed by residents and staff. While the need for positive relationships is implicit within each of these ethnographic accounts, little appears to be known about how these relationships explicitly contribute towards the experience of residents, families and staff.

While older people, families and the staff who cared for them in these studies identified the importance of relationships, there was little information about how these relationships influenced care experiences. Subsequently I considered studies from the wider literature that focussed on different sets of relationships in order to investigate the nature of relationships within care homes in more detail.

The nature of relationships in care homes

Relationships between staff and residents

Interpersonal aspects have been recognised as important factors in the delivery of care (Brechin 1998, Grau et al 1995; De Veer and Kerkstra 2001,Roe et al 2001). For example, Grau et al (1995) found that for many residents, their best or worst experiences within a nursing home, revolved around their interpersonal relationships with staff and staff have also described their relationships with residents as a key factor in their experience (Cohen- Mansfield 1989; Pursey and Luker 1995; Kruzich 1995; Bowers 2000 and Bowers 2001b).

There was some evidence within the literature to suggest that residents and staff actively developed relationships with each other. Bowers et al (2001a) identified a group of residents who described their care in terms of the relationships they developed with staff. This emphasised the close relationships these residents had with staff which often revolved around the sharing of personal information between them as care was provided (Bowers et al 2001a). Jackson (1997) also described emotional caring that included acts that went beyond the routine work of caring and suggested friendship between residents and staff

There were some residents who chose not to develop relationships with staff and these residents described 'care-as-service' where they were more likely to concentrate on the instrumental aspects of care (Bowers et al 2001a). Moreover, Davies (2001a) using a mixture of participant observation and interviews, found that relationships based on an organisational philosophy 'customer care' were often cordial but superficial and reserved (Davies 2001a). In Bower et al's study, relationships that developed between residents and staff when residents described their expectation as 'care-as-service' were based on how quickly and consistently staff attended to their needs with the expectations of residents becoming a central feature in the evaluation of the quality of the care (Bowers et al 2001a). 'Care- as -service' also emphasised the visible nature of caring that was similar to 'the bottom line' described by Rantz et al (1999) which represented the minimum expectation of physical tasks being undertaken. Families and residents in this study, made their views clear, that without good staff good care would not happen (Rantz et al 1999). This is further emphasised by Chou et al (2002) who, using a quantitative model, found a statistically

significant association between resident satisfaction with staff care and all other aspects of satisfaction.

Residents who experienced greater frailty or higher levels of dependence developed good relationships with staff, to ensure timely assistance and so prevent discomfort (Bowers, et al 2001a). Nurse aides being uncaring, or not responding to requests for help have been identified among the worst experiences for residents (Grau et al 1995). Conversely, timeliness of response is considered an indicator for good quality care (Rantz et al 1999). These studies suggest the importance of relationships with staff in the residents' experience of care.

Relationships between staff and families

A number of studies demonstrate the importance of relationships to the experience of family members following an older person's admission to a care home. Most family members actively work to maintain their relationship with the older person and seek to work collaboratively with staff (Bowers 1988, Duncan and Morgan 1994, Kellet 1998, Ryan and Scullion 2000, Davies 2001a). Families for example, identified the importance of staff to the well-being of both family member and resident as this enabled families to participate in and enhance the care of their loved one (Duncan and Morgan 1994; Ryan and Scullion 2000; Seddon et al 2002; Davies 2001a; Sandberg et al 2001), although some families have felt that they have to be the ones to take the initiative (Hertzberg et al 2001, Sandberg 2002).

Relationships between staff and families have been reported to be fraught with misunderstandings compounded by lack of time (Hertzberg and Ekman 2000) or lack

of understanding (Sandberg et al 2001). Strain in relationships can also develop if there are unclear or conflicting expectations of participation in care (Bowers 1988, Kellett 1998). It has been suggested that this may be influenced by the roles family carers take when their relative moves to a care home with staff sometimes feeling under pressure when families do not appreciate the need of their relative for care or understand the demands experienced by staff (Ryan and Sculllion 2000). Furthermore, regular communication and consultation by staff and concern for the family member as an individual have been described as underpinning positive relationships between families and staff (Seddon et al 2002).

Relationships between residents

Few studies were located that considered relationships between residents, but those that were, identified this as an important but often ignored set of relationships (Powers 1988, Reed and Payton 1997). Residents often develop relationships with other residents in care homes (Powers 1991, Diamond 1992) although being together does not always guarantee friendships (Wilkin and Hughes 1987). Mattiasson and Andersson (1997), for example, asked 60 older people residing in nursing homes in Sweden to assess the quality of their care. The responses pointed to the significance of their social relationships in the home, with the majority of residents indicating that it was important to make new friends, and to have a nice time with other residents. These older people wanted to engage in social relationships with fellow residents but found the opportunity to do so was unsatisfactory in the nursing home setting. This may have been due to the fact that staff do not see residents as capable of having social relationships with other residents (Reed and Payton 1997). However, Reed and Payton (1997) also found that residents often invested large amounts of energy in

getting to know the social norms of the environment suggesting the value they place on developing relationships with other residents in care homes.

Savishinsky (1991) described the time residents spent in developing their own social networks and the role these play in maintaining the resident's sense of identity within the institution. Powers (1992) used an ethnographic study based in a US nursing home to observe the type of social networks developed by residents. These relationships often included other residents, staff and families. She described these networks as a typology that featured institution networks, small cluster networks, kin centred networks and balanced networks (Powers 1991; 1992; 1996) (Table 2.2).

Table 2.2. Typology of residents' social networks (After Powers 1991)

- *Institution centred networks* - ties were simple, concentrated on the institution and were of low intensity.
- *Small cluster networks* -contained established cliques of resident operating within larger networks. These residents regularly spent time together, providing opportunities for reciprocity and support.
- *Kin-centred networks* - concentrated on relationships with family who visited regularly. Residents in these networks often resisted forming relationships with other residents based on fear or the disturbing behaviour of others.
- *Balanced networks*- had the largest amount of people within them drawn from contacts that included other residents, staff and families. These networks showed the greatest interconnectedness within the home.

Powers (1991) suggests that some residents continued previous friendship patterns similar to those experienced prior to admission. For example, residents who described themselves as loners before they entered the nursing home were more likely to describe a hierarchy of acquaintances in an institution centred network, which included acquaintances or buddies to pass the time of day. Relationships were often not reciprocal as those in institutional networks tended to pride themselves on their self sufficiency and ability to keep busy or be useful (Powers 1991). For some residents, their families remained their most valued relationships and these residents described kin centred networks that only included superficial interactions with other residents (Powers 1996). Residents who described themselves as naturally gregarious seemed able to develop relationships easily and tended to form small cluster networks (Powers 1991). Women were prominent in these networks and limited the amount of relationships they engaged in, resisting relationships with those outside their clique (Powers 1996). When residents described their admission as an opportunity to make new friendships they tended to describe relationships with other residents, staff and families in a balanced network (Powers 1992). In these networks, close ties with other residents revolved around shared experiences that ranged from quarrels to laughter, providing residents with a sense that they were not alone. Residents who described balanced networks or small cluster networks often described the most satisfying relationships with other residents (Powers 1991, 1996), which seemed to influence their experiences of living in a care home.

An important component of relationships between residents seems to be the potential for helping others (Aller and Van Ess-Coeling 1995). This was succinctly captured by Diamond (1992) who described often very frail residents finding ways of giving to

others whether it was in services, advice or companionship. The reciprocal nature of relationships between residents was also described by women in Powers' small cluster networks (Powers 1996). Residents in these networks also expressed feelings of self worth as they were a person on whom others could rely (Powers 1991). Powers (1996) also found that women had more social contacts that demonstrated closer contact with others in their networks compared to men's relationships that were often superficial and included fewer people.

Mor et al (1995) provide an assessment of a measuring tool for social engagement, widely used in United States care homes (part of the Minimum Data Set) but suggests the need to understand how relationships are developed in care homes in ways that move beyond counting the amount of social interaction to assessing its quality. Abbott et al (2000) undertook an interview study of older people in the UK in supported residential environments and from these accounts, suggests that the experience of social participation for older people was perhaps one of adjustment rather than friendship. Although many older people like to be involved with others, this does not necessarily imply friendship or intimacy and residents themselves recognised that a shared environment did not necessarily imply shared interests or outlooks (Abbott et al 2000).

Relationships between staff

Studies that considered relationships between staff appeared to be more concerned with organisational issues such as team working; skill mix and quality of care, with scant reference to the potential impact on residents or families (Hannan et al 2001, Jervis 2002). Friedman et al (1999) describe a comparison of Nurse Aide

satisfaction between those working in a community based programme, PACE (Programme for All Inclusive Care of the Elderly) and others working in nursing homes. The higher level of satisfaction in the community appeared to relate to the working environment where Nurse Aides working with PACE described more control over their workload and involvement in decisions. Conversely, Walker et al (1999) described poor communication between team members and not involving direct care staff in the planning of care as important obstacles to implementing individualised care. This suggests that relationships between staff may also influence other relationships within the home.

Including all perspectives

From this initial review, it was found that few studies considered all perspectives within care homes. Many studies did identify the importance of relationships although this was rarely their focus. Therefore, a further classification of items was required in order to generate themes that would be of relevance to exploring relationships within care homes. In line with recent developments of relationship centred care and creating community in care homes, I initially sorted the literature to ensure all perspectives within care homes were included. This meant that each paper was placed according to the main perspective that was being reported on within each paper:

- Resident Perspective
- Family Perspective
- Staff Perspective

Some studies may have considered two perspectives, such as the perspective of staff and residents for example. These were then classified in both groups as relevant. I generated preliminary themes that captured what was important to residents, families and staff using key papers from within each perspective. From this I developed what appeared to be common themes across the perspectives.

Three themes emerged relevant to the interpersonal processes that supported the development of relationships. These became my initial sensitising concepts that provided insights into how relationships were developed in care homes.
They are as follows:

- Being an individual
- Being involved
- Being partners

Being an individual

Recognising people receiving care as individuals has become an increasingly important part of health and social care (Reed 1992, Liaschenko 1997, Stanley and Reed 1999). Meeting the needs of the individual have been cited by staff, residents and families as central to good quality care (Rantz et al 1999). Within the literature an important aspect of being an individual was receiving care that was personal. 'Being personal' was a phrase used to describe different types of care in a range of interview studies that involved residents, families and staff (Deutschmann 2001a, Jackson 1997, Gjerberg 1995). In these studies, being personal included paying attention to small details in care (Jackson 1997, Gjergberg 1995) often by staff with a

good attitude (Deutschmann 2001a). When asked in focus groups about what made good quality care, residents, families and staff identified considerate and compassionate caring (Rantz et al 1999). This reflects the findings of Wilde et al (1995) where older people expressed the importance of interpersonal aspects of care. Grau et al (1995) also found that residents often described their relationship with staff in terms of the way care was provided. For these older people, a good relationship inferred a good standard of care. When positive relationships were described between resident and staff, residents often used terms such as 'being connected' or 'belonging' (Cohen-Mansfield 1989, DePoy and Archer 1992, De Veer and Kerkstra 1997, Jackson 1997).

Conversely, DePoy and Archer (1992) in a naturalistic inquiry of a 120 bed nursing home in the US, found that residents who required the most care giving appeared to be the most disconnected, being described as 'invisible' to those who cared for them. This finding has been echoed in subsequent studies. For example, Jackson (1997) found that when time was limited or staff were unsupervised, then the invisible interpersonal aspects of caring was reserved for those residents who were able to develop special relationships with staff. Mor et al (1995) also found that residents with reduced cognitive function were less likely to be involved in social engagement. This suggests that as residents become more frail and dependent, they may be unable to actively nurture relationships, requiring more support from staff to achieve this.

Establishing positive relationships with older people has also been described as crucial to the delivery of effective care (Pursey and Luker 1999). In one study, Bowers et al (2000) asked front line staff to identify factors contributing to high

quality care. Their responses indicated that the quality of care was influenced by the quality of relationships they were able to develop with residents in the way they delivered care. Interpersonal relations with residents have been described as providing the greatest work satisfaction (Cohen-Mansfield 1989). The staff in Bowers et al's (2000) study described a process of personalising care as Nursing Assistants developed knowledge about each resident by talking to them during personal routines. Furthermore, when there was insufficient time, it was these interpersonal aspects of care that were often neglected as there was less likely to be repercussions compared to the physical aspects of care (Jackson 1997, Bowers et al 2000). Such findings highlight the invisible nature of emotional care undertaken by staff, which is rarely considered in the daily allocation of work schedules (Jackson 1997). This reveals the tension experienced by those providing care between the need to balance efficiency with the emotional labour of caring (Gattuso and Bevan 2000).

These studies raise questions about how staffing levels may affect the amount of time spent with residents, which is integral to building relationships. Equally, getting to know residents enables staff to personalise their care by doing little things which may be overlooked when inadequate staffing increases the workload (Bowers et al 2000). When staff see care in terms of developing relationships with residents, they become dissatisfied when this is not possible (Bowers et al 2000). Nursing assistants described how inadequate staffing meant that they had to rush residents through their care not allowing for individualisation or having time to chat to residents about their own lives, which often caused distress to both staff and residents (Bowers et al 2000). Using a grounded theory approach, a process described as 'bundling' represented how

nursing assistants fitted a range of tasks together to reduce time spent with residents. Derived from participant observation and interview data 'bundling' described an alternative approach to care that staff felt they had to adopt to get the work done. This approach limited the opportunities for reciprocity within the relationship and staff felt they were delivering a low quality of care (Bowers et al 2000). Staff in other studies have also described how the lack of time and pressure of work, prevented them from meeting residents' needs for independence or social interaction, which also reduced the care workers' job satisfaction (Morgan et al 2002).

These studies suggest that the type of interaction between residents and staff influences the relationships that develop. An early ethnographic study (Gibb and O'Brien 1990) for example, described strategies that reduced the time spent in providing direct care to residents by minimising opportunities for social conversation, which also reduced the opportunity to develop relationships with residents. In a separate study, enrolled nurses also demonstrated similar strategies to increase the efficiency of providing technical care to residents, which limited the emotional care provided (Boeje et al 1997). Bowers et al (2001b) found that when nurses needed to make sure the work was done, they organised their care by task to reduce interruptions. This had the follow-on effect of reducing the time and opportunities for interactions with residents, limiting the development of personal relationships (Bowers et al 2001b). DePoy and Archer (1992) use the term functional relationships to describe the interaction between staff and residents in their study when confined to a caregiving function. These interactions were limited and often contributed to feelings of isolation experienced by the residents (DePoy and Archer 1992).

Families have been found to try to support staff in personalising the care of their relative, through sharing biographical information (Duncan and Morgan 1994), more recently in the form of life histories (Hertzberg et al 2001). Rowles and High (1996) suggest that when families become involved in direct caregiving , they personalise care by dressing their relative in ways consistent with their former lifestyle, by bringing in favourite foods or the continuation of favourite activities such as listening to classical music. However, Hertzberg et al (2001) found that some families expressed uncertainty as to whether the information they shared was being used by staff. When staff relayed information to families about the resident's daily behaviour, this demonstrated to families the personal caring the resident was receiving and supported meaningful relationships between families and staff (Duncan and Morgan 1994). Families often see relationships with staff as an important way of ensuring their relative is seen as a person and receives individualised care (Duncan and Morgan 1994). Further to this, families work very hard in demonstrating to staff how emotional or psychosocial care should be provided in addition to the more instrumental aspects of care (Bowers 1988, Duncan and Morgan 1994) and described this as a joint responsibility between themselves and staff (Dempsey and Pruchno 1993).

Although these studies discuss how residents, staff and families see being personal (including sensitivity, caring and respect) as integral aspects of care, the part these attributes play in developing relationships appears little understood.

Being involved

Maximising the extent to which the older residents of care homes are enabled and empowered to exercise choice is increasingly accepted as essential for quality of life (Kane et al 1997). Most studies have examined the impact of involvement in decision-making at the macro level, for example, making the decision to move into long-term care and choosing a care home (Nolan et al 1996). However, supporting residents in participating within the decision making process within care homes has presented a range of challenges (Mitchell and Koch 1997, Raynes 1998, Reed et al 1999), which need to be addressed if residents are to be fully involved in decisions that impact on their lives. In other health care environments, some studies suggest that in participation in decision making, there is a recognition and understanding between staff and patients as to the other's experience and concerns (Ashworth et al 1992, McCormack 2001). Although this may require the staff to understand what is important to the patient as a person (Liaschenko 1997, McCormack 2001).

The continuing importance of maintaining personal control in day-to-day activities as far as possible has been demonstrated (Bamford and Bruce 2000) with some residents identifying the lack of choice as detrimental to their enjoyment of life (Fiveash 1998; Kane et al 1997). Stirling and Reid (1992) used a quasi randomised controlled intervention study to teach nurses strategies that would enable older people to become more involved in their care through a method of participatory control. Participatory control is a process where a person increases their sense of control in relationships with another. This study suggested that by altering the care giving behaviours of nurses, the well being of older people could be improved. Through the nurse-patient interaction, older people felt they had more input into the decisions being made and

that this was valued. This suggested that a model of participatory control was relevant to older people in long term care settings as it represented the development of a mutually beneficial relationship between residents and staff (Stirling and Reid 1992).

When residents have been asked over which aspects of their day they wish to participate in making decisions, these are often different to what is assumed by staff (Matiasson and Andersson 1997). For example, staff rated flexibility of routines as a priority but residents would choose the opportunity to go out of the home in preference to this (Matiasson and Andersson 1997). In other studies, flexibility of routines has not been associated with well being (De Veer and Kerkstra 1997, Wilde et al 1995). Staff have also identified the importance of residents exercising choice but often feel that constraints within the home work against this (Kane et al 1997).

Limited involvement in decision making has been found to reduce levels of job satisfaction and increase turnover amongst staff (Banaszack-Holl and Hines 1996), which could decrease the opportunity for relationships to develop within the care home. Working relationships among teams within nursing homes have been criticised for being overly hierarchical (Norburn et al 1995, Kruzich 1995, McAiney 1998, Jervis 2002). This means that daily decisions usually occur from the top down with limited involvement of direct care staff (Jervis 2002). Kruzich (1995) suggests that involving nursing assistants in shift report and team meetings supports their perception of influence in resident care, which has been found to influence job satisfaction in other studies (Banaszack-Holl and Hines 1996). A team approach to care planning also provided opportunities for sharing knowledge and experience

between team members, which in one study, supported the development of patient centred care (Tonuma and Winbolt 2000). In this study, a range of strategies were initiated that included consistent assignment to teams where staff were able to develop a more in depth knowledge of patients and their needs (Tonuma and Winbolt 2000). Consistent staff assignment has been seen to be mutually beneficial in the development of relationships between residents and staff (Teresi et al 1993) and interpersonal relationships are often given as the reason staff choose their jobs (Friedman et al 1999).

Davies (2001a) described a home where the experience of staff was very different. Here, there was a hierarchy among the direct care staff which bred animosity and made some feel their contribution was not valued. This was also reflected in how staff attempted to take control of care routines, often going against the expressed choices of residents (Davies 2001a). Jervis (2002) undertook an ethnographic study into the power relations between staff in one home and found polarised views between professional and non-professional staff. Direct care staff felt disconnected from the decisions being made by nurses, who were more removed from the front line of care, although care staff believed they knew more about resident preferences (Jervis 2002). This highlights the impact that a lack of control over their daily working lives can have on front line care staff, with potential repercussions on the relationships that may develop.

Families' involvement in the care home has been described as depending on the care relationships with their relative prior to being admitted to a care home (Hertzberg and Ekman 2000). For many families conserving a place in their relative's world was of

great importance (Kellett 1998). Continuing family rituals or routines provided families with a sense of continuity (Kellett 1998) and such strategies were used as a means of keeping it special between them (Sandberg et al 2001). Families have also been found to identify roles they feel comfortable with over time which did not infringe on what were considered to be the domain of staff (Ryan and Scullion 2000). One study identified that most carers had negotiated these roles with staff, providing a basis for positive relationships based on mutual respect for each other's roles and responsibilities (Seddon et al 2002). Davies (2001a) described four types of relationships between staff and families in care homes, which are described in Table 2.3.

Table 2.3 Types of relationships between staff and relatives (from Davies 2001a)

- *substitutive care* - 'getting on with it' where relatives perceived gaps and deficiencies in care and attempted to fill these gaps themselves.
- *submissive care* - 'putting up with it' where relatives respond passively, fitting in with the routines and expectations of the home
- *partnership care* - 'working together' which was characterised by reciprocal relationships, with clearly established responsibilities, alongside staff recognition of the relative's need to contribute to and monitor care.
- *confrontational care* -'battling it out' where relatives perceived no alternative but to continually register complaints about care standards on behalf of the older resident

Sandberg et al (2001) described how families maintained cordial relationships with staff and role modelled how they would like care to be delivered, similarly to substitutive care (Davies 2001a). Families in other studies have also been described as taking responsibility to undertake emotional and psychosocial care to address staff shortcomings (Bowers 1988, Dempsey and Pruchno 1993).

Relationships between families and staff were often couched in descriptions of how staff performed their caring activities with residents (Hertzberg et al 2001). Duncan and Morgan (1994) found that many families viewed the quality of the care received by the resident in the context of their own relationships with staff. Bowers (1988) also described how families would become angry when they felt staff were eroding their relatives' sense of self, suggesting their dissatisfaction with the care being delivered. Sandberg et al (2001) refer to situations where families were 'keeping an eye' to ensure that care was being delivered appropriately for their relative (Sandberg et al 2001). If care was considered deficient, then families became more vigilant, (Sandberg et al 2001), which had the potential to alter relationships between families and staff.

Families explained that being unable to access information from staff was a major obstacle in the development of relationships and they made judgements that staff had no time to talk to them (Hertzberg et al 2001). When staff took the initiative in communication with families, these strategies were reported as strengths (Friedemann et al 1997). While families recognised the need for technical care and expected staff to undertake this they also felt that staff lacked biographical expertise leading to disagreements in how care should be delivered (Bowers 1988). Kellett (1998) found

that families also described a sense of concern of being out of control and not being heard. This often resulted in tensions between families and staff about ownership and control of the care process. When families felt they were not being heard by staff, small issues became magnified into problems, leaving families less confident in the quality of the care and feeling their perspective was not valued (Kellet 1998). This situation has the potential to create strained relationships between families and staff. Davies (2001a) referred to these relationships as confrontational where families felt their only option left was to register complaints.

Some families operating within the constraints imposed by the organisation also felt disempowered if they were excluded from participating in care (Kellet 2000). In these relationships, similar to submissive care (Davies 2001a) relatives found it difficult to raise issues with staff for fear of causing problems in their relationships with them (Kellet 2000). Other studies describe strategies families use in this context as 'keeping your distance' where families felt it futile to complain and so ignored concerns (Sandberg et al 2001). Family carers have also expressed the need to fit into the nursing home routine, working within these constraints to avoid disagreements with staff (Kellet 2000). Hertzberg et al (2001) identified how some families felt resigned after a period of trying to improve care for their relative and being ignored.

Although it can be seen that families' experiences are dependent upon good relationships with staff, little is known about how these relationships are developed.

Being partners

Davies (2001a) describes a care home where relationships between residents and staff were reciprocal. In this study staff shared break times with residents, resulting in a feeling of 'community' throughout the home. In another study, residents emphasised the close relationships they had with staff that revolved around the sharing of personal information between them as care was provided (Bowers et al 2001a). These residents gave examples of how they would try to help staff as part of their personal relationship, which was described 'care –as – relating' (Bowers et al 2001a). Reciprocity from the resident's perspective also included the sharing of past identities with the staff and staff attending to this past identity in their care (Grasser 1996, Bowers et al 2001a). Staff involved in these relationships would also share personal information about themselves, with the potential for the resident to provide advice in return (Bowers et al 2001a). These relationships then enabled a reciprocal exchange between the staff and resident (Bowers et al 2001a , Davies 2001a , Roe et al 2001).

It is important for staff to feel valued if they are to value the people they care for (Tesh et al 2002). Davies (2001a) found in one care home, collegiality and blurring of roles ensured all staff felt their contribution was valued within the home, which was then reflected in the positive relationships between staff and residents and between staff and families.

Kellet (1998) described how families felt a sense of worth in their expertise on the needs, values and experience of their relative. Lindgren and Murphy (2002) suggest that it is important for staff and families to understand that while their perspectives may vary, each knows the resident in a different way and has a significant

contribution to make to the well-being of the resident. Families tended to look for staff willingness to accept their knowledge about the resident and their ongoing involvement, which encouraged them to develop relationships with staff (Duncan and Morgan 1994). Seddon et al (2002) revealed how family caregivers would negotiate their roles in the care home setting and then use their experience of this to rise to the challenge of continuing to support their relative.

A key feature for many family care givers was learning to trust the staff (Seddon et al 2002), which some studies suggest arise from family members observing care within the home (Friedemann et al 1997, Hertzberg and Ekman 2000). Hertzberg and Ekman (2000) found that families became concerned when they found negative examples of care but would often look for reasons why this might have happened. Families also emphasised the need for staff to show caring behaviours towards both the family and resident, which influenced their relationships (Duncan and Morgan 1994). When care met the families' expectations, trust in staff was reported alongside mutual affection in relationships between families and staff (Friedemann et al 1997). Davies (2001a) suggests that the most positive experiences described by family members were when they were able to work in partnership with staff, confident that their views and opinions would be taken into account. This feeling of partnership was often reflected in informal and regular opportunities for communication between staff and families with a clear recognition of each other's roles in the life of the resident (Davies 2001a). Sandberg et al (2002) describes empathic awareness from staff where there is an understanding of how difficult it is for the family caregiver to let go in the new situation. These relationships between staff and family feature open communication and involvement in care decisions leading to trusting relationships

where roles were understood and negotiated openly (Sandberg et al 2002). McGilton et al (2001) suggest that further research is needed into the conditions necessary to develop and maintain good relationships between families and staff.

A key issue that was emerging as the literature was being reviewed was a focus on different ways of approaching care. Three approaches were apparent within the literature that discussed the value of relationships: person centred care, relationship centred care and care homes as communities. Each of these approaches considered relationships from different perspectives and so were reviewed in more detail.

Conceptual Frameworks

Person centred care

The notion of person centred-ness has become embedded in the literature of health and social care but the term lacks clear definition (Lutz And Bowers 2000) and remains poorly understood. The growing interest in person centred care has been attributed to the growing consumerist approach (Williams and Grant 1998) and the desire of people to be involved in decisions about their health (Lutz and Bowers 2000). In a concept analysis of the term 'patient centred care' Lutz and Bowers (2000) found this concept had been defined as 'identifying patients' needs, preferences and expectations and re-organising health services to meet patients' needs' (p.177). This functional approach is also reflected in recent UK policy with 'person centred care' defined as respect for individuals with care being organised around their needs (DOH 2000). This appears qualitatively distinct from the meaning ascribed to person centred care in services for people with dementia. Person

centred care in dementia services is often based on the concept of person centred-ness that Kitwood (1997) applied to dementia care. Drawing on exemplars of good practice in the care of people with dementia, Kitwood (1997) defined person-centredness as:

> '..a standing or status that is bestowed on one human being, by others, in the context of relationship and social being. It implies recognition, respect and trust.'(Kitwood 1997p.8)

Kitwood (1997) further suggests that people with dementia have five overlapping needs for inclusion, attachment, comfort, identity and occupation. Each of these will be influenced by the environment in which they are cared for and those who care for them (Kitwood 1997). Kitwood suggested a way forward for dementia care that proposed to make staff aware of how their actions worked against the well-being of people with dementia often unintentionally. He based this work on the idea of a 'malignant social psychology' that often robbed people with dementia of their self esteem, confidence and eventually their personhood. Person centred care with people experiencing dementia has been based on the how this process of depersonalisation can be turned around to improve the experience of the person with dementia and the person caring for them (Kitwood 1997). Dementia care mapping (DCM) was developed by Kitwood and colleagues at the Bradford Dementia Group as a way of assessing the well-being of the person with dementia and the interaction they had with their environment and others using a coded observational schedule. Observers are trained to code signs of well-being or ill-being demonstrated by the person with dementia into time frames that provide an overall impression of how long a person

may experience either well-being or ill-being. In addition to this, actions from care workers are also recorded. Actions that fall into the categories of malignant social psychology are described as personal detractors and could include ignoring someone when they are trying to attract attention. Actions that support the well being of people with dementia are described as personal enhancers and could include validating the experience of the person with dementia. Examples of these actions are included in the feedback as ways that caregivers are dealing well with certain situations or issues that may need to be improved to improve the experience of both the person with dementia and those caring for them. Kitwood's approach has been considered important for relocating the person with dementia as central to dementia care but Kitwood's work has also been criticised for lack of transparency in his research methodology (Adams 1996). There is interest in developing person centred care for older people (DH 2000) but studies that have considered person centred care have to date been concentrated in services for people with dementia. These studies provide insights into how relationships are developed within care homes and so will be considered in further detail.

When caring for people with dementia in a person centred way, showing them respect as a unique person is central to the care giving process (Kitwood 1997). Hansebo and Kihlgren (2002) described respect as demonstrating kindness, politeness and invitations to participate in an activity. When asked, people with dementia frequently mentioned issues that gave them 'sense of being in control' (maximising autonomy), a sense of retaining their personal identity (being valued for who they were) and feelings of security (Bamford and Bruce 2000). Graneheim et al (2001) considered the interactions between one woman with dementia and her caregivers and found that

issues of conflict often arose in areas of privacy, security, identity and autonomy particularly in the provision of direct care. In a small scale qualitative intervention study, Hansebo and Kihlgren (2002) found that to achieve the well being of the patients and caregivers, the caregivers had to maintain a balance between performing tasks and establishing and maintaining relationships, which often involved managing complex situations. Rundqvist and Severinsson (1999) undertook a small interview study with formal caregivers and concluded that the foundation of the caring process with people experiencing dementia was the relationship between caregiver and patient conducted in a caring climate. In this study, values such as consideration, patience and compassion were described (Rundqvist and Severinsson 1999).

Williams et al (1999) developed a model of person centred-ness in social psychiatry that involved a client- staff relationship where the client is valued as an individual but there is also an expectation of shared responsibilities. Based on an individual case study, Greenwood et al (2001) also suggest that care provision needs to consider a relationship between care provider and client based on mutual responsibility as having benefits for both client and staff. Greenwood et al (2001) propose that it is often the conceptualisation of caring that prevents effective working with people experiencing dementia and that a re-conceptualisation of the relationships within caring is required. Hansebo and Kihlgren (2002) observed care givers achieving this by trying to see the reality from the point of view of the person experiencing dementia or meeting them in their own world. This was termed confirmation (Hansebo and Kihlgren 2002) and resonates with Kitwood's description of behaviour that validates the experience of the person with dementia (Kitwood 1997).

Powers (2001) undertook an ethnographic study in one nursing home in the US and proposed four domains as a framework for working with people with dementia:

- preserving the integrity of the individual
- defining community norms and values
- learning the limits of intervention
- tempering the culture of surveillance and restraint

Underpinning these domains is the concept of shared values between the staff and residents experiencing dementia. Although this requires further development and testing, it is suggested as a model to support staff in making decisions when caring for people with dementia. Davies et al (2002) used an action research cycle designed to develop practice in a UK nursing home caring for people with a range of mental illness. Part of this process provided an opportunity for staff and relatives to develop the service recognising shared values within the organisation.

The concept of person-centred care appears to be well defined in dementia care. The small scale studies reviewed in this section suggest that person centred care can be enacted in small dementia care units where there are low numbers of residents per staff member. External to dementia care, the term person centred care lacks clear operational definition, with many practitioners uncertain about the implications for their practice of adopting a person-centred approach. Therefore, the appropriateness of person-centred care as the **key** concept to guide practice with older people and their families has been questioned (Davies et al 2002, Nolan et al 2002). Furthermore, the impact of person-centred care on health-related outcomes for older people and their

families has yet to be determined. These debates suggest that it is timely to reconsider appropriate goals of care within a range of settings where older people receive care.

Relationship centred care

Long Term Care in the UK has been described as lacking a clear therapeutic direction (Nolan et al 2001). To address this, Nolan (1997) developed the 'Senses Framework' to provide a rationale for the care of older people in Long Term Care environments. The Senses Framework was subsequently revised by Nolan et al (2001) to provide a therapeutic direction for the care of older people in a range of care environments (Table 2.4).

Table 2.4 The Senses Framework- after Nolan et al (2001)

A sense of security – of feeling safe and receiving or delivering competent and sensitive care
A sense of continuity – the recognition of biography, using the past to contextualise the present
A sense of belonging – opportunities to form meaningful relationships or feel part of a team
A sense of purpose – opportunities to engage in purposeful activities or to have a clear set of goals to aspire to
A sense of achievement – achieving meaningful or valued goals or to feel satisfied with ones efforts
A sense of significance – to feel that you matter, and that you are valued as a person

The term 'senses' was chosen to reflect the subjective and perceptual nature of what determines 'good care' for both older people and staff, supporting the development of

therapeutic relationships. Based on a growing body of empirical evidence (Davies et al 1999, Davies et al 2002, Nolan et al 2002), the 'Senses Framework' supports a clear therapeutic rationale for staff who care for older people. The subjective nature of the 'Senses' would suggest that different contexts and interventions could create the 'Senses' for people in different ways, although further work in this area is required (Nolan et al 2001). It is proposed that when staff, older people, and their families experience the 'Senses' an enriched environment for care is created where positive relationships may develop (Nolan et al 2002).

Relationships in health care practice have been described as central to the therapeutic encounter by Tressolini et al (1994) in the development of their concept of relationship-centred care. This concept challenges a purely biological approach to health care through consideration of the significance of the relationships between practitioners and those they care for as well as the communities within which they practice (Tresolini et al 1994). Relationship centred care is based on a therapeutic relationship which should have as its foundation a shared understanding of what health and illness means to the person and those close to them, in the context of the community in which they live. It however goes beyond the holistic person centred model to consider relationships between other practitioners as well as between the person and their community:

> *'Practitioners' relationships with their patients, their communities and other practitioners are central to health care and are a vehicle for putting into action a new paradigm of health that integrates caring, healing and community. These relationships form the context within which people are*

helped to maintain their functioning and grow in the face of changes within themselves and their environment.'

Tressolini et al 1994 p.24

Tressolini et al (1994) have summarised the skills, knowledge and values that practitioners need to build therapeutic relationships with the people they care for as well as the community and other practitioners. These include appreciation of the whole person, recognition of the person's life story, treating them with dignity and respect as well as the ability to be self reflective and work constructively with other professionals as well as communities in which they are located (Appendix 1). Relationship centred care was developed for the education of health care professionals and is still emerging, with further work needed to explicate its dimensions (Tressolini et al 1994). The notion that the encounter of a therapeutic relationship requires shared meanings between professional and patient, suggests an opportunity to explicate the dimensions of relationship centred care in other contexts where relationships are central to the caring process. Furthermore, this model of relationship centred care enables the inclusion of relationships that extend beyond the individual person receiving care to consider relationships between practitioners and relationships within the community. This approach may have relevance to the consideration of relationships in a communal environment such as a care home.

Care homes as communities

Many care homes try to be 'home like' and this should be encouraged. However, maintaining the notion of 'home' as a realistic concept for care homes has been questioned (Peace and Holland 2001). It is for this reason that considering care

homes as a community where a complex set of relationships exist, may be of greater value (Davies 2001a). There is some evidence to suggest that many care homes in parts of the United States are considering ways of transforming the environment to create a more dynamic community (Tesh et al 2002). 'The Eden alternative' suggests an enhanced environment to create a thriving community that involves pets, plants, children and links to the local community (Barba et al 2002). Here, residents are encouraged to take an active role in the community, which supports social attachment and gives meaning to the residents' lives. Staff at all levels are valued and given responsibility in a supportive environment (Barba 2002). Davies (2001a) describes a complete community as one where residents, families and staff all feel valued. To promote a culture of community staff need to share common values and leaders within the organisation should promote information sharing, participation and involvement (Deutschman 2001b).

Communities have been described as both territorial (Bell and Newby 1973) and relational (McMillan and Chavis 1986). McMillan and Chavis (1986) propose the following elements to their definition of community: membership, influence, integration, fulfilment of needs and emotional connection. Applying this notion of community to care homes however, may be more problematic as many residents arrive in care homes due to failing health rather than through affiliation (Abbott et al 2000). Increasing dependency of care home residents also makes it difficult to support ongoing integration with others due to hearing or sight impairment or cognitive decline (Mor et al 1995, Resnick et al 1997). Drevdahl (2002) proposes a more complex view of community noting its inherent contradictions:

' that is - community being both home (a location of refuge, similitude and familiarity) and border (a place of peril, difference and unfamiliarity)' (p.10)

Furthermore, communities are rarely homogenous where people enter with a preformed identity but are constituted by the individuals within them (Drevdahl 2002). Davis (2000) suggests that community is 'within each of us' (p.296) and takes into account the relationship between the individual and the community as well as environmental, social and political structures that influence it. This means that relationships become the context in which communities develop (Davis 2000) and suggests the need to know more about relationships if we are to develop community in care homes.

Throughout this review, relationships between staff, residents and their families have emerged as fundamental to the experiences of residents, families and staff in care homes. However, few studies have considered relationships as central to their objectives.

Limitations of the literature

Much of the research in care homes originates from the United States, Scandinavia and Australia with limited work generated within the UK. The dominance of the US research reflects a preoccupation with the measurement of resident outcomes in their search to improve care in this sector. While this is to be applauded, it creates a focus on the organisational requirements to achieve this, such as the amount of staff, or recruitment and retention issues. Part of this is due to the accessibility of large scale multiple data sets that provide these measurements as a requirement for funding

(Harrington et al 2000). This approach to research maintains a clear focus on what is needed to be done in terms of the tasks of care. While it is essential that care homes provide high quality care for some of the oldest and most vulnerable older people within our society, focussing exclusively on the physical aspects of care appears to be missing the more qualitative dimensions of what it is like for people to live, visit and work in a care home. When residents, staff or families are asked what is important to them, such as in the Bowers' group of studies (Bowers 1988, Bowers et al 2000, Bowers et al 2001), it becomes very clear that interpersonal relationships and how caring is enacted is essential for good quality care. This focus is however, largely absent from the literature.

Two methodological approaches are prominent within the literature: quantitative designs and ethnographic studies. The quantitative studies reviewed, often described statistically significant relationships between a range of variables that are hypothesised to impact on the stated outcomes. While it is useful for managers to know the significance that different factors have in affecting outcomes of care, these studies lack an explanatory framework. This means that it is often left to the researcher to provide explanations and suggestions for practice. While these may be relevant, researchers are not always practitioners and may not have a working knowledge of the care home environment. In many cases practitioners are then left with knowing what is wrong but not why, or feeling that suggestions for practice are often unrealistic aspirations on the part of the researchers. This leaves a very negative picture of what is actually happening in care homes with few studies identifying positive work that is being achieved.

A range of ethnographic studies was also reviewed (for example, Gibb and O'Brien 1990, Savishinsky 1991, Diamond 1992, Henderson and Vesperi 1995). Ethnographies are often characterised by a study of culture with the researcher becoming part of that culture. Within these accounts, a more human account is portrayed about what it is like to live, visit and work in a care home. By their nature these studies consider one or a small number of homes and provide us with an insight into both the best and worst of these situations. The reader is able to consider the issues presented and possibly some solutions to those issues. Often the researcher provides suggestions for practice based on their involvement within those cultural areas and their interpretation of the participants' accounts. However, the intention of ethnographic work is to provide a description of the situation, developing the readers' understanding. A key limitation of this approach in care homes is the lack of explanation as to why a particular situation occurs or what could be done to alter the situation on a day to day basis.

It is somewhat surprising and disappointing to compare how many findings from early studies in long term care environments were being replicated in small scale qualitative studies ten years later. Much of the qualitative work reviewed revolved around asking residents, families or staff what was important to them. Consistently from this work, residents, families and staff identify similar issues of concern such as the lack of time staff have, the attitude of staff towards them or how care routines are delivered. In addition to this, each group have issues specific to them within the care home, which have been reviewed in this chapter. A key limitation of many of these studies is the lack of an interpretive framework that may provide possible explanations for why different situations arise. Again this leaves practitioners with a

clear idea about what may be wrong but limited information in how to address the range of issues that emerge within many of these studies. A consistent message from the research reviewed has been that residents, families and staff in care homes value interpersonal relationships. Furthermore, it is often these relationships that influence the experience of residents, families and staff. However, there remains a dearth of studies that consider relationships as a central focus of inquiry.

Summary

The review of the literature within this chapter suggests the importance of relationships to older people, their families and staff in care homes. Although the focus of care homes needs to be on the delivery of good quality care, how that care is delivered has a major impact on the experiences of residents, families and staff. In some studies, relationships were seen as integral to the care process. Staff having time to spend with residents in care routines enabled them to personalise routines and develop relationships that gave residents a feeling of significance. The value of developing personal knowledge and seeing the resident as a person is also a recurrent theme in the literature surrounding the families' role in care homes. Relationships between families and staff also contribute to the families' feeling of significance and involvement in the care home. Interpersonal aspects of their role have been found to be very important to staff and may influence staff retention. Conversely, if there is a high turnover of staff, this has the potential to constantly disrupt the development of relationships within a home. Relationships between staff appear little understood but those studies that were reviewed suggest involvement in decision making and utilising all members of the team in this process are integral factors in staff satisfaction and the development of individualised or person centred care.

From this review, a clearer picture of the value of relationships within care homes has been formed. However, little is known about relationships between residents, families and staff within the same care home. There has been limited studies that have considered relationships in terms of person centred and relationship centred care but those that have, provide useful insights into the development of relationships in care homes. However, any of the studies that considered all perspectives described these relationships as a by-product of the main focus of the study. This suggests the need for a study that considers relationships between residents, families and staff within the same care homes as the main focus. Therefore, I proposed to answer the following question:

> 'How do relationships between older people, family caregivers and care staff influence their experiences within care homes?'

To answer this question, I also identified three further objectives:

1. To describe the nature of relationships between older people in care homes, their families and staff
2. To consider how these relationships are developed and the implications this has for practice in care homes
3. To provide an interpretive framework to understand how these relationships influence the experience of older people, their families and staff in care homes

The following chapter will describe the methodology I used to achieve these objectives.

CHAPTER 3- METHODS

Introduction

In Chapter One, I described how my personal experience suggested that the voices of those living, working and visiting in care homes have been marginalized. While this may have been in part due to the largely negative perception of care homes in society, I was still left with this feeling following my review of the literature in Chapter Two. It appeared that a large part of the research appeared to favour the voice of residents, families or staff, with few studies that considered all perspectives. This underpinned my initial perceptions that to make this research relevant to practice an inclusive approach was needed that enabled the voices of residents, families and staff to be heard simultaneously. This decision was to be a major influence in deciding on the appropriate methodology for this study. This chapter will outline how the decision to undertake a constructivist methodology was taken.

Towards a qualitative approach

In Chapter Two I discussed the purposes of reviewing the literature and described what was known about the relevance of relationships in care homes between older people, families and staff. From that review, a number of methodological limitations were apparent; specifically the descriptive nature of many studies and the inability of researchers to provide explanation from within the data as to why the findings existed. My initial reason for undertaking this study, as outlined in the introductory chapter, was to make a difference to experiences of care within care homes. Therefore, my chosen methodology would need to result in suggestions for developing practice in ways that would enhance the experience of all stakeholders.

To reiterate, my objectives for the study were:

1. To describe the nature of relationships between older people in care homes, their families and staff
2. To consider how these relationships are developed and the implications this has for practice in care homes
3. To provide an interpretive framework to understand how these relationships influence the experience of older people, their families and staff in care homes

When designing a research study, the approach to research is largely determined by the questions being asked. Since relationships are experienced subjectively, a qualitative research methodology that would provide insights into how relationships were perceived and experienced was most appropriate to answer the research question and achieve the objectives. A key feature of qualitative approaches is that the research is conducted within the natural setting of the phenomena under investigation as the following quote demonstrates:

> *'Qualitative research is a situated activity that locates the observer in the world. It consists of a set of interpretive, material practices that make the world visible. These practices transform the world. They turn the world into a series of representations, including field notes, interviews, conversations, photographs, recordings and memos to self. At this level, qualitative research involves an interpretive naturalistic approach to the world. This means that qualitative researchers study things in their natural settings, attempting to make sense of or to interpret phenomena in terms of the meanings people bring to them'.*
>
> (Denzin and Lincoln 2000, p. 3)

As Denzin and Lincoln (2000) identify above, the practice of qualitative research renders the world visible. The literature reviewed in the previous chapter indicated the invisibility of relationships and how they were developed. It also provided few indications of how older people, families and staff perceived their relationships. Therefore, an exploratory approach was needed that allowed participants the opportunity to identify issues that held relevance for them. A qualitative approach to the current study would provide opportunities to explore the meanings that older people, families and staff attribute to the relationships they developed with each other while living, visiting or working in a care home. However, such meanings may be very different for the individuals involved and this raises the question of how understandings are developed between older people, families and staff in care homes. Consequently, the research design would need to capture the interplay between each of these groups and how this supported the development of relationships within the care home environment.

Finding a perspective

Qualitative research is a broad field of enquiry that privileges no single methodological practice over another, with no distinct practices it can call its own (Denzin and Lincoln 2000). Cresswell (1998) suggests that it is relevant to consider appropriate perspectives when framing a study:

> *'An initial phase of (research) design is to consider not only whether a qualitative study is suitable for the study of a problem but also to frame the study within philosophical or theoretical perspectives'.* (p.73)

From the research reviewed in Chapter Two, it seemed that a broad array of qualitative approaches had been employed in research in care homes, with disparate philosophical and theoretical underpinnings. Therefore, I needed to identify a qualitative approach that was congruent with the objectives of this study.

It has been suggested that all research is guided by a set of beliefs referred to as a 'paradigm' (Lincoln and Guba 2000). These beliefs reflect the researcher's world view and guide the questions they ask and the interpretations they bring to the process (Denzin and Lincoln 2000). Guba and Lincoln (1998) contend that the beliefs that guide paradigms can be illuminated by answering three questions: what is the nature of reality (the ontological question); what is the relationship between the inquirer and the known (the epistemological question) and how can we can gain knowledge of the world (the methodological question). I will consider each of these questions in relation to the research question and objectives posed in Chapter Two.

In the context of my research study, each participant may hold a different perspective on their relationships, influenced by the time, the context and by others with whom they share relationships. The nature of what is real for those within this study is local and context specific, dependent upon multiple and sometimes conflicting social realities. Therefore, as the purpose of this research is to explore how relationships influence the experience of different groups of people within the specific context of care homes, it requires an ontological position that acknowledges that these perspectives have equal value.

Relationships and what they mean to people develop and change over time and are in turn influenced by other relationships. In order to explore relationships in care homes, an epistemology which enables the development of a relationship between researcher and participants would be required to actively support the development of shared meanings.

People are often involved in relationships without thinking about them, which can make it difficult to identify how relationships are developed. Therefore a methodology was required that enabled participants to discuss and explore the meanings generated by everyday actions, that may not always be considered as important. While a range of methods are open to the qualitative researcher, the choice of methods also reflects the world view the researcher holds. As these questions are seeking to explore the nature of relationships and their impact on experiences of older people, staff and families, a framework that supports an ongoing dialogue with all participants could potentially support a deeper understanding of the meanings ascribed to these relationships.

Lincoln and Guba (2000) summarise the key paradigms as positivism, post positivism, critical theory and constructivism (Table 3. 1). The review of these three paradigmatic questions led me to consider paradigms that I as a researcher could subscribe to while answering the questions posed. The paradigm that I felt most closely aligned to these areas was that of constructivism.

Table 3.1 Paradigm positions on selected issues. Adapted from Lincoln and Guba (2000)

Item	Positivism	Post positivism	Critical theory et al.	Constructivism
Aim of inquiry	explanation: prediction and control		Critique and transformation; restitution and emancipation	Understanding; reconstruction
Nature of Knowledge	Verified hypotheses, established as facts or laws	Non falsified hypotheses that are probable facts or laws	Structural/ historical insights	Individual reconstructions coalescing around consensus
Knowledge accumulation	'building blocks' adding to 'edifice of knowledge'; generalizations and cause- effect linkages		Historical revisionism; generalization by similarity	More informed reconstructions; vicarious experience
Quality criteria	Conventional benchmarks of rigor: internal and external validity; reliability and objectivity		Historical situated ness erosion of ignorance; action stimulus	Trustworthiness and authenticity
Values	Excluded- influence denied		Included- formative	
Ethics	Extrinsic: tilt towards deception		Intrinsic- moral tilt towards revelation	Intrinsic: process tilt towards revelation; special problems
Voice	Disinterested scientist as informer of decision makers, policy makers and change agents		Transformative intellectual as advocate and activist	Passionate participant as facilitator of multi voice reconstruction
Training	Technical and quantitative- substantive theories	Technical; qualitative and quantitative- substantive theories	Resocialisation; qualitative and quantitative; history; values of altruism and empowerment	

The constructivist approach

Guba and Lincoln (1989) describe the constructivist paradigm as having:

- A relativist ontology where truth, rather than being absolute, consists of multiple realities constructed by individuals in a specific time and place;

- A subjectivist epistemology in that the interaction between the researcher and participants shapes what emerges from the investigation and knowledge is then created jointly through this interaction;

- A hermeneutic methodology involving an iterative dialectic process between all participants and the researcher where understanding can be explored by the researcher and shared with others.

Schwandt (1998) suggests that terms such as constructivism should be used as sensitizing concepts as their particular meanings are often shaped by the intent of their users. This is aptly reflected in the application of constructivist principles to the practice of social work by Rodwell (1998). As previously described, part of the rationale for my study was to make a difference in practice, therefore, it seemed appropriate to consider Rodwell's application of constructivist principles to a practice (social work) setting that shared the values of involvement and empowerment (Rodwell 1998).

Rodwell's (1998) interpretation of constructivism is underpinned by the following assumptions:

- Realities are considered multiple, constructed and holistic with meanings being negotiated and shared. Meanings however are dependent upon one's perspective and are constructed in a way that is reflective of all participants.

- The researcher and participants are interactive throughout the research process with reciprocal relationships emerging.

- Constructivist findings are tentative rather than being able to be generalized because they are bound to a specific time, place and context. The researcher needs to produce a final report with sufficient information and richness to allow the reader to determine the relevance to another context.

- As multiple realities exist, patterns and relationships between realities may emerge within the context.

- All research is value based and requires trust and rapport between the researcher and participants.

Rodwell (1998) also proposes that not all research projects are appropriately addressed through a constructivist lens, suggesting that the question and context under investigation must fit with the above assumptions for a constructivist study to be feasible. Since the main intention of my own study was to explore the nature of relationships in care homes and how they influence the experience of people who live, visit and work there, a constructivist approach would enable all perspectives to be valued, with the opportunity of developing shared meanings between participants.

The constructivist paradigm therefore seemed highly appropriate. The next step was to consider how this approach could be operationalised within my study.

Research Design

A key feature of constructivist research is that the design emerges as the research progresses. However, Lincoln and Guba (1985) suggest that there are elements of an emergent design that can be specified in advance:

> *'Design in the naturalistic sense, means planning for certain broad contingencies without, however, indicating exactly what will be done in relation to each.'* (p. 226)

An emergent design is central to constructivist research, involving an interactive and iterative process between data collection and analysis (Rodwell 1998). This suggests that the process of constructivist research may result in overlap between the research design, data collection and analysis phases of the study.

Rodwell (1998) provides a clear account of the methodological implications of conducting a constructivist study:

- The research is undertaken in the natural setting of the phenomenon under investigation

- The primary means of data collection is via the researcher as a 'human instrument' as it is only humans who can grasp the meaning of interactions

- Tacit or 'felt' knowledge is also required to understand the nuances and communicate meaning

- Qualitative methods are preferable as they are more able to deal with the multiple realities that may emerge

- Purposive sampling supports the breadth of data collection to identify the multiple realities

- Design is emergent as no predetermined design can take into account the multiple realities that may exist in a context

- Outcomes, such as meanings, interpretation and products are negotiated with participants, as they retain ownership of the data

- Findings are generally reported in case study format so that multiple realities are better captured

- Findings remain tentative as they may not have relevance to other contexts

- The quality of the research is assessed using the criteria for trustworthiness and authenticity

(Based on Rodwell 1998)

Quality issues

In their extensive review of the literature relating to qualitative research, Murphy et al (1998) found no consensus in how to approach the issue of rigor within qualitative research. Lincoln and Guba (1985) proposed criteria designed to parallel the positivistic standards of validity and reliability, in a way that had relevance to constructivist research. These are referred to as the Trustworthiness criteria (Table 3.2)

Table 3.2 Trustworthiness criteria (based on Rodwell 1998)

Credibility	The process of understanding the depth and scope of the issues under investigation.
Dependability	The appropriateness of methodological decisions are demonstrated
Confirmability	The results that are reported are linked to the data
Transferability	Information created and lessons learned in one environment may be of relevance to other environments. This decision lays with the reader of the report

Credibility is generally achieved through a range of activities including prolonged engagement in the field, participant observation and member checks (Lincoln and Guba 1985). How each of these aspects was to be achieved will be discussed in the methods section of this chapter. Dependability suggests that all practices of data collection and analysis fall within the expectation of constructivist principles and can be accounted for, generally through a methodological log (Rodwell 1998). I proposed to maintain a methodological log where I captured my decisions as the research design emerged. Confirmability ensures that the product of the research captures all perspectives and is not simply a product of the researcher's cognitive processes (Rodwell 1998). To ensure this aspect of the trustworthiness criteria, I proposed to undertake member checking to ensure all participants felt their perspectives were

included. I also kept a reflexive journal during data collection and analysis where I recorded interpretations and decisions I made. Transferability is a consideration of how useful tentative findings from one environment may have applicability in another (Rodwell 1998). While this judgment rests with the reader of the report, my role is to provide thick description to impart a vicarious experience of the situation for the reader.

Guba and Lincoln (1989) subsequently suggested that quality criteria should reflect the underpinning philosophy of the research process and developed criteria based on constructivist assumptions known as the Authenticity Criteria (Table 3.3). These criteria have been described as potentially the most radical dimension of constructivism (Rodwell 1998) and will be used to discuss the quality of this research in more detail.

Table 3.3 Authenticity Criteria (after Rodwell 1998)

Fairness	Even handed representation of all viewpoints; different perspectives are encouraged and considered to be of merit within the inquiry
Ontological authenticity	Increased awareness by participants of their own perspectives and possibly a greater appreciation of the complexities involved in the situation being investigated
Educative authenticity	An increased understanding of and respect for the values of others, as well as an increased understanding of why differences may exist
Catalytic authenticity	The facilitation or stimulation for action as a result of the rethinking or reshaping that occurs through shared constructions. Participants may identify the possibilities for change to occur
Tactical authenticity	Has effective change occurred for the participants involved? Have they been empowered or impoverished by the process?

The purpose of these criteria was to move beyond the focus on methods although there is limited guidance in the literature in relation to how this can be achieved (Rodwell 1998). Nolan et al (2003) have considered the underlying principles of the Authenticity Criteria and developed a more accessible terminology rendering the criteria more comprehensible for all participants involved in the research (Table 3.4).

Table 3.4 Comparing nomenclature in quality criteria

Guba and Lincoln 1989	**Nolan et al 2003**
Fairness	Equal access
Ontological authenticity	Enhanced awareness of self
Educative authenticity	Enhanced awareness of others
Catalytic authenticity	Encouraging action
Tactical authenticity	Enabling action

In moving beyond the 'methods' dichotomy in the rigor debate, Nolan et al (2003) make Guba and Lincoln's (1989) approach more explicit with the use of a simple matrix to identify when the authenticity criteria can be applied throughout the research process (Table 3.5). I used this matrix as a planning device to consider how the relevant criteria could be demonstrated at each stage of the research process, placing ticks in the boxes where I felt the criteria were relevant to this study.

Nolan et al (2003) do not advocate that all boxes in the matrix need to be ticked to ensure 'good' research. The matrix is proposed as a tool to support shared decision making between researcher and participants in what should be the relevant quality criteria for the research being undertaken. Within this research, equal access was necessary at each point of the process, to support the development of shared meanings. With an emergent research design, I realised the potential for participants

to develop increased understandings of themselves as the research progressed. I planned to present the findings of each case study as a report that was made available to the home concerned. This was a potential vehicle to represent the perceptions held by residents, staff and families for each other to consider. I also planned that if people wished to be critical of issues within each home, that an opportunity for them to make suggestions would also be provided. These suggestions could be used within the report as a vehicle to encourage action. The product in this sense had the potential to enhance awareness of self and others as well as provide the vehicle to encourage action. These issues will be considered in more detail in Chapter Seven.

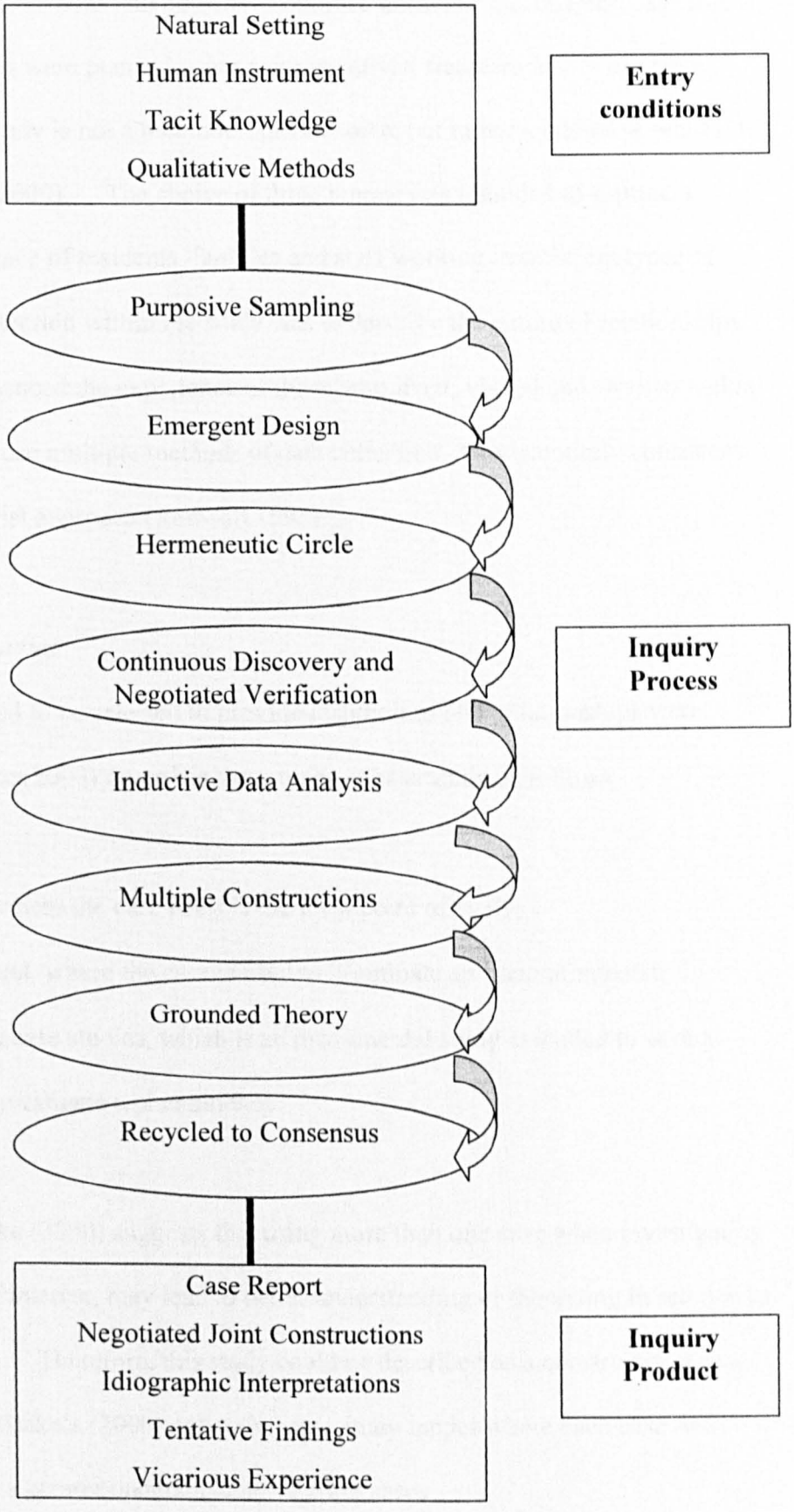
Table 3.5 Criteria used to assess quality in the current research study

	Planning	Process	Product
Equal access	✓	✓	✓
Enhanced awareness of self		✓	✓
Enhanced awareness of others		✓	✓
Encouraging action			✓
Enabling action			

(After Nolan et al 2003)

Rodwell (1998) provides a useful diagrammatic representation of a constructivist study reproduced in Figure 3.1. I used this as a methodological framework to identify a range of data collection methods that could support the development of shared understandings between myself and the participants within each care home. However, it was also necessary to tailor the design to the context of the care homes where data collection took place. This process will now be discussed in detail.

Figure 3.1 The Form of a Constructivist Inquiry



Adapted from Rodwell 1998 p 53

Overview of Methods

In order to achieve the aims and objectives outlined earlier in this chapter, case studies of three care homes were planned using a constructivist framework. It has been argued that case study is not a methodological choice, but rather a choice of what is to be studied (Stake 2000). The choice of three homes was intended to capture a breadth of experience of residents, families and staff working in different types of home. As my intention within the study was to describe the nature of relationships and how this influenced the experience of those who lived, visited and worked within them, I needed to use multiple methods of data collection. This is entirely consistent with a constructivist approach (Rodwell 1998).

Selecting Case studies

Care homes needed to be selected to provide insight into how relationships were developed. Stake (2000) describes three types of case study as follows:

- Intrinsic, where the case itself is the focal point of study;
- Instrumental, where the case is used to illuminate an issue of interest;
- Collective case studies, which is an instrumental study extended to several cases to investigate a phenomenon.

Furthermore, Stake (2000) suggests that using more than one case when investigating a phenomenon of interest, may lead to better understanding or theorising in relation to that phenomenon. Therefore, this study could be described as a constructivist case study, following Stake's (2000) collective case study model where each case was chosen to lead to a greater understanding of other cases.

Selection criteria in a qualitative enquiry are often dependent on what is being studied. Reed et al (1996) propose the need for a transparent sampling strategy that relies on more than serendipity or convenience. With this in mind, I considered the key issues that needed to be taken into consideration for this study were as follows:

- The environment needed to be able to yield a richness of data (Reed et al 1996) with positive relationships able to be identified;
- Participants needed to be able to 'illuminate' the question (Stake 2000) and so had to recognize that relationships were relevant to their experiences within the home;
- As Constructivist research is concerned with the development of joint accounts (Lincoln and Guba 1989), it was important for participants to want to actively engage in the creation of these accounts;

Using these priorities, three care homes were chosen incrementally across the course of the research. The ability of individuals within each home to contribute to the focus of the study was considered using foreshadowed questions derived from the current research literature surrounding care homes. Therefore, each case study was considered in relation to the following criteria:

- the desire of staff, residents and families to be involved in the study
- location
- size

- how the home was managed
- range of resident needs including cognitive impairment and complex health needs

Negotiating access

I negotiated the participation of each home initially with the Nurse Manager, who then approached residents, staff and families. Participants within each home agreed to be visited over a four to six month period for one to two days per week. Both observation periods and interviews were planned to reflect the breadth of experience within each home. To support this, I arranged data collection in consultation with staff to cover a range of days, times and events within each home. To allow for an emergent design, each case study site was planned incrementally, building on insights developed within each home to shape subsequent data collection and analysis. How I collected data within each case reflected the local context and was influenced by the willingness of staff, residents and families to become involved. The implications of this will be reflected on in Chapter Seven.

Within each home, I made all residents, families and staff aware of the research with a verbal invitation for them to participate as they wished. To supplement this, I placed an information poster within the home and made written information available to residents, staff and families. As the research progressed, specific people within each home were invited to contribute to my understanding of how relationships developed. A range of staff at each home were invited to participate in interviews based on the nature of their personal relationships with residents and families. These decisions were made through participant observation and discussion with residents and families.

Families were approached following discussion with residents and staff as well as by direct contact when they expressed an interest in speaking with me. Residents were approached following discussions with regular staff and those who expressed a willingness to participate were involved on a regular basis. As the study progressed, people who appeared to hold differing views were also approached to be involved after being identified through conversations or observations. I recorded these decisions in my field notes at the time.

Rodwell (1998) describes the process of observing and speaking with participants as the 'Grand Tour' which supports the development of foreshadowed questions. These are described as:

> *'a product of the inquirer's personal/ autobiographical history, and conceptual work... they are the tentative assumptions that guide the initial steps into the inquiry context.*
> (Rodwell 1998 p. 118)

The foreshadowed questions I developed were a combination of the sensitising concepts derived from the literature review and my initial observations in each home. They covered the following areas:

- *Relationships between care staff*: working together, communicating between each other; how the care routines were organised
- *Relationships between residents and care staff*: how these were developed over the course of the day; communication between residents and staff;

sharing of personal and biographical information during care routines; flexibility when the situation changes and how staff recognise reciprocity from residents;

- *Relationships between family caregivers and care staff:* how these were developed over time; how staff took opportunities to communicate with families; opportunities provided for families to participate in care routines if they wished; how each group saw themselves working together;
- *Relationships between residents:* opportunities provided for residents to get to know each other socially; residents' ability to provide mutual support and the facilitation of this by staff and each other; how the environment enabled the development of relationships
- *Other significant relationships:* such as the changing nature of relationships between residents and family caregivers.

Participating in the life of the home

I planned to participate in a range of activities within each home, which also included direct care giving. I described this role as being a pair of 'helping hands' and it became evident as 'the Grand Tour' progressed that adopting this role required flexibility. Developing relationships with staff in each care home was key to undertaking participant observation within this study as Rodwell (1998) describes:

> *Participant observation is preferred because the data is created in relationship and the inquirer can check for meaning in the moment.*

Constructivist participant observation must be a many sided, long term relationship with those being observed. It includes weaving a process of looking, listening, watching and asking into the natural context of observation. (Rodwell 1998 p. 127)

Relationships with participants were developed by offering to be of assistance at busy times of the day such as helping to take residents to the dining room, helping to feed residents at meal times, fetching and carrying and meeting residents social needs for conversations when staff were busy elsewhere. In two of the three homes within the study there appeared little interaction between staff and residents in communal spaces. In these homes, key staff were asked individually if I could work alongside them to participate in care routines. These observations were arranged with the staff and residents in advance and included residents who had consented to my presence in the context of the care routine. When participating in care routines, I introduced myself to the residents and reminded them of my role on the day. This was to ensure immediacy of consent and it was made clear that I was not observing the care routine but the interaction between staff member and resident within the care process.

My periods of participant observation in the range of activities described, extended from 4 to 12 hours each day, depending on the routines of the home and shift patterns employed. During these periods of observation, I tape recorded my field notes verbally in my car, away from the home. I did this at regular intervals which either coincided with staff breaks or a break in resident activities. These notes were then transcribed verbatim within the next 24 hours.

Interviewing

Interviews are generally used when the research is aimed at understanding what people do, believe or think and revolves around asking them to comment on their experience (Murphy et al 1998). I used interviews to support the dialectic process of developing shared meanings between each of the participants and myself (Guba and Lincoln 1989). This was achieved through the use of two types of interview: general conversations that revolved around what was currently happening within each home (recorded in field notes); and semi structured interviews that were pre-arranged, tape-recorded and transcribed.

I conducted interviews in the following ways:

- Interviews with staff occurred while staff were on duty. These were time limited to prevent unnecessary disruption to the routines of the home.
- Families who agreed to participate were given a choice of location for the interview. Some families wished the interview to be conducted in their own home while others used their visit to the care home to speak with me.
- Residents without cognitive impairment were invited to be interviewed within the home; residents with cognitive impairment, who wished to participate, were involved in regular informal conversations that were not taped.

Kvale (1996) likened the interview process to a construction site, where both parties are actively engaged within the process, referring to it as an 'Inter View'. This perspective acknowledges that the interaction between researcher and participants becomes an integral part of the research (Seale 1999). Gubrium and Holstein (2002)

suggest that interviews should be conducted as interactive conversations, which recognises the activity of both the participant and the researcher in contributing to the interpretations throughout the interview process. The notion of the interview as a construction site of knowledge is consistent with the aims of my study, which seeks to understand the nature and impact of relationships from the point of view of those experiencing these relationships.

In keeping with Kvales' notion of an interview as a construction site, I introduced into interviews my embryonic thoughts and ideas about how relationships had developed within each of the homes, based on my periods of observation. As I participated within the life of the home, my observations began to shape my foreshadowed questions into tentative descriptions of reality that supported further data collection and analysis (Rodwell 1998). These tentative descriptions fell broadly into the following areas:

- Motivation behind the contribution each person made to the care environment
- What was important to each person in how care was delivered
- The importance of the environment within the home
- How they saw the role of residents, families and staff within the home

These broad areas allowed each participant to speak about what was important to them in their experience within the home. It also provided opportunities for each participant to comment on their own understanding of the contribution of others within each home. Where there were similarities or differences between viewpoints, these could be identified and discussed to develop a shared understanding

of the situation. This approach contributed towards the further refinement of my tentative descriptions and the development of a joint construction within each home.

Involving participants in Focus Groups

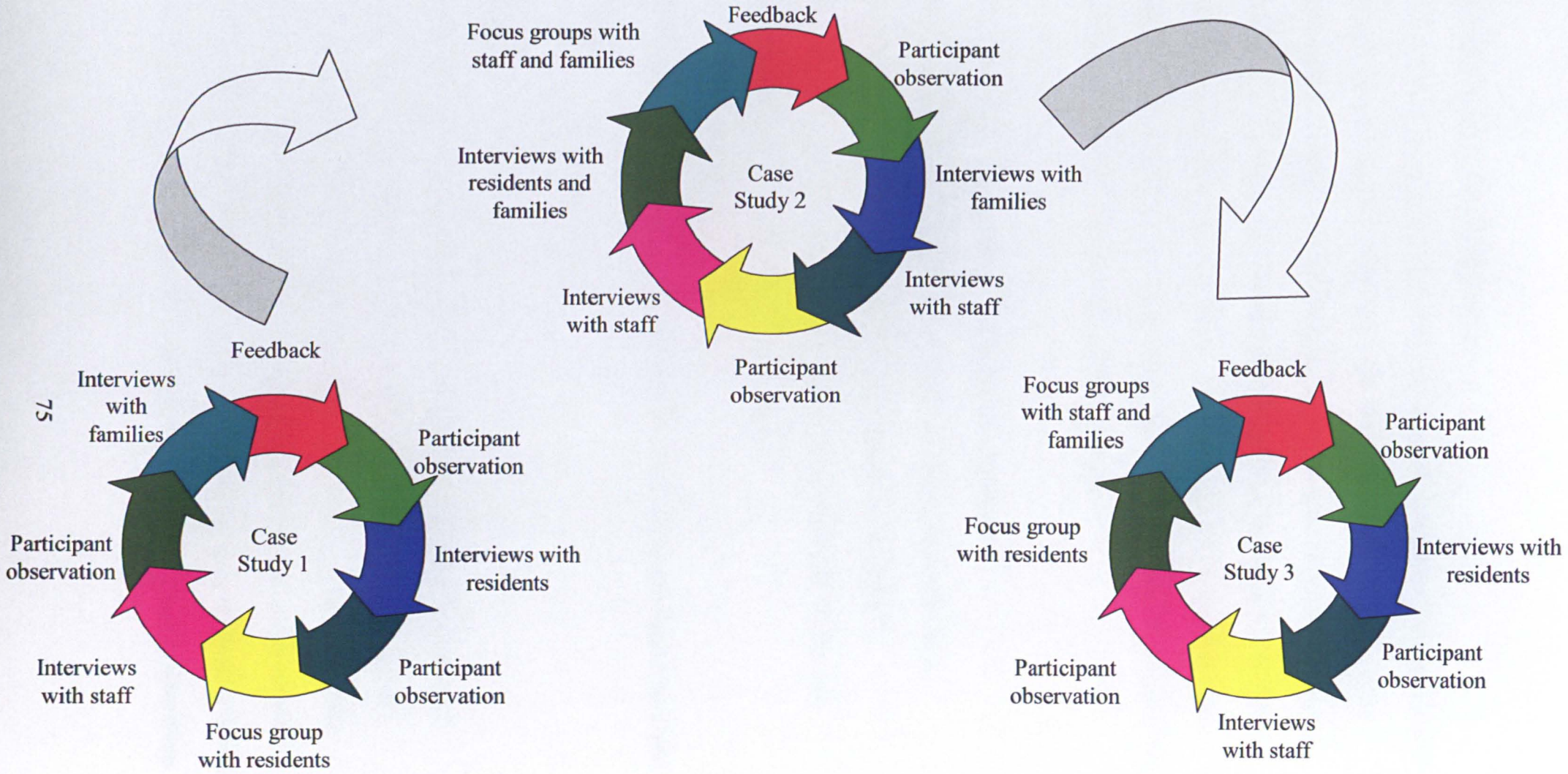
Focus groups also have the potential to provide the researcher with a unique insight into cultural values or group norms which may not be explicit in other ways (Kitzinger 1994). Rodwell (1998) contends that the group dynamics within a focus group might support people to explore and clarify their views. I therefore anticipated that the use of focus groups would enable participants to develop their understanding of the positions of others through joint discussion. Within each home, I used existing fora such as staff, relative and resident meetings to facilitate focus groups. These group interviews primarily explored issues that emerged with staff and families in the context of individual interviews (Morgan 1997). I used informal focus groups with residents to enable them to comment on ideas and interpretations I had developed through participant observation (Morgan 1997). The use of focus groups also provided a forum for participants to discuss the constructions for their own group including areas of both consensus and disagreement. This process enabled me to feed back to these participants, my developing understanding of the development and nature of relationships within each care home. Opportunities were also provided in each focus group for participants to identify other situations that they felt to be relevant.

Developing the Hermeneutic Circle

A key tenet within constructivist research is the development of the hermeneutic circle (Lincoln and Guba 1989). Rodwell (1998) describes this as a circle of

information created between participants to enable the sharing of perspectives. This is a process whereby views and ideas are shared between participants to support the development of shared meanings resulting in a joint construction (Rodwell 1998). This is achieved primarily through the spoken word, with interviews being the method of choice, so I planned to develop a dialectic process between participants by returning, where possible, to key individuals within each care home (Rodwell 1998). This process enables perspectives of the participants to be compared and is referred to as the hermeneutic dialectic (Rodwell 1998). My research was also concerned with everyday situations that people may not consider important when taking part in an interview. Therefore, I planned to further develop the hermeneutic circle using informal discussions during participant observation and focus groups where possible (Figure 3.2).

Figure 3.2 Developing the hermeneutic circle within homes and across homes



Analysing each case during field work

Within a constructivist study, there is an iterative movement between data collection and analysis. Data were recorded using field notes, audiotape recordings and a reflexive diary. As data were collected, transcription and coding were undertaken concurrently within each case. Rodwell (1998) suggests that inductive analysis is the method of choice as it is not possible to know what perspectives will emerge within the constructivist inquiry at the outset. Lincoln and Guba (1985) suggest that the initial process of data analysis proceeds in four stages:

- Unitising- locating units of meaning within the text;
- Categorising-taking all the units of data and sorting them into ideas
- Member checks- feeding back the categorisation to participants
- Filling in patterns- searching for convergent and divergent opinion and seeking explanation for these discrepancies

Each of these stages will be considered in relation to the processes undertaken within my study.

Unitising

Unitising has been described as a process where some understanding or action is singled out as a unit and should be able to stand alone (Lincoln and Guba1985). With this in mind, I began to locate units of meaning within my transcribed field observations in the margins of a hard copy and then transferred to a separate word document under broad descriptive headings. Initially, these units of meaning revolved primarily around the experience of residents so where possible, I based my headings

on the wording used by participants. This helped me, as the researcher, to remain attuned to the participants' views (Charmaz 2000). As data analysis progressed, I made notes about 'hunches' and ideas in a reflective field diary. I also made links between these units using my observation notes and subsequent interviews with residents, families and staff. These links then became signposts to support me in the process of creating categories. I then began the process of placing these units of meaning into provisional categories (see Appendix 2 for an example).

Categorising

Lincoln and Guba (1985) describe the process of categorising as following the method of constant comparison initially described by Glaser and Strauss (1965). This process requires the sorting of the initial units of meaning into piles by comparing the units with each other. As I followed this process, links emerged between the units which enabled me to produce analytical categories. As these categories developed, possible explanations emerged for what was occurring within the data (Charmaz 2002). This process of the deconstruction of data into units now enabled me to reconstruct them into categories with greater degrees of abstraction (Rodwell 1998). This process, it is suggested, leads the researcher to construct an analytical understanding as possible relationships between the categories begin to emerge (Charmaz 2002).

Member checking

As preliminary categories emerged, I was able to take this understanding back to participants for further discussion and member checking (Lincoln and Guba 1985). This ensured that the analysis was not simply my own construction as researcher, but

was shared by participants within each home. Rodwell (1998) suggests that this process enables participants to comprehend what has been produced so far, enabling them to see if their voices have been reflected. These preliminary categories were used as headings within a report, which was distributed to all participants within each home for further comments. When participants are able to understand the results of the data analysis, Rodwell (1998) suggests the final report can be constructed. As I completed the first case study report, I used the category headings as sensitising concepts for data collection across the other case study sites (see Appendix 3).

Filling in patterns

Following data collection in the second case study site, there was the risk of data overload, where the inquirer is unable to process further information (Rodwell 1998). To prevent this happening, I took some time out from data collection, to review the data from the first two case study sites. All interviews and field notes were re-read and colour coded according to their source (resident, staff, family or field notes) for ease of reference. The piles of data representing each unit of meaning were inserted onto individual grids using the preliminary categories (See Appendix 4 for an example). I then reviewed these grids with the intention of filling in patterns that were emerging. This was achieved by ordering and sub ordering of categories until relationships between them emerged, supporting the development of more refined concepts. This became an iterative process moving between and within categories that contributed to my developing understanding of the data (Appendix 5). The refined categories that emerged through this process following the second case study site became the sensitising concepts for the final case study site (Appendix 6). The data generated from the third case study site were subjected to constant comparison

with previous data to identify the potential emergence of new categories and to identify congruence or divergence with previous data.

The flexibility required to support the involvement of all stakeholders within this iterative process of data collection and analysis raised ethical issues, which will now be considered.

Ethical considerations

It has been suggested that the researcher within a nursing home context, is required to take on the responsibility of a moral agent, adapting to the needs of others within the research relationship rather than adhering to a prescribed ethical protocol (Madjar and Higgins 1996). This was particularly relevant when seeking to involve frail older people in a hermeneutic process contributing to joint constructions between participants. Tensions emerged throughout this process in the areas of informed consent, confidentiality and privacy.

Consent

One of the pre-requisites for obtaining consent is being provided with information so that an informed decision can be made (Beauchamp and Childress 2001). To achieve this, I prepared an information sheet and consent form for all stakeholder groups following the guidance of the Local Research Ethics Committee (see Appendix 7). Madjar and Higgins (1996) suggest that, within the context of nursing homes, seeking informed consent to research is an ongoing process and consent will need to be continuously negotiated. This was achieved by using a range of strategies summarised in Table 3.6.

Table 3.6. A summary of the types of consent used as an ongoing process

- Consent (verbal) to researcher being invited into their home
- Signature indicating consent to being involved in the full study
- Consent (verbal) to speaking with the researcher on a day-by-day basis
- Consent (written) to being more formally interviewed using a tape machine
- Consent (verbal) to being involved in a focus group to discuss the findings
- Consent (written) to use of personal information

During participant observation, I introduced myself to residents, staff and visitors explaining who I was and why I was there. At this point consent related to my involvement in the life of the home. However, people's choices and opinions also change over time, so the information collected through participant observation was discussed regularly with residents to ensure ongoing consent. This was in the form of typed summaries reflecting the data that involved individual participants. These summaries were shared with the participants and comments invited. They were then asked for their consent to use the information in the form it was presented. All participants were advised of the right to withdraw at any point within the study. I provided this advice at the outset in writing, and also re-iterated it verbally during the course of the study.

In order to make the process of consent more meaningful to the participants within my study, I sat and spoke with residents in public spaces within the home identifying myself as a researcher. In these conversations, I explained my interests and listened to the stories people told. I was asked repeatedly by one resident if I was getting the information I 'needed' as her understanding of research lay in the asking of fairly structured questions. As I felt the older people were developing an understanding for

the style of research I was undertaking and what this meant, I then introduced the information sheets and spent time with people individually discussing the content. This allowed older people to identify whether they wished to be involved in the study in the longer term, and many signed the consent form at this point. Older people's motivation to be involved in the study had a common theme – the opportunity to speak to someone different. For many older people in my study, consenting to being part of the research was, for them, of secondary importance.

There were also residents, staff and families within each care home who were happy for me to be in the public spaces but did not want to be formally involved in the study. Many informal conversations that became part of my data, contained important personal information that provided insights into how many older people within my study approached life within the home. I used this information to produce written stories that included the range of information shared with me, alongside my participant observations. Many of these stories contained biographical information, which gave the residents receiving them much pleasure. This process also provided each resident with the opportunity to consent to the use of information they had shared with me, which all participants did.

Given the increasing frailty of older people within care homes, it was important to provide residents experiencing cognitive frailty with the opportunity to contribute to the study. For these participants, a process consent approach was utilised (Dewing 2002). This involved the use of prompts to identify myself as different from the care staff. For example, I carried a red folder and wore the same type of clothes at each visit. The same process of re-orientation to my role within the home was

undertaken during each episode of data collection to ensure consent prior to data collection. I was also particularly alert to any non-verbal indicators of discomfort such as agitation or facial expression suggesting anxiety (Dewing 2002). In following current guidelines for ethical conduct at the time of data collection, written consent was also obtained via a proxy (Department of Health (DH) 2001b).

Confidentiality

All data were carefully protected as confidential and were stored in a locked cabinet. All tapes, transcripts and field notes were anonymised and no participants were named within reports arising from the study. As I discussed my observations with participants in each home, I realised that the use of quotes had the potential to alert readers within the home to the identity of participants. Furthermore, when participants became involved in conversations with me, it was not always clear if they were consenting to speak to me as the researcher or if they were speaking to me as a visitor. This also raised the potential that participants may not always be fully aware of how the information they shared might be used. To prevent confusion or potential distress, all participants were given copies of summaries of their contribution. These summaries also included quotations from interviews I wished to use within the final report. This enabled me to gain consent to use these quotations prior to sharing them in a public forum. Some participants, while consenting to my use of the information in my thesis and publications, requested that I should not disseminate it locally. I complied with this request.

Privacy

As a qualified nurse, currently registered with the Nursing and Midwifery Council, I planned to use my professional judgement to maintain the privacy and dignity of participants during periods of observation. During this time, I was aware that I might be included in episodes of intimate care. When involved in intimate care, I would be observing how the resident and staff member interacted in the context of their relationship. These observations would then form the basis of conversations to discuss the meaning each participant ascribed to the situation.

One of the most difficult ethical challenges of observational methods in health and social care settings relates to decisions about appropriate action when poor practice is observed (Higgins 1998, Koch et al 1995). In cases where I witnessed the potential for distress as a result of care I supportively intervened. An example of this was residents becoming distressed by a lack of sensitivity from care staff. On these occasions, my usual strategy was to acknowledge that the resident was becoming distressed, to acknowledge that something was not working between the care staff and resident and then to offer to support the care staff in the care being delivered. For example when a confused resident became distressed while having her nails cut, I suggested to the staff member concerned that she might prefer to have this done later; but the member of staff said they would not have time to come back. I offered to cut the resident's nails later when she had calmed down and the staff member agreed to this. On another occasion, a resident became distressed when approached to go to the dining room. As I was sitting near her, I offered to take her when we had finished speaking and the care staff agreed to this, moving to another resident who was happy to go to the dining room.

As a pair of helping hands, there were occasions when I shadowed staff when delivering personal care. This could mean that I would be caring for residents who may not have consented to be involved in the study. On these occasions, I planned to inform each resident cared for, of my role as researcher to enable them to consent to my involvement in their care. However, I only used examples of personal care in my data from residents who had consented to be part of the study. Residents were not approached for research purposes if they appeared upset, distressed or unwell.

There is the potential for therapeutic benefits to be experienced by the person involved in research such as feeling useful or making a contribution, which may not be common in other aspects of their daily lives (Dewing 2002). When I spent time with residents in each of the homes encouraging them to speak about themselves and their daily lives, some residents communicated that they appreciated the opportunity to make a contribution to my research. To enhance the positive experience for residents involved in my research, I endeavoured to involve residents in interviews in ways that did not interrupt the pattern of their day (Higgins 1998). For example, all residents were invited to move to a private space for taped interviews, but not all residents felt comfortable leaving their usual place so the decision to move or stay was made by them.

Issues of research governance

Governance frameworks are increasingly being seen as more important in research as a means of protecting the public. The Department of Health requires all research involving patients, service users, care professionals or volunteers, to be reviewed

independently to ensure that the research meets ethical standards (DH 2001d). However, concern has been expressed within the literature as to whether qualitative methodologies within health services research, are fully understood by NHS Research Ethics Committees (Stevenson and Beech 1998, Murphy et al 1998). Recent guidance provided by the Department of Health has suggested that committees should be reconfigured with expert members, who have experience of qualitative methodologies and social care research (DH 2001c). At the time this study was undertaken, there was no pre-requisite for gaining ethical approval for research undertaken in private sector care homes. However, ethical approval was sought from and provided by the Local Research Ethics Committee for this study (Appendix 8).

At the time of data collection, guidance provided by the Department of Health, identified that if clients or staff were accessed via the health service, then local organisational approval was required using the research governance framework (DH 2001d). This placed additional responsibilities on the host organisation, which has added another layer of bureaucracy to the research process (Ramcharan and Cutcliffe 2001), although its intention was to improve standards and protect the public (DH2001d). At the time of my study no formal arrangements had been made for service users of Social Service Departments or residents in private sector care homes, so I approached the local Primary Care Trust (PCT) for guidance on organisational approval. At the outset of the study I was advised that organisational approval was not required. Further developments in the extension of payment and assessment for nursing care in care homes (DH 2001e) meant that more residents were being funded partly by the NHS and were therefore considered to be NHS patients, falling within governance arrangements. All residents in the first care home were privately funded,

however this was not the case for subsequent homes where there were a proportion of residents with health service funding. Following further discussions with the PCT, organisational approval was applied for and granted for the remainder of the study (Appendix 9).

Although research ethics committees scrutinise ethical proposals, the responsibility still lies with the researcher to protect participants through the ethical conduct of their study (Orb et al 2001). The lack of clear guidance for the governance of research in care homes, places greater responsibility on the part of the researcher to ensure that ethical principles are used as a guiding framework for decision making throughout their research. These issues will be discussed further in Chapter Seven.

Summary

This chapter has outlined a philosophical and methodological framework within which relationships in care homes were explored. Starting from the position that reality can be understood from the multiple perspectives of the people involved in a specific context, this research constructed an emergent design to elicit the perspectives of older people, families and staff in care homes. Using the researcher as human instrument, a hermeneutic framework supported the development of joint constructions within three case study sites. A range of data collection methods were utilised within this framework enabling an iterative cycle between data collection and analysis. Analytical techniques, including categorising and constant comparison, were used. Throughout this process, ethical issues and issues of rigor were addressed as they emerged. The following chapter will discuss the findings from each case study site.

CHAPTER 4- FINDINGS FROM THE WITHIN CASE ANALYSIS

Introduction

This chapter presents initial findings from the case studies within the three care homes. The main purpose is to describe the relationships that existed between residents, staff and family caregivers within each home and to highlight similarities and differences.

As described in Chapter Three, the case study homes were purposively selected to provide a range in terms of size, location and client group. Important characteristics of the three homes are summarised in Table 4.1 Within each home, a range of data collection methods was used as illustrated in Figure 3.2 (on page 75). A summary is provided in Table 4.2.

Table 4.1 Key Features of the case study sites

FEATURE	CARE HOME 1 The Beeches	CARE HOME 2 Holyoake	CARE HOME 3 Chestnut Lodge
Number / type of places	28 places Self funding residents Nursing and residential beds	70 places EMI home Nursing and residential beds	28 places Residents with complex health needs including mental health problems. Nursing and residential beds
Ownership	Family owned home with employed Matron	First home acquired in a large chain	Family run home with Owner/Matron
Location	Rural area, poorly served by public transport	Situated on an industrial estate in an outer suburb	Rural area poorly served by public transport
Buildings	Converted Georgian Manor	Purpose built with recent extensions	Converted farm buildings

Table 4.2 Summary of the data collection methods in each home

FEATURE	CARE HOME 1 The Beeches	CARE HOME 2 Holyoake	CARE HOME 3 Chestnut Lodge
Participant observation	100 hours	96 hours	60 hours
Focus groups	2 with residents 1 with staff	1 with families 1 with staff	1 with residents 1 with families 1 with staff
Interviews with residents	6	Not recorded	4
Interviews with staff	6	13	6
Interviews with families	6	10	2

On entering each home, there was a period of 'reconnaissance', referred to as the 'Grand Tour' in Chapter Three. This included getting to know the environment and daily patterns of life within each home through observing and speaking with participants. This initial period of exploration was to gain an understanding of the physical and social dynamics and involved identifying a range of appropriate questions to ask, adding to the foreshadowed questions highlighted by the literature review. Throughout this time, observations and conversations with residents, their families and staff both helped me to determine what was salient and supported the development of my relationships with participants. It quickly emerged from conversations with families and residents that their relationships with staff had the most direct influence on their experiences of life in the Home. The way that staff approached caring for residents also recurred as an important theme in the experiences of staff, residents and their families. This early discovery reinforced the rationale for the study. However, as the study progressed, it became evident that residents and families could also actively influence the type of relationships that developed within the home. Key themes began to emerge as I considered the different sets of relationships between residents, staff and families within each home.

This chapter will:

- Describe the characteristics of each of the three case study homes from the perspective of residents, families and staff in each home
- Present a within case analysis including first impressions of the relationships between staff, residents and families and identify some of the processes that appeared to influence the nature of relationships within each home.

THE BEECHES - Making it our home

The environment

The Beeches, which provided the setting for the first case study, provided accommodation for up to 28 residents in a converted Georgian building with large grounds and extensive gardens. The home was a family concern, owned by a married couple, with their daughter employed as the administrator. The rural location of the home was identified by many residents and families as an important reason for choosing it:

> *'When we knew that mother had to move from hospital to a nursing home, we asked her what was important and she told us, gardens, birds, trees and that narrowed down our choice quite a bit. She didn't want to be in the city and wanted to be on this side of the city because it had been on this side of the city that she and my father had been out for lunch and visits to garden centres.'*
>
> *Mark- son – the Beeches*

As a Georgian Manor, the Beeches had a large staircase in a grand entrance hall. Beneath the staircase was a small lift providing disabled access to the bedrooms on the floor above, few of which had en-suite facilities. The current owners had extended the rear of the home to provide single en-suite accommodation on both floors. The communal lounges and dining rooms were located on the ground floor. The lounge had a spacious, yet homely feel with furniture that would not look out of place in a private residence. Full-length windows to the garden on two sides provided views of the surrounding countryside and residents were given a choice of where to sit. Families would often visit in the lounge, with some relatives feeling comfortable enough to move furniture into a familiar family group. A daughter of one of the residents had decorated the mantel above the fireplace with family photos enhancing the feeling that this was 'home' to her mother. A piano, belonging to another resident, was located beside the fireplace. Residents who had recently moved in had also brought a grandfather clock with them which had been placed in the Hallway, contributing to the sense that this was their 'home' also. The administrator of the home commented:

> *'We have always encouraged people to bring in their own belongings, but that is the first time we have had something like that, but it was important to find somewhere, for it and that was going to be safe.'*
>
> *Bella- Administrator- the Beeches*

Many residents had brought in personal belongings and memorabilia of their lives into their rooms. One resident commented:

'I have a lot of photos in my room, that's because when I'm in bed, I can look and see my family around me and that makes me feel comfortable.'

Betty- resident- the Beeches

The same residents appeared in the lounge most days with the majority of residents remaining in the private space of their rooms between meals. Residents were encouraged to come together at meal times although they also had the choice of remaining in their rooms if they wished. There were two dining rooms: one for those residents who were independent in eating where meals were served by the kitchen staff, and a smaller dining room where residents were assisted by care staff. A programme of external entertainment was provided in the home, and a Christian service was held each month.

There was also an outdoor seating area where the residents could sit in fine weather and it was a short walk to the local village.

Residents and their families

The majority of residents had moved to the home due to failing physical abilities that meant they were unable to manage independently in their own homes. A few residents had experienced the onset of dementia since moving to the home although the majority of residents had good cognitive and communication skills. Few of the residents had lived locally prior to coming into the home. Most had relatives or friends who lived in the nearby or adjacent villages and this had been one of the reasons many residents had moved here. The staff supported residents to maintain familiar ties in the locality; for example one woman was taken to the local Women's

Institute meetings until her health prevented her from attending. Another resident was taken to the home of her close friend once a month because there was limited public transport for her friend to visit. Residents and families commented on being made to feel welcome:

> *'When I came, Matron said to me, 'this is your home now' and that's what it feels like'.*
>
> *Beatrice- resident- the Beeches*

Families also described a sense of visiting their relative in their home. Many families spoke about the hospitality they were offered as reminiscent of something their relative would have done when they were visited in their own home. Other families remarked on the 'home-like' quality of the environment making them feel they were coming into their relative's home. However, some families also recognised the sense of community that had developed within the home:

> *'You (residents) speak to each other about what you are all doing. It's bit like a village in that respect, everybody knows what everybody else is doing and what the close relatives are doing as well, so it makes it a bit more like a family.'*
>
> *Mark- son- the Beeches*

These comments suggest that the sense of 'homeliness' was also reflected in the social relationships the residents had developed within the home. Many families I spoke to in the Beeches also described an informality in their relationships with staff

members, which contributed towards their involvement with their relative and for some, others in the wider community of the home.

The staff

At the Beeches 14 regular staff had been employed for periods ranging from 18 months to 12 years. Two members of staff were undertaking qualifications: one senior care worker was completing a National Vocational Qualification (NVQ) level 3 and another care worker was undertaking NVQ level 2. Many staff lived in the local or adjacent villages although a significant number of staff drove in from the city approximately twelve miles away.

Shifts were arranged over six hours with one Registered Nurse on duty per shift alongside three to four care workers. Many staff worked part-time. The role of the Registered Nurse was largely concerned with the management of the home, including admissions, discharges and transfers, although they also undertook aspects of direct care including medications and dressings. Each shift was managed by a senior care worker whose role was to organise care delivery by allocating staff to care for residents in specific locations within the home. The teams of care staff were led by the senior care worker with the whole team being responsible for the care of residents in the allocated areas. As the senior care worker was working alongside staff, this provided a sense of leadership in the daily care routines.

The home was managed by the Matron who had been in post for five years. She was described as a 'hands on' Matron which meant she was often the only Registered Nurse on duty. She described how she would try to fit in her administrative duties

within the usual working day. However, in reality she was observed to achieve this by working on either side of her shift. The Matron described how she tried to manage the home in a way that would promote positive relationships between residents, residents and staff and staff and families. One care worker described that he felt they were all part of a family:

> *'I think there's feeling of love here, we all (staff) feel like we're part of their (residents) family.*
>
> *Jay- senior care worker- the Beeches*

'Making it 'our' home' also meant that residents needed to feel like they belonged here as they would in their own home. One member of staff described how she achieved this:

> *'this is like their home now, you like to feel comfortable and you like to feel special in your own home and it's up to us to make them feel comfortable, to make them feel special and if they want something doing for them, well then let's see if we can do it for them.'*
>
> *Ann- Marie- care worker- the Beeches*

Ancillary staff within the Beeches also developed personal relationships with residents as they shared stories about their lives external to the home. This contributed to varied social exchanges throughout the home. For example, when care staff advised the Registered Nurse of changes to the residents, these would be interspersed with anecdotes of what residents had said or done. I observed a number

of informal exchanges between staff about how the residents were feeling or amusing things they'd said or done over the course of the day. This informality appeared to be the pattern of communication not only between staff but also between staff and residents in the communal areas of the home.

A key worker system was in operation within the home with key workers encouraged to build special relationships with their assigned residents. This approach meant that all residents, even those without close family members, had someone special in their lives. One resident identified her key worker as a 'country bumpkin' like herself and told me that they would share stories about countryside affairs. The relevant member of staff identified how she helped rekindle childhood memories for this resident:

> *'I saw some blackberries down the bottom there, some real thick briars coming over the fence and I thought, she'd really like to see them, so I got her right close up and she tasted them and she said that brings back a lot of memories'.*
>
> *Jilly- Senior care worker- the Beeches*

Residents were respected as individuals, with staff recognising the value of residents' past lives:

> *'They have done things with their lives, they were not the people you see here now and you have to respect that.'*
>
> *Jane- Deputy Matron- the Beeches*

Many staff at the Beeches, described their personal philosophy as 'do unto others,' which often reflected how they approached life:

> *'..the way I look at it is that I treat them the way I would like to be treated. It's the way I look at life really respect them and treat them the same way I would like to be treated.'*
>
> *Sandra- care worker- the Beeches*

Staff who demonstrated this personal philosophy were more likely to focus on the resident as a person. For other staff, caring for people in a way that you would like to be cared for was a form of reciprocity - giving something now with a view to getting something back later. This was succinctly captured by one care worker:

> *'We don't know if we will be like this (the residents) one day and I think to myself, give what you can give now, because maybe in later years, you'll be wanting someone to be doing it for you.'*
>
> *Ann Marie- care worker- the Beeches*

Most staff at the Beeches described a similar personal philosophy that influenced their approach to care and the relationships they developed with residents and families.

Within the Beeches, each day appeared to work along similar lines with all staff playing their part. Both residents and staff described a communal routine where each resident knew they had a place and felt comfortable with that position. Subsequently, if work was not going to plan, staff could approach residents whom this might affect

and negotiate a change to their usual routines. This suggested that in making it 'our home', everyone had a part to play.

Relationships - first impressions

Relationships between staff and residents within the Beeches appeared to be close, warm and friendly. One member of staff described this as a feeling of 'love' within the home that extended between staff, residents and families. Staff and residents were regularly observed sharing personal information and care routines were organised in ways that appeared to meet the needs of all residents. When discussing their relationships with residents, care staff would use examples of personal care routines such as meeting hygiene needs, meal times or helping residents to use the toilet to illustrate how their relationships developed:

> *'..well if I'm getting her up, I go in and always make sure she is presentable; with her earrings, her necklace, cause she likes them doing, her watch, her glasses. She likes to talk about her sons, so ask her how they're doing, talk about her family, because she very much likes to talk, so it's really a matter of listening.'*
>
> *Jay- Senior care worker- the Beeches*

Through these events, most staff seemed keenly aware of the details of care that were significant for individual residents, and appeared to work hard to ensure that care was delivered according to residents' wishes. Furthermore, there appeared to be regular negotiation and compromise between residents, their families and staff. For example, when unexpected events took place that did not allow staff to meet

everyone's needs as they were accustomed to, the staff tended to involve residents and their families in negotiating a change to the usual routine. Although trust was not explicitly referred to, I gained the impression that for negotiation and compromise to occur, there needed to be trusting relationships between staff, residents and families.

Families and residents at the Beeches, described their confidence that most members of staff would do as they said they would:

> *'I always say I feel safe with her. Well if I ask her for something, she does it. Some of them well they take ages. She'll say I'll go and get somebody and you know that she will come back with somebody very soon, she's very good.'*
>
> *Freda –resident- the Beeches*

This consistent approach appeared to support trusting relationships between residents and staff at all levels within the organisation, which highlighted the critical nature of staff doing what they said they would do:

> *'If you say you are going to do something, you've got to really try to do it because they depend on it. Then they can rely on you that little bit more and they're confident with you.'*
>
> *Jane- Deputy Matron- the Beeches*

As staff consistently followed through in their care, residents felt able to believe what staff said:

'I don't like to be a nuisance, but they say if you need the toilet you can always ask and they don't mind. I believe they mean it.'

Betty- resident- the Beeches

In the Beeches, there were many residents who were able to communicate easily. Families here identified their confidence that residents would feel able to express their opinions within the home:

'...and I think that the residents are quite happy to let people know when things aren't satisfactory, and if they are relaxed in their own home enough to say that 'that was no good' then that's fine. I can imagine in some homes, the atmosphere might not be so relaxed and people may not feel able to say and that shouldn't be the case and it's definitely not the case here.'

Sarah-daughter in law- the Beeches

Some residents and families also described ways in which they would try to make a contribution to the life of the home. This suggested that relationships were sometimes reciprocal. For example, one resident described how she would give advice to care staff and these staff described this resident like their 'grandma'. The recognition of this contribution was a feature of the reciprocal relationships that developed in the Beeches.

Although the predominant pattern of care at the Beeches, suggested personal or reciprocal relationships, on a number of occasions, alternative approaches were observed. When regular staff were not on duty, and replacement staff had limited

knowledge of individual residents, staff tended to focus on a series of tasks that needed to be completed. This threw into sharp contrast the very personalised and responsive care practices that I was witnessing at other times. This caused me to think about the way in which staff approached the care of individual residents and how this might influence the nature of the relationships that developed between staff, residents and families.

Three months into the period of data collection at this home, an event took place that altered the dynamics within the home. The Matron resigned and this clearly upset the residents and their families, many of whom had formed a strong attachment to her. Many staff members were also upset by this decision with some care staff making the decision to leave as well. As a result, there followed a crisis of staffing with a greatly increased dependency on agency staff:

> *'Well a lady of eighty or ninety odd years of age suddenly finds somebody they have never seen in their life before, is looking after them in a very intimate way with their care, ...when it's a regular practice, it's not right and it's not good, you could say it's not acceptable, but I guess there's no other way.'*
>
> *Dylan - son – the Beeches*

While relationships between the regular staff, residents and families remained positive, having staff around who did not know the residents seemed to result in a different emphasis in how care was delivered at different times. It was this observation, which first suggested to me that the different approaches to care were

influencing the relationships within the home. This will be discussed in the cross case analysis presented within Chapter Five.

As the data collection period within this home was concluded, two main types of relationship had been observed. One type of relationship could be described as personal and responsive and resulted when staff adopted a resident-centred approach. The other was described as reciprocal, and was experienced by some staff, families and residents when staff adopted a relationship centred approach. There were examples of staff adopting a more task centred approach, but this was rare and did not appear to have a lasting impact on relationships between permanent staff, the residents and their families. The descriptions of these types of relationships and the approaches that staff seemed to take, remained tentative as I entered the second care home, Holyoake.

HOLYOAKE- Making it a safe home

The environment

The second case study site, Holyoake, was a large purpose built unit for older people with enduring mental health problems or dementia. The home was built by a private businessman in the late 1980's and was purchased in 1999 by a corporate chain, however the Manager had a high degree of autonomy in decision-making. The home had been extended and refurbished and at the time of data collection provided accommodation for 80 residents. Holyoake was divided into four units, each of which had its own dining room and lounge space. Each floor had two units which were described either as the main floor or the 'extension', which referred to the later

additions to the home. Access to each section was via a key pad system to prevent residents from wandering out of the home.

The main floors had two lounge rooms where chairs were all identical and arranged around the walls. Each extension had one lounge room with standard high backed chairs, also arranged around the walls. All residents were brought out of their rooms to the lounge areas during the day to aid supervision. Residents who were mobile were able to return to their rooms, but few were encouraged or assisted to do so. On the ground floor, there were doors opening from each lounge room to an outdoor, secure garden. There was a range of outdoor furniture and a number of gazebos that provided additional shade. In fine weather, families would often bring their relatives outdoors during their visits. All residents came to the communal dining areas for meals unless they were unwell and confined to bed. Some families requested opportunities to spend meal times with their relatives in the privacy of their rooms, and staff supported this.

Residents and families

Residents throughout the home had a range of physical and cognitive needs and all had been assessed as requiring specialist mental health care in a secure environment. Some families lived locally, while others travelled some distance to visit. Many residents had mental health needs that had resulted in reduced abilities to communicate:

> *'He tried to tell me about these people the other night, but he can never remember enough words to explain what the people were like but I get a sense*

with my dad that with some of them he's on guard. There's certain people, he doesn't want them to come near him and he's always got his eyes on them, he's sussed out who's who in his own mind.He sort of seems to be a little bit in charge in that area now sorting people out, keeping them in order.'

Heather- daughter- Holyoake

Many of the families I spoke to in Holyoake had cared for their relative prior to them coming into the home and these families were encouraged to become involved in the care of their relative, with many taking this opportunity. Some families had undertaken specific training courses such as moving and handling, to enable them to continue helping staff with the personal care of their relative. Other families had undertaken a Food Hygiene course and would come in to help at meal times. Many families described different ways they would try to continue their relationships with their relative, either by maintaining special routines within the home or taking the resident to places that held special significance in their lives:

'We've been going to see the swans nesting and the cygnets hatching at the lake for about 8 years now. I go every year to see when it happens and then I take Milly.'

Richard- husband - Holyoake

When there was an issue with the care of their relative, families were encouraged by the Manager to approach registered staff rather than care staff. This situation had been prompted by some care staff giving families the wrong information about their relative, which the Manager had considered to be unsafe. Families were now advised

that if they were unhappy with any aspect of care, they should write a note and post it in the box outside her door. This method of communication appeared to create a focus on making sure that care was being delivered. The formality of this process seemed to contribute towards the development of pragmatic relationships between families and staff as the focus remained on the practical nature of caring.

Staff

Established staff had worked at Holyoake for periods ranging from seven months to twelve years and staff were assigned to one of the four units for up to twelve months. Staff appraisals, held annually could result in staff being reassigned to different units to develop their skills. Individual staff members could also be moved between units if there was a problem with staffing such as someone calling in sick. There was an active programme of NVQ training which all staff were encouraged to undertake. Five staff were in the process of undertaking NVQ 2 with a further two who had elected to take a BTEC course at a local college in preference to on-site training. All senior care workers within the home held a NVQ 2 qualification.

Holyoake employed a part-time activities co-ordinator and all residents had been assessed to identify appropriate individual and group activities. The budget had recently been increased to recruit more staff to undertake activities with residents.

The Manager at Holyoake was supernumerary to the required staff ratios and rarely became involved in direct care. This was in direct contrast to the Beeches where the Matron had been described as 'hands on'. The Manager's office was located close to the entrance of the building and she suggested that she was accessible to staff and

families as she would do what she called 'walk rounds' at least three times a day to see what was happening. The Manager had been in post for two years and told me that she had prioritised issues relating to risk management as she felt these required immediate change and had worked with staff to achieve this.

The purpose of Holyoake could be described as 'making it safe' for residents, their families and staff. Nobody I spoke to in Holyoake referred to it as the residents 'home.' For the Manager, safety was an over-riding priority as she described her concerns that record keeping, primarily in the form of risk assessments should be maintained to a high standard. This approach had been influenced by a recent coroner's case following an incident where a resident had choked during a meal. While the staff had acted appropriately, the Manager had been relieved that a risk assessment had been completed for the resident prior to the incident. Subsequently communication throughout the home was managed centrally in the form of memos for staff to read. This emphasis on the management of risk appeared a key factor in influencing a pragmatic approach towards the care of the residents:

> *'..we have four staff on constantly watching the residents. You have to be thinking about it(safety) at all times. So if a resident gets up and you know they're prone to falls you'll sit them back down, that way there's less accidents.'*
>
> *Sally- Senior care worker- Holyoake*

There was a designated Registered Nurse (RN) on each unit at all times, who had responsibility for managing the unit. This included supervising care delivery and

providing elements of direct care such as giving medications. Organisation of the daily routine within each unit was the responsibility of senior care workers. Some staff in Holyoake felt that the dominant approach of making it a safe home had created a focus on paperwork. This was attributed by some, to the new National Minimum Care Standards, which they felt had altered the dynamics of the role for registered staff in this home. As I spoke to a range of staff, there was a sense that this development had occurred by default due to increasing demands rather than as a planned strategy:

> *'Since Care Standards took over, the opportunity for role modelling has lessened because of the paperwork. The opportunity to role model is leaning more and more on to the senior care, because when you are getting new staff, it is the senior care who would be expected to show them how to communicate and things like that.'*
>
> *Adam- Deputy Manager – Holyoake*

The emphasis on risk management also appeared to influence how staff interpreted guidance from the National Minimum Care Standards. For example, staff identified that residents should not go twelve hours without food as a result of the National Minimum Care Standards. This was interpreted to mean that all residents had to be up, dressed and in the dining room for breakfast by 09.00am each morning. When I discussed this with staff, it was apparent that such guidance had been interpreted very rigidly with all staff feeling they had no choice but to follow this regime. This subsequently focussed staff on the task of getting everyone up in this timeframe and influenced how staff communicated with residents during their care routines.

For example, I observed one episode of care where a resident had expressed a wish to remain in bed, but this choice was considered secondary to the need to have all residents ready for breakfast. As long as residents co-operated, they were encouraged to get up. This interpretation of the '12 hour rule' had been communicated to all staff members and became a feature of the way things were done throughout the home. The strategies of communication within the home appeared to support a focus on making sure the job was done, which contributed towards staff being focused on the practical nature of caring. As staff tried to complete the necessary tasks within the time frame they had been set, their communication with residents also became quite pragmatic to help them get the job done.

Although the predominant focus in Holyoake was on making it a safe home, including an emphasis on paperwork, staff within one unit seemed more concerned to get to know residents as individuals. For example, one member of staff described how she had altered her practice in order to do this:

> *'Well I have changed the way I do things. I will go out now and sit outside the lifts to do my writing and the other night, we had a good communication time, I said 'well lads it's Saturday night, what are we going to do now?' And Henry said well we usually have something fancy on a Saturday night and he was talking about cakes and things, so it was good.'*
>
> *Ruby-Team Leader RN – Holyoake*

Other staff within this unit also described how they personalised the care of residents by using biographical information provided by families.

> *'Henry was asking where he could get a pint of lager, so I asked his daughter and she said he used to have one every night. I checked (his medications) to see if he could have it and I asked his daughter if she could bring some cans in. Now he has one every night and he loves it, it makes a difference. I'll check to see if we can do it if it's important to them.'*
>
> *Ruth- Senior care worker- Holyoake*

This suggested, that staff on this unit adapted their approach to care when they could. When I asked them why they did things differently, staff on this unit, described a different motivation to staff on other units:

> *'..well that's the reason we're there, not just to change their pad, anybody can change their pad, but it's to make a difference and as for me personally, that's why I'm in care, to actually make a difference.'*
>
> *Samuel- care worker- Holyoake*

For staff in this unit, respect for others was something that came from their own upbringing:

> *'It's about respect, but I was brought up to respect people.'*
>
> *Ruth- Senior care worker- Holyoake*

Other staff described how knowing about a resident's past resulted in respect for the type of person the resident had been before they entered the home:

> *'Her and her sister, they used to watch Forest (Football team) and I remember them in their regalia catching the bus. They are still a human being inside that little body.'*
>
> *Deanna- Senior care worker - Holyoake*

On this unit, the staff appeared to consider more than the physical needs of the residents, which was reflected in their personal approach to care.

Relationships - first impressions

On first impressions, relationships between staff, residents and families in Holyoake appeared to be focussed primarily on the physical needs of the residents. This was in direct contrast to the personal and intimate relationships observed in the Beeches. The focus on making sure everything 'got done' was reflected in daily task allocation across the units where individual carers were assigned to specific tasks such as shaving or cutting nails rather than caring for named residents. In general, it appeared in this home that the approach adopted by staff, in combination with the complex needs of the residents, resulted in the development of pragmatic relationships, where the focus of work remained on getting the job done. However, this was not a uniform response. In particular, a group of staff working on one of the units described how they used personal care routines to develop relationships with residents and their families:

'I'll always try to come back and if I promise them anything, a drink or whatever, I'll always try and do that, so if I am in a big rush, I won't promise.'

Malcolm- care worker- Holyoake

Being consistent, so residents knew they could rely on the staff member was an important element in developing personal relationships and this was similar to what I had observed at the Beeches. At Holyoake, there were fewer residents who were able to articulate how they developed trust in staff. However, staff on one unit described how they felt that consistency in their approach to care had the potential to develop trust between residents and themselves:

'With Gertrude, she really doesn't want me to be there. She doesn't like getting changed by blokes but if I have to change her, I'll stand behind her and slip her nightie over her clothes so she has her dignity and she trusts me to be like that. It's about getting to know them quickly and forming relationships with them and gaining their trust'

Samuel – care worker- Holyoake

Staff in this unit, also seemed aware of the need to develop trusting relationships with families:

'If you spend time listening to the families, then they know you will spend time looking after their relative, and they trust you because they know you are looking after them.'

Ruth- Senior care worker- Holyoake

Some families responded by demonstrating their developing trust and confidence in the staff:

> *'I've started for the first time taking two consecutive days (without visiting). I tried it and I was very anxious but I didn't ring because I think they have enough to do. Leon told me after the first day he was looking for me but now he has stopped, so soon I will be able to take three days. I trust them to tell me the truth.'*
>
> *Elizabeth- wife- Holyoake*

This last example illustrates how families were able to consider their own needs once they trusted the staff to focus on the resident. Families also described specific care workers who they felt were caring for their relative in 'the right way for them' suggesting that they were in agreement with the care worker's personal philosophy. Families who described conflicting relationships often disagreed with the way individual members of staff were caring for their resident. Many of the residents had communication difficulties which prevented me from asking them directly about their experiences. However, my observations suggested that residents recognised staff who were familiar to them and seemed to respond well when these staff maintained a regular routine in their care.

During my time at Holyoake, I was able to gather more information about what I began to describe as an individualised task centred approach. I had identified a similar approach through a small minority of my observations at the Beeches mainly as a fall-back position during times of staff shortage. My observations at Holyoake

suggested that an individualised task centred approach might be an underpinning philosophy for some staff. In other words, some staff and families at Holyoake, seemed to feel that adopting this approach was the best way to 'get the job done'.

For some staff, the main motivation for being in care work seemed to be to do 'a good job', which tended to support the development of pragmatic relationships. This philosophy was described by many staff in Holyoake, which appeared to fit in with the dominant focus of making it a 'safe home'. Here, many staff described the rewards in terms of a 'job well done':

> *'It's rewarding, very rewarding knowing that the residents, when I leave here at night they're well fed, clean, dry, comfortable until the next day when I come back in.'*
>
> *Leon- care worker- Holyoake*

There were also staff at Holyoake who adopted a more resident-centred approach and, in conversation, provided examples of how they attempted to understand the past person in relation to the present person:

> *'..it's like with Paul, he used to work down the pit, so he has always spoken like that, if he swears at me, it's out of frustration, it's not personal.'*
>
> *Deanna- Senior care worker- Holyoake*

In Holyoake, I also observed a number of staff in one unit, working together who described how their personal experience influenced them to adopt a 'do unto others' approach in the care of the residents:

> *'I know it's the way I'd like my dad to have been looked after. Maybe that's why I care so much, because I couldn't look after my dad when he was like this.'*
>
> *Ruth- Senior care worker- Holyoake*

Many staff who described a do unto other's philosophy as a contributing factor in their care were also more likely to describe how this influenced them to see the perspective of others, which supported them in developing more personal relationships with residents and their families:

> *'Families want the best for their relatives and you can't blame them for that, it would be the same if it was my dad, it makes me care more.'*
>
> *Ruth- Senior care worker- Holyoake*

Families who experienced staff acknowledging their perspective described how they felt supported by these members of staff:

> *'Yvonne (manager)said to me, it's worse for you than it is for him because you have that worry but he's happy.'*
>
> *Heather - daughter- Holyoake*

Some staff also described how they used their personal philosophy when working with other staff:

> *'I make them(staff) go up in the hoist. I take them up slow and I take them up fast so they can see what it's like and how frightening it is and they introduce it a lot better then.'*
>
> *Ruth-Senior care worker - Holyoake*

This approach encouraged other care workers within this unit to experience care from the resident's perspective and reflect on how this might influence their approach:

> *'You think all that discomfort again in reverse, so you have to think things out. I try to put myself in their position, I think fear is an ever present thing for them. I like to think I'm sensitive to their moods and I like to walk away from them feeling that they feel a bit better from that time we had together.'*
>
> *Malcolm- care worker-Holyoake*

An interesting observation was that the same members of staff could be seen adopting different approaches to care at different times of the day. For example, staff throughout the home adopted an individualised task focussed approach in many of the care routines which, when combined with the focus on safety, tended to encourage relationships that focused on the tasks of caring. This was also reflected in the process of care where the job being done was the most important feature of the routines. When this was underpinned by the staff holding a philosophy of 'doing a good job', relationships that revolved around the practicalities of getting the job done tended to

develop. These different influences seemed to support the development of primarily pragmatic relationships. However, staff on one unit, also displayed a more resident centred approach at other times, contributing to the development of more personal and responsive relationships. This supported the idea that the different approaches to care influenced the type of relationships that could be developed between staff, residents and families.

Before I entered the final home, I carried out a detailed analysis of the data from Holyoake and the Beeches, to ascertain whether the suggestion that different approaches to care influenced and shaped relationships was consistent with all my data and not simply the product of isolated observations within each home. This further developed my understanding of how relationships were developed and supported my data collection in the final home, Chestnut Lodge.

CHESTNUT LODGE- Making it the residents' home

The environment

Like the Beeches, Chestnut Lodge was owned and run by a family, who were fully involved in the day to day administrative and management functions. In discussion, the owners spoke about the importance of making it 'the residents' home', which included valuing relationships between residents, families and staff. They told me that this philosophy was regularly communicated to both families and staff. Consistent with this, many families I spoke with described the personal relationships they had developed with the owners. One family member described how she was initially attracted to the home because of this personal contact:

'It's Valerie and Peter(owners), they are very friendly and at the end of a phone if I need to speak to them. One home told me they had to ring the owner in Saudi Arabia before they could take my mum. That's not what we wanted. We wanted something more personal.'

Kelly- daughter- Chestnut Lodge

The home was in a rural location and had been converted from farm buildings approximately twelve years prior to the period of data collection. A key pad on the entrance allowed staff and visitors to access the home freely while also providing security for residents who might wander out to the road or nearby fields. At the time of data collection, Chestnut Lodge was home to 28 residents many of whom had a degree of cognitive impairment. Most bedrooms were shared.

Bedrooms were arranged in a horseshoe configuration with a communal area located centrally. This was open plan and divided into four separate seating areas. One was designated a quiet area with a fish tank where some residents enjoyed watching the fish. Next to this was a larger seating area with full length windows and patio doors across each side of the room letting in natural light. An unlocked door led to an enclosed garden that residents used as the weather permitted. Bird tables and flowering pots were visible from the windows. There was also a television area where the activities co-ordinator created seasonal displays. The television area led to the dining area which was also used for activities.

A rolling monthly activities programme included hired entertainers and there were also regular church services. Seasonal events were organised within the home to

which relatives of past and present residents were invited. The activities co-ordinator supported residents to make jams, preserves and cakes for sale at these events. External visits included trips to the pantomime in the winter and a boat trip in the summer as well as shorter journeys to local areas of interest as the weather permitted. Relatives were also invited to take part in these outings.

Residents and families

Many of the residents at Chestnut Lodge were cognitively frail with a range of physical care needs. Many had lived within close proximity to Chestnut Lodge. The families of these residents often spoke about knowing the owners or the owners' parents, with some children of residents mentioning that they knew the owners from their schooldays. Other families who lived nearby had actively chosen this home for their relative so they could visit regularly. Some families who lived locally described this as being able to 'pop in' during the usual course of their day. For some families, this had been the pattern of their relationship with their relative prior to admission.

Many staff in Chestnut Lodge were seen regularly engaging in conversation with family members during their visits. This was in marked contrast to the approach at Holyoake where families were encouraged to speak only with registered staff. The more flexible approach at Chestnut Lodge enabled staff to relate anecdotes about the resident's behaviour which often prompted further discussion with the family about the relevance of this behaviour to the resident's life prior to their admission to the home. This informality in communication provided families with a sense that staff knew their relative as an individual:

'I find it very relaxed, quite informal, very caring; the staff seem to understand the problems the residents have.'

Catherine - daughter- Chestnut Lodge

Staff were also conscious that different families wanted to be involved in different ways and would support them in the degree to which they wished to be involved. For example, when one son came in to assist his mother at meal times, staff would offer him a meal as they knew he lived alone. When another family member saw staff were busy, he would 'put on a pinny' to help give out night time drinks. Staff valued this support and families described how it enabled them to show their appreciation to the staff. When families visited their relative, they often visited other residents and would frequently be seen to engage with residents who approached them. Many families knew other residents by name and would accommodate them into their visit.

The staff

Many of the staff here had been employed within the home for several years, with a smaller number of staff appointed within the previous eighteen months. There was one Registered Nurse per shift, with three to four care workers. The Registered Nurse appeared to be responsible for the medication rounds, transfers, admissions and discharges. Shifts were arranged over six hours although many staff also worked 'long days' which included the morning and afternoon shifts. Staff worked in pairs, either 'upstairs' or 'downstairs' on a one month rotation and were responsible for the daily organisation of care.

Due to the location of the home, staff required their own transport and many travelled some distance to work. The home offered an enhanced salary to enable staff to do this. There was an active staff training programme within the home and at the time of data collection, all staff were completing a diversity training package by distance learning. This was in addition to NVQ training, with two members of staff undertaking level 2 and two staff undertaking level 3. There were no designated senior care workers at this home.

The activities co-ordinator had previously been a care worker and was developing her role with the support of the managers. She created a life history with all new residents, which was used to inform each resident's care plan. In addition to organising internal and external events, activities also included discussing photo albums or personal items with residents on a one to one basis and facilitating small group work such as cooking or reminiscence.

Many staff I spoke to described Chestnut Lodge as the residents' home. One member of staff described how she communicated this approach through the personal relationships she developed with the residents:

> *'I look on this as it's their last home, their last stop in life, and I think they all need that little extra care and loving and I think if they were at home, it is something that they would be getting.*
>
> *Gayle- care worker- Chestnut Lodge*

The Manager at Chestnut Lodge, encouraged a person centred focus as an approach to care, and this was communicated by the Registered Nurses who were responsible for the allocation of staff. The organisation of work had been taken on by senior care workers at Holyoake who provided the day to day example in care delivery. Without senior care workers in Chestnut Lodge, care staff appeared to work independently following the initial handover from the Registered Nurse.

Many staff described how they spent time during the personal care routines having conversations with residents, for example about pictures in their rooms, or sharing personal information about themselves. This style of communication supported the development of personal relationships between residents and staff, which was in marked contrast to the pragmatic level of communication observed in personal care routines in Holyoake. However, these relationships did not always result in the individual needs of residents being met. For example, many residents spoke about getting up at different times, depending on 'who' was on duty at the time, which at times could upset them. This suggested that 'making it the residents home' might not always acknowledge the competing demands created by the communal nature of the home.

Relationships - first impressions

Staff at Chestnut Lodge described friendly relationships with families, residents and other staff. Informal conversations with families during their visits to the home suggested similar experiences. Residents spoke about the staff being kind but made few other statements that described their relationships. The layout of the communal area encouraged informal interactions between staff and residents throughout the day

as staff traversed the area during the course of their work. Many staff members spoke with respect about individual residents, recognising the importance of their personal biography. While they used the care routines to get to know the resident, they also began to develop the routines of care, based on that knowledge:

> *'I think the most important thing is respect for clients. Older people have done things with their lives and deserve respect. You've got to think of what they want not what you want.'*
>
> *Robert- care worker - Chestnut lodge*

Most staff within the home described their work in terms of being responsive to a resident's needs and families were seen as part of the residents' lives. These observations, suggested a dominant focus within the home that was resident centred.

In Chestnut Lodge many staff I spoke to, also described a 'do unto other's philosophy. This could have contributed towards the dominant resident centred approach that was often observed within the home. Staff often referred to how they would like their loved ones to be cared for:

> *'I'd like to think if I had somebody in a home, they would be treated like we treat them here. It's treating them like a normal person to a certain degree. That's the way I look at it, it's what I would like if it was my parent or a relative of mine'*
>
> *Gayle– care worker- Chestnut Lodge*

Operating with this philosophy also suggests that these staff saw relationships with residents as personal. Describing relationships with residents in terms of their own family members provided these staff with a rationale for their care. This personal philosophy appeared to fit well with the dominant focus of 'making this 'the resident's home' as described by the owners. The personal philosophy of staff seemed to influence the types of relationships that developed in Chestnut Lodge. A philosophy of 'do unto other's appeared to create a more personal focus on the process of care. When staff described this personal philosophy, they personalised the care routines for each resident responding to what the resident felt was important. The dominant focus and environment in Chestnut Lodge was more homelike which also supported the development of personal and responsive relationships.

At Chestnut Lodge, observational data were collected primarily through participant observation in the communal areas of the home as there were limited opportunities to become involved in the delivery of personal care. It also took time for many staff to feel comfortable in talking to me, reducing the opportunities for informal conversations. Initially, it had been unclear why this had occurred. However, towards the end of my time in Chestnut Lodge, the Manager had shared with me that she and the staff had been wary of how I might interpret their practices and so for some time avoided me. Few families were available for formal interviews, with some sharing that they were happy with the care and so saw no need to be involved in my research. Other families were happy to speak with me informally during the course of their visits and when they attended organised events, such as the Easter Fayre. Although similar relationships were observed at the Beeches, further insight was gained into how relationships were influenced by the different approaches to care that

had been identified. This will be discussed further in the cross case analysis described in Chapter Five.

Typology of Relationships

The data from the three care homes, suggested that different types of relationships were being developed within each of the homes. A preliminary analysis of the data suggested that there were three types of relationships, which could be described as:

- Pragmatic- focused on the practical nature of caring, with communication revolving primarily around the task at hand
- Personal and Responsive- focused on respect for who the resident was, with communication involving social conversations with both residents and their families
- Reciprocal- featuring negotiation and compromise which took the needs of staff, residents and families into account within a trusting relationship.

The key features of these relationships have been summarised in Table 4.3.

TABLE 4.3 A typology of relationships in care homes

	PRAGMATIC	PERSONAL AND RESPONSIVE	RECIPROCAL
Dominant focus of home	Making it a safe home	Making it the residents home	Making it our home
Personal philosophy of staff	Doing a good job	Do unto others	Doing something for others now, because we might need it in the future
Process of care	Focus on the task Communication revolves around the task at hand Making sure everyone is safe and the care is done	Attention to important details Social conversations Changes made according to a person's needs supporting residents in meaningful activity	Organisation of care to meet needs of all residents, staff and relatives Negotiation and compromise when this is not possible Supporting relationships between residents
Residents and their families	Having basic care needs met, having to wait until staff have time to attend to you	Feeling welcomed, sharing personal biographical information, having confidence in staff, developing trust	Feeling they are making a valued contribution to the home, having confidence in staff in a trusting relationship

Conclusion

This chapter has presented a within case analysis of the three care homes, suggesting a typology of relationships summarised in Table 4.3. Within each home there appeared to be one type of relationship that was most common. In Holyoake, for example the emphasis on making it 'a safe home' contributed towards a focus on the tasks of care resulting in primarily pragmatic relationships between staff, residents and families. Personal and responsive relationships were most apparent in Chestnut Lodge and at the Beeches. The emphasis on making it 'the residents home' at Chestnut Lodge and making it 'our home' at the Beeches was conducive to familial relationships. Staff spoke about respect for residents and often used examples of how they personalised their care to take into account things that mattered to each resident.

Reciprocal relationships were most apparent at the Beeches where there was more of a sense that this was home to a community of people. Residents and families spoke of developing confidence with staff, implying a trusting relationship that the needs of both residents and families would be taken into account. Residents and families also found ways of giving something back to the staff, implying that the needs of staff were also taken into account.

Following this preliminary analysis, I was left with the impression that as staff adopted different approaches to care, different relationships became possible with residents and their families. This led me to undertake a more in depth analysis across the three case study sites to establish if there were different approaches to care and how they might influence the relationships I had observed. This is reported in the following chapter.

CHAPTER 5 – FINDINGS FROM THE CROSS CASE ANALYSIS

Introduction

This chapter presents findings from the cross case analysis of the three homes. As described in Chapter Four, a typology of relationships emerged from the within case analysis. As data collection progressed across the three homes, I observed both similarities and differences in how staff approached the care of the residents, which appeared to influence the type of relationships that developed between staff, residents and families. As these findings emerged, I took them back to participants within the three homes to see if this understanding resonated with their experience. The result of this process will be discussed in Chapter Seven.

On completion of data collection in the third home, I returned to the data from all the homes to undertake an in depth analysis. This process has been described in Chapter Three. A number of themes emerged that focused on how care was delivered, which supported earlier impressions that different approaches to care influenced the type of relationships that developed. These themes included the motivation of staff, the process of care and consequences for residents, families and staff . From this analysis, a typology of approaches to care emerged which is summarised in Table 5.1.

The motivation of staff to 'do a good job' appeared to influence the process of care contributing towards an individualised task centred approach. Staff seemed to use care routines to get to know the resident and how they liked care to be delivered. Residents and families contributed by sharing information about themselves and co-operating with the routines of care. Communication was often limited to the task at hand, which tended to support the development of pragmatic relationships.

The resident centred approach to care illustrated the value of staff attending to significant details in each resident's care. Staff who adopted this approach across the three homes, described how understanding about a resident's previous life supported them in making these judgements. This approach also encouraged sharing of personal information by residents and families, which contributed towards personal and responsive relationships.

The relationship centred approach featured a more community focus in the process of care. This often included the need for negotiation and compromise in how care was delivered, which contributed towards a shared understanding of what was happening in the home. Residents and families were encouraged to make a contribution to the life of the home which suggested reciprocal activity that took into account the needs of everyone within the relationship.

Across the three homes, a relevant finding was that the same staff were observed adopting different approaches to care at different times of the day or on different days. In interviews and informal conversations, staff discussed the intention behind their decisions to do things in different ways according to the needs of the residents, staffing or other issues that arose. The approach to care which staff adopted most regularly appeared to influence the type of relationships residents and families were able to develop. The data also suggested that as these relationships developed, this could also influence the approach taken by residents and their families towards staff. This chapter will describe each of these approaches to care in detail including how they contributed towards relationships between residents, families and staff.

Table 5.1 **TYPOLOGY OF APPROACHES TO CARE**

	Individualised task centred	Resident centred	Relationship centred
Motivation of staff	Doing a good job	Do unto others	Doing what's right for all of us
Processes of care	Getting the job done and getting to know the resident	Finding out what matters and Knowing why the routine is significant to the resident	Knowing how we all fit into the community
Staff contribution	Asking about resident's life, encouraging involvement in routine and individualising routine	Attention to important details, consistent approach that values the resident as a person	Anticipating needs of residents, families and staff, in context to community
Consequences for staff	Satisfaction of doing a good job	Making a difference	Being in the right place at the right time for everyone
Contribution of residents	Sharing personal information and co-operating in routines	Sharing personal information with and from staff, responding to staff on an emotional level	Seeking to help others in the wider community, negotiation and compromise
Consequences for residents	Having to wait Individualised care	Feeling cared about	Shared understanding of what's happening in the home
Contribution of families	Working behind the scenes, engaging in direct care giving	Showing an interest in staff welfare	Identifying ways of making a valuable contribution to the life of the home
Consequences for families	Feeling the need to make sure the care is delivered	Feeling the staff are friends	Shared understanding of what's happening in the home
Relationships developed	Pragmatic	Personal and responsive	Reciprocal

Individualised task centred approach

The staff perspective dominated this section of the typology as the focus rested on the task of caring. Although this approach was particularly dominant in Holyoake, it was also observed across the three homes when:

- new members of staff were getting to know the routines
- staff were getting to know what new residents needed
- individual members of staff were on duty who believed this was the best way to deliver the care required
- there were staff shortages and families and residents were concerned that care should be delivered to a minimum standard
- agency staff were employed, who didn't know the residents

Meeting the essential care needs of residents required knowledge of both the job of caring and the routines of the home. This was described, most often at Holyoake, as the bottom line for residents and families. When staff adopted this approach, the routines of the day became their main focus. This approach often resulted in pragmatic relationships between staff, residents and families based on an understanding of the practicalities of the work that needed to be done.

Individualised task centred care involved a focus on two processes: getting the job done and getting to know the resident.

Getting the job done

An individualised task centred approach was most apparent at Holyoake. Many of the staff here suggested that having a routine and 'getting the job done' ensured that the residents received good care. Staff who routinely worked in this way, did so because they believed this was the best way to deliver care to residents with complex needs. For these members of staff, the routines were particularly important:

> *'Well if you didn't have a routine, you wouldn't get the jobs done, like getting them washed and dressed in the morning, and getting them to breakfast for a certain time or making sure the pads are changed- because if they get into that routine, and if it is a certain time then you don't forget.'*
>
> *Ruth- Senior care worker- Holyoake*

However, working in this way did not provide staff with the motivation to develop personal relationships with residents as the focus was on the practicalities of the task. This was reflected in the development of pragmatic relationships that focused on specific tasks to be achieved, as suggested by the following pattern of communication:

> *'Once you start getting used to that resident you know how to handle them: we say 'I'm going to take you to the toilet sweetheart.' And he will stand, you know with a nice soft calm voice they'll do anything. Sometimes they do take advantage of you they think you're soft and think 'I'll just do nothing' so you raise your voice and they think 'Oh well I'll do it now.'*
>
> *Sally –Senior care worker- Holyoake*

When the personal care routines occurred in the context of time constraints, being seen to maintain a visible standard of care required a focus on specific tasks:

> *'It's important if they are sitting in a room with 20 other people and seeing other people's families visit, that they don't have clothes with a hole in it or a rip. If they do they will be changed'*
>
> *Deanna – Senior care worker- Holyoake*

Many of the family members across all units at Holyoake expressed an understanding of how much the staff had to do. For example, one family member reflected on how she felt it was unrealistic to expect the staff to provide any more than the minimum level of care, which she described as keeping her husband, 'fed, clean and watered':

> *'I like him to be changed at 12, then I know he's been done. I don't know what time they do him in the morning because I'm not here but I like him checked every few hours, so I make sure it's done. They're (staff) busy most of the time you know, they have to bath them, shave them, do their nails then it's time for a cup of tea, then it's pad changing time; they haven't got the time.'*
>
> *Vera – wife – Holyoake*

Some families offered to help out with the general routines:

> *'I'll say do you need any help with the teas, I've done a food hygiene course, most of them say 'yes please'. I'll count out twelve cups and if only 11 come back, I know someone hasn't had a drink, so I can do that for them. Then*

there'll be twelve dishes and twelve spoons to wash so I do that and then I know everyone's had a meal.'

Mavis- wife – Holyoake

Many staff and some families at Holyoake felt that maintaining the routines meant that the care would be delivered. However, my own observations suggested that for some residents, the consequence of having staff focus on the task was that their individual likes and dislikes were sometimes overlooked. This was reinforced through discussions with some family members:

'Brian doesn't like fish sandwiches, but he's still gets them put on his plate, but he can have toast or cornflakes instead as long as they know.'

Mavis- wife- Holyoake

While an individualised task-centred approach was described by other families and some staff in Holyoake, it was also observed at Chestnut Lodge. For those staff who adopted this approach, personal routines were often focused on the task that needed to be done, rather than the significance of that task for the resident. This meant that even when care was individualised, there were times when significant details were not taken into account. Examples of this included residents telling me they would get up each morning according to what staff were on duty rather than their known preferences. I also observed details of care described by residents as important being omitted by some staff, who explained how they saw the morning priority as getting people up for breakfast rather than attending to these small but significant details of care. For example, when I arrived one morning, a resident asked me to help her adjust

her cardigan. She commented to me that some staff didn't care what you looked like as long as you were dressed.

The focus on getting the job done that had been observed predominately at Holyoake and to a lesser extent in Chestnut Lodge was different to the approach to personal care adopted routinely at the Beeches, which was more usually resident-centred. However, even here, a focus on the routine of the job was sometimes apparent. The individualised task centred approach was most commonly observed at the Beeches during meal times, when a number of residents needed to be moved to a certain place for a certain time. One resident in particular commented on the impact this had on her experience of meal times:

> *'I have dinner more or less on my own. They (staff) waste a lot of time. I'm sitting there for ages before my meal and I have no-one to speak to. Then when I get it (my meal), the carers are always in a mad rush as though they haven't got time to do it.'*
>
> *Gwen-resident- The Beeches*

On these occasions, staff became focused on the need to make sure all residents were receiving their food and being helped as they required, which limited opportunities for social exchange. Residents at the Beeches also discussed the issue of waiting, which often resulted when staff adopted a more task centred approach:

> *Freda came in and said she had been waiting for a long time to come down and she hadn't had her hair done yet. Betty said 'well you do here, don't you,*

wait I mean'. Freda agreed: 'I was waiting to go to the toilet and I was really desperate, so I said I had been waiting for a long time and he (agency carer) said I had to wait some more. I'll have the words 'wait' on my gravestone you know, she said smiling, I'll get to heaven's gates and there will be St Peter and he'll ask me who I am and he'll say 'You'll have to wait, we're not ready for you yet'.' Then she said, 'I shouldn't be facetious about things like that'.

Field Observations – the Beeches

Although this exchange was made in a humorous vein, this resident was making the serious point that staff did not always recognise the significance that waiting had for her on a personal level. When staff were focused on tasks, residents could not be sure that they would respond to requests for help, so would ring their bell more often. This had the potential to cause conflict between residents and staff:

'Freda sometimes gets told off but we ring the bell and then we ring again and we get told off but we say how do we know you've heard? They (staff) make it clear that you shouldn't ring, when you ring for someone else.'

Betty- resident- the Beeches

The individualised task centred approach did not always result in care being delivered as residents or families would have liked and, at the Beeches, this was most apparent when there were agency staff on duty who did not know the residents. One family member, while acknowledging that fundamental care needs were usually met, commented on the small omissions that had the potential to make a difference to her aunt's experience:

'There is no continuous staff at the moment and I know that upsets Aunt Em. There's that lack of being personal with agency staff; they aren't to know that she likes a few biscuits when she gets upstairs or she likes her books. She's got to the stage now, where she won't ask, so they aren't going to know to keep to the routine she enjoys.'

Helen - niece – the Beeches

This suggests that it was important for the staff to get to know the resident to ensure they received the individualised care that was needed.

Getting to know the resident

Some staff at Holyoake described how they built up knowledge about each resident through the personal care routines. This was particularly noticeable with new staff. For example, one recently appointed member of staff described how he developed this knowledge 'on the job':

'..just the logistics of it, the mechanics of it, bring the clothes up to the top of the shoulder, how much tension can it take. You go to a resident who won't stand still, so you think, how do you approach them? It's about knowing what each one requires. This one will let you do anything with him as long as you tell him what you're doing and you don't make fast jerky movements, you move steady and slow. But with others, you've got to be fast because they don't like it too slow: it's horses for courses.'

Malcolm- care worker- Holyoake

In Holyoake, many residents had communication difficulties, which meant that some staff would find out what different residents wanted through a process of trial and error:

> *'You tend to know when he wants something because he's shouting. You guess, if he's in the dining room, it's because he wants another drink, he doesn't like what he's eating or he wants some more, so in a way there's the circumstances that he's in when he's shouting. If he's in the lounge in the afternoon, and he's shouting, it's do you want to go to bed and sometimes he does, and then he nods his head, but you take him into his room and he starts shouting – and you say, oh we got that one wrong. Sometimes he calls out because he's disgruntled, or he's in a bad mood, or he needs his bowels opening, that kind of thing.'*
>
> *Sian – care worker – Holyoake*

However, these staff also described the importance of getting to know each resident as an individual:

> *'They've got different characters that's how I see them.. different likes and dislikes, you've got to get to know them.'*
>
> *Sally- Senior care worker- Holyoake*

This included knowing about the person's past:

'...like when she comes out of there she switches all the lights off so, and when a school teacher leaves a room - better turn the lights off and shut the door. So that's where it comes from. So it's just helps you understand some of the things they're doing and why they're doing it. You find out their past and it answers your question for you'.

Leon- care worker- Holyoake

For staff working in this way, information about the resident's life history was used mainly in a functional way, which was to help them 'get the job done' rather than to develop a deeper understanding of what was significant to the person. While this meant that physical care needs were generally met, small details might be overlooked.

Another aspect of getting to know the resident as an individual was becoming familiar with their personal routine. In Chestnut Lodge, for example, staff identified how knowing the preferences of individual residents helped them anticipate who was likely to be awake and wanting to get out of bed, or who might need to go to the toilet next:

Well everyone has a personal routine and you get to know when they like to get up or go to bed, or if they need a rest in the afternoon. Like now, it's getting near 10 so I know that James will need to go to the toilet, so I'll take him next.

Wayne -care worker Chestnut Lodge

However, such an approach was not consistent at Chestnut Lodge: when asked if they were able to get up at a time they preferred, some residents suggested that this

depended on which staff were on. Staff at the Beeches seemed to use a more systematic approach to identifying residents' preferences. For example, the importance of taking time to get to know each resident was captured by one care worker:

> *'It's like when you care for them, you speak to them, then you get some feedback and so you get to know how to approach them.'*
>
> *Sandra- care worker- the Beeches*

Ongoing conversations between residents and staff, gave staff insights into the type of person the resident had been and the type of person they were now. The interactions, which took place primarily within the routines of care, suggested that there is the potential for staff to 'get to know the resident' by 'getting the job done'. As staff developed knowledge of the residents in this way, families also became aware that there were opportunities to develop relationships with staff:

> *'I think the fact that the staff know her, get to know her as individual and ideally treat her as an individual. We are very interested in developing relationships with staff and we hope they are with us too.'*
>
> *Sarah- daughter in law- the Beeches*

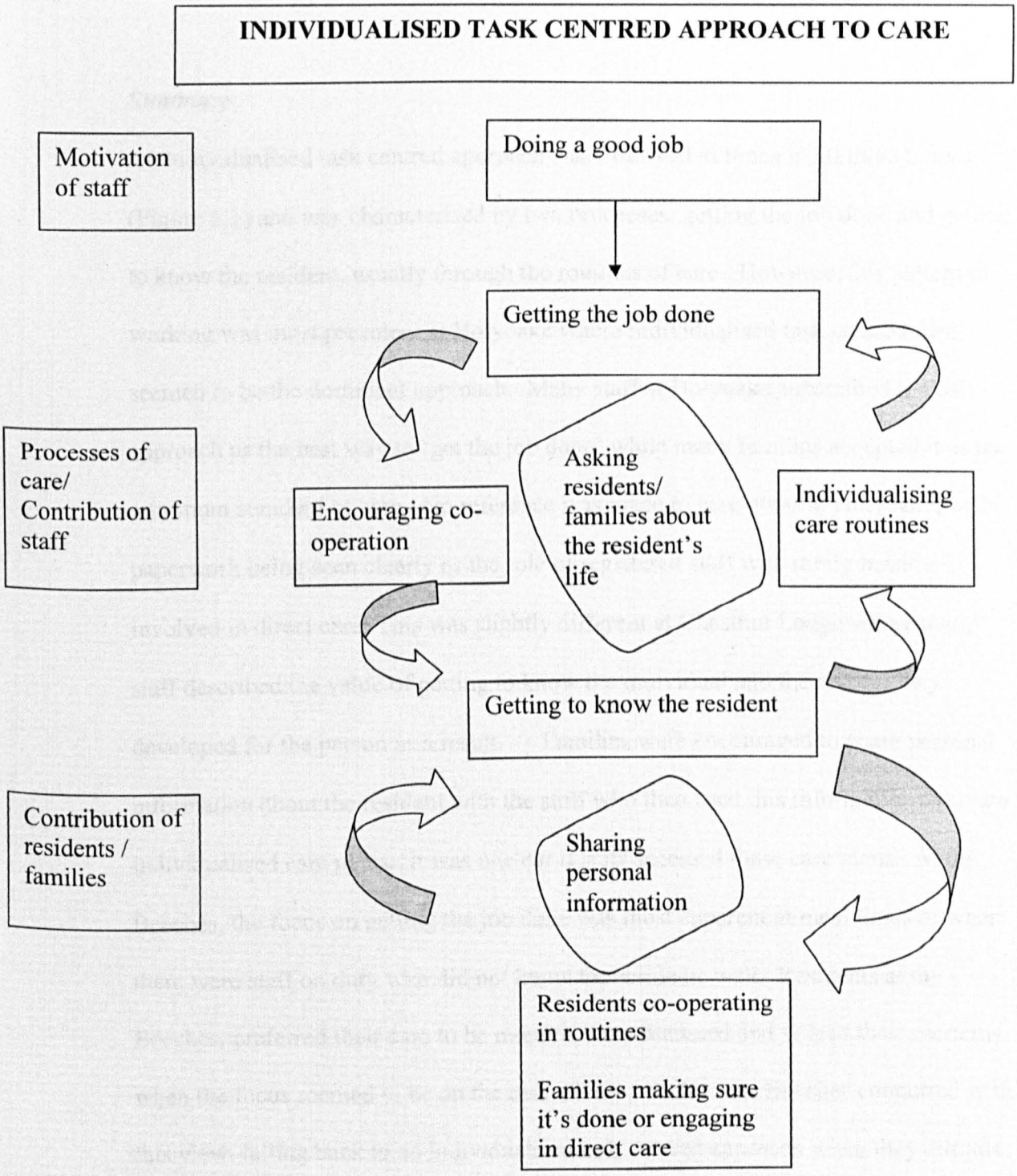

INDIVIDUALISED TASK CENTRED APPROACH TO CARE
Motivation of staff
Doing a good job
Getting the job done
Processes of care/ Contribution of staff
Encouraging co-operation
Asking residents/ families about the resident's life
Individualising care routines
Getting to know the resident
Contribution of residents / families
Sharing personal information
Residents co-operating in routines
Families making sure it's done or engaging in direct care

Figure 5.1

Summary

An individualised task centred approach was observed at times in all three homes (Figure 5.1) and was characterised by two processes: getting the job done and getting to know the resident, usually through the routines of care. However, this pattern of working was most prevalent at Holyoake where individualised task centred care seemed to be the dominant approach. Many staff at Holyoake subscribed to this approach as the best way to 'get the job done' while many families accepted it as the minimum standard of care. No reference was made to care plans at Holyoake, with paperwork being seen clearly as the role of registered staff who rarely became involved in direct care. This was slightly different at Chestnut Lodge where many staff described the value of getting to know the individual and the respect they developed for the person as a result. Families were encouraged to share personal information about the resident with the staff who then used this information to create individualised care plans. It was unclear if staff accessed these care plans. At the Beeches, the focus on getting the job done was most apparent at meal times or when there were staff on duty who did not know the residents well. Residents at the Beeches, preferred their care to be more resident focussed and voiced their concerns when the focus seemed to be on the task of care. Staff at the Beeches concurred with this view, falling back to an individualised task centred approach when they felt this was the only alternative available to get the job done such as seating everyone for a certain time at meal times.

The staff who suggested they adopted an individualised task centred approach routinely, often described their relationships with residents and families in pragmatic terms that focused on the task of caring. There were families and residents who

appreciated this focus and also described their relationships with staff in terms of how they contributed to the practical tasks of caring. However, there were other families and residents who signalled to staff they would like to develop more personal relationships with them. The staff who spoke about developing respect as they got to know residents in more detail, also described their relationships in more personal terms. This suggested that these staff were focusing more on the resident than the task.

Resident centred approach

Getting to knowing each resident as a person enabled staff to understand how the resident had approached life in the past which provided insights into the type of person they were. Understanding what was important to each resident appeared to move the focus of attention to the small details that contributed to the resident's ongoing sense of identity. This approach appeared to be most apparent at Chestnut Lodge and the Beeches. As the resident became known to staff through the personal care routines, some staff members attempted to develop an understanding of the things that were important to the resident. Many families worked to support staff in 'seeing the person' by sharing personal details about the resident with them and acknowledging staff when they incorporated this information into the care routines. This approach resulted in the development of personal and responsive relationships between residents, staff and to a lesser extent, families.

Resident centred care involved a focus on two key processes: finding out what matters to the resident and knowing why it is significant for the resident.

Finding out what matters

Developing an understanding of the biography or life story of a resident, supported staff in seeing the resident as the person they had been, as well as the person they were now. Personal belongings including photographs, which were often kept on display in a resident's room, encouraged staff to discuss aspects of that resident's life with them. In Holyoake, staff rarely commented on belongings kept in residents' rooms. Significant life events and memories shared by a resident or their family with members of staff, also contributed to a store of biographical knowledge about each resident. Staff at the Beeches frequently described residents in terms of the type of person the resident had been before they came into the care home and how their life experiences had contributed to who they were now. In generating this knowledge, staff recognised details of personal care that were significant to each resident. For example, one staff member described how for one resident, maintaining her personal appearance was of great significance to her sense of identity:

> *'It's like Enid, with her earrings and necklace. You always ask which one do you want today and she'll say what do you think looks best and we have this little discussion and it's very important to her. She is 99, 98 now and that is a good thing that she is still interested in how she looks.'*
>
> *Ann Marie- care worker- the Beeches*

Staff adopting this approach recognised the importance of doing 'the little things' in the residents' care routines:

'Little things, little details make all the difference and we endeavour to meet those little needs as well as the general caring. It's the little things that have to be part of it.'

Jane- Deputy Matron-The Beeches

Staff also recognised that attention to significant details had the potential to influence the quality of a family's visit. On many occasions for example, I observed staff offering a resident choice about what clothes to put on and then discussing and comparing the jewellery that would match. This attention to detail was commented on by some family members:

'There is some care taken with dress and it's just not go to the wardrobe and pull something out, but it does match and the earrings and necklace match.'

Mark- son- the Beeches

When staff worked in this way, they developed personal relationships with the residents, which included staff sharing information about their personal lives away from the home:

'You see them more than your own grandparents, so you do get to know them. It's like with Beatrice, she doesn't have any family so we go in and speak to her about what we're doing in our lives.'

Jay- Senior care worker- the Beeches

With the sharing of personal information, other connections and shared experiences became apparent between staff and residents and their families. This further supported the development of personal relationships:

> *'It's like with Jay and Ann Marie, we found out that they went to the school my father taught at, so there's a connection there.'*
>
> *Mark- son – the Beeches*

Staff were also seen to develop personal relationships with family members at Chestnut Lodge, where the informal exchange of personal information often took place in the communal areas of the home during family visits.

Many staff at Chestnut Lodge also appreciated the significance of the residents' appearance to both residents and their families and incorporated such details into personal care routines:

> *'Jane's son is coming in to see her tonight so I take the time with her appearance, the hair and she's got to be just right, she wants to look how she wants to look and that's important to her.'*
>
> *Diane- care worker- Chestnut Lodge*

Although these details were often small things, they had the potential to make a difference:

'Well a little bit of lipstick, it cheers you up. Oh yes, I've always worn makeup and the girls, they'll sit on the stool and they'll put my cream on my face.'

Dorothy- resident- Chestnut Lodge

Attending to details such as those identified in the preceding examples enabled staff to develop resident centred care routines. A further attribute of resident centred care was to understand the residents' interpretation of what was happening in their daily life and how this influenced their behaviour and experiences.

Knowing why it is significant for the resident

In order for staff to understand what is important for each resident they needed to use the personal knowledge they had developed primarily through the care routines to interpret the resident's behaviour and responses. For example, staff in the Beeches described how the type of person the resident had been influenced the way he or she approached life within the care home:

'I would say it's the individual, and what their nature is like and how they react; if they have been a person who has given or a person who has taken in their previous life. Then if they have been a person who has taken, they want you to be doing for them, and you know they are still like that and it doesn't matter what is going off around them, it's 'me, me who needs attention, me who needs to be looked after.' There is one person who has always been like that and she always will be like that. You just go with it and do your best.'

Ann Marie- care worker- the Beeches

Accepting how a resident approached life and exploring ways of working with them, was a feature of a resident centred approach.

For staff at Chestnut Lodge understanding what was important for residents often meant trying to understand what their cognitive and physical impairments meant to them in their everyday experience:

> *'Bettina says she feels useless, I ask her why she feels useless and she asks me if I can knit and I say I can't knit but that doesn't mean I am useless and she said 'but I can't do anything I can't even feed myself.' So in her interpretation, feeling useless is because she can't feed herself so we try to give her finger foods like sausage for breakfast and she feels better because she is doing something for herself.'*
>
> *Diane – care worker – Chestnut Lodge*

Some staff spoke about using photographs to allow residents to express themselves, and to alleviate distress when a resident was unable to understand their current situation:

> *'Maggie gets very agitated because she needs to get back to her children and in her mind, they're young so she needs to get back and she's distressed. We can't tell her don't be so silly, the children are in their fifties now, because it's real to her. So we'll get the photo album out to try and explain how things have moved on and to relieve that distress.'*
>
> *Diane- care worker- Chestnut Lodge*

These actions indicated the importance for residents of appropriate and timely action from staff. This suggested the development of responsive relationships, which were personal to the resident concerned. This was apparent with one resident who liked to be in charge of household activities:

> *'I like to be busy but not for busy's sake; it has to be for a purpose. It helps when you do it with others, you can talk with them and it helps you get through the work faster.'*
>
> *Ivy – resident- Chestnut Lodge*

Staff had identified that for this resident, household routines had been significant to her before she came into the home, and took action to enable her to continue this activity on a daily basis.

Finding out what was significant to each resident and adapting this to the personal care routines was most apparent at the Beeches and Chestnut Lodge. As a result, relationships between staff and residents in these homes seemed to be responsive and personal to each resident. There was one unit in Holyoake where staff also developed personal and responsive relationships but these were not part of the dominant focus, and were not as readily recognised. For example, when staff understood what was important to a resident, they were sometimes observed to respond to small signs in ways that demonstrated this understanding:

I was sitting in the lounge one evening and Ruth came and sat down beside James and held his hand. She initiated a conversation with him to which he responded although he had no verbal communication. She told me he was feeling a bit down today because a member of staff who usually has a laugh with him has been off for some time and he was missing her. When I asked how she knew, she said she could tell by the way he was tonight, not his usual self. He looked at me and nodded his agreement.

Field observations- Holyoake

As staff developed their understanding of how each resident approached their life, they were also more easily able to identify when things altered for the resident and adapt their approach accordingly:

'He believes in God, so I always say God bless to him and there are some days when he talks about angels and I sit and listen to him and I'll acknowledge him. I am a Christian myself and I respect his beliefs and he respects mine, that's important... and sometimes, he's frightened that he has seen angels and I'll say they're just looking over you and that calms him down.'

Ruth- Senior care worker- Holyoake

Knowing what was significant to a resident in the context of their previous life enabled staff in this unit in Holyoake to understand the behaviour of the residents and subsequently recognise the person they were now. This approach supported the development of personal and responsive relationships in this unit.

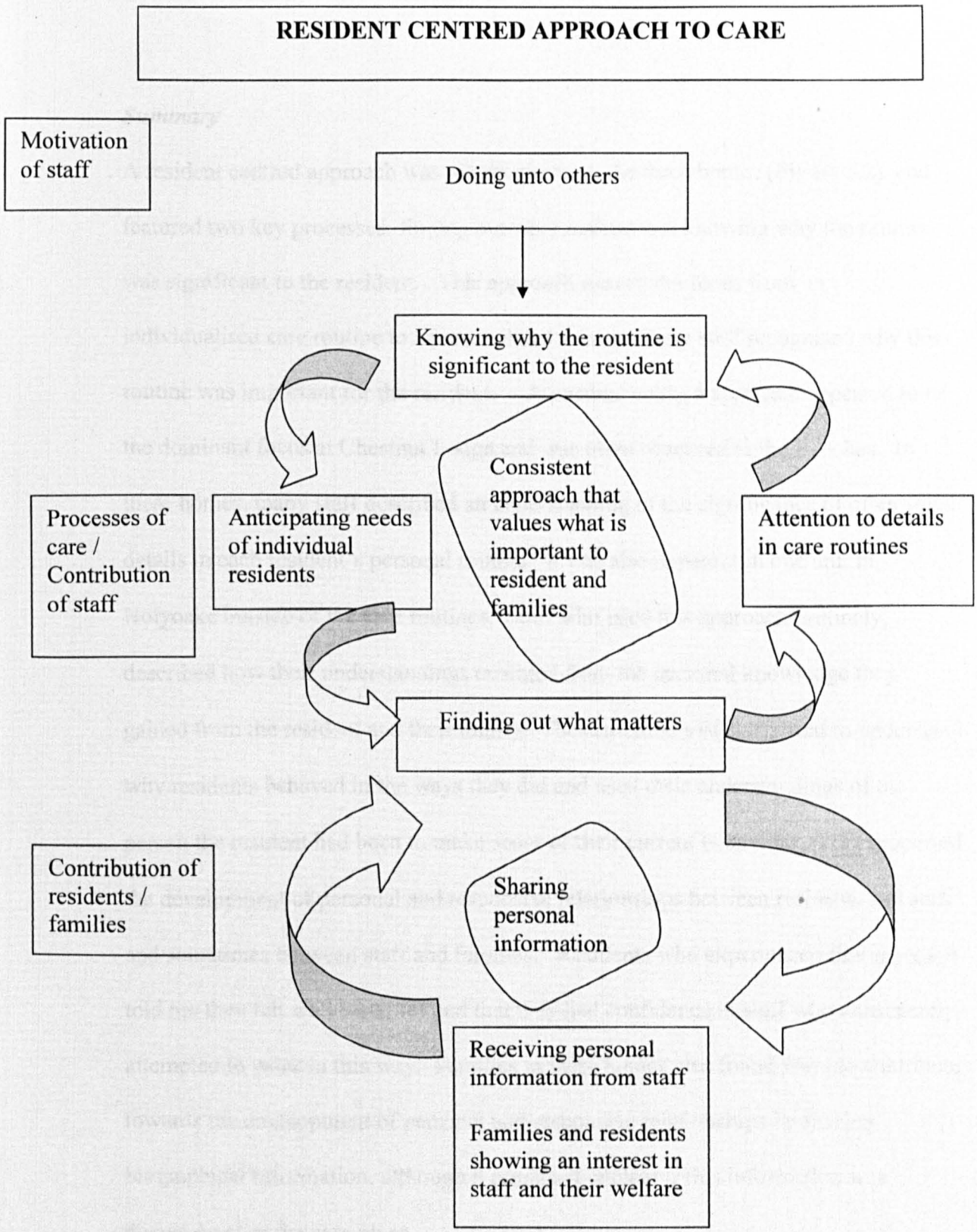

RESIDENT CENTRED APPROACH TO CARE
Motivation of staff
Doing unto others
Knowing why the routine is significant to the resident
Consistent approach that values what is important to resident and families
Processes of care / Contribution of staff
Anticipating needs of individual residents
Attention to details in care routines
Finding out what matters
Contribution of residents / families
Sharing personal information
Receiving personal information from staff
Families and residents showing an interest in staff and their welfare

Figure 5.2

Summary

A resident centred approach was observed across the three homes (Figure 5.2) and featured two key processes: finding out what matters and knowing why the routine was significant to the resident. This approach moved the focus from an individualised care routine to a personalised routine where staff recognised why this routine was important for the resident. A resident centred approach appeared to be the dominant focus at Chestnut Lodge and was often observed at the Beeches. In these homes, many staff described an understanding of the significance of often small details in each resident's personal routine. It was also apparent in one unit in Holyoake outside of the care routines. Staff who used this approach routinely, described how their understandings emerged from the personal knowledge they gained from the resident and their family. These members of staff, tried to understand why residents behaved in the ways they did and used their understandings of the person the resident had been to make sense of their current behaviour. This supported the development of personal and responsive relationships between residents and staff and sometimes between staff and families. Residents who experienced this approach told me they felt well cared for and that they had confidence in staff who consistently attempted to work in this way. Families in these homes also found ways to contribute towards the development of personal and responsive relationships by sharing biographical information, although it remained unclear if this information was documented in the care plans.

The staff who suggested they consistently adopted a resident centred approach also described trusting relationships with residents and families. However, over the course of my observations in each home it became apparent that when the focus of care was

exclusively on the resident, it did not always take into account the effect on other residents, staff or families. Furthermore, in a communal environment it was not always possible to meet all the needs of individual residents at the same time. When this occurred, some staff were seen to use an alternative approach of organising care that seemed to take account of what was significant to all residents, appearing to be in the right place at the right time to deliver care for everyone. This approach recognised the needs of staff, residents and families alongside each other and was described as a relationship centred approach.

Relationship centred approach

A relationship centred approach involved a focus that moved beyond the needs of individual residents to recognise the significance of all members of the care home community and the relationships between them. This approach was most apparent at the Beeches. Here, there appeared to be an overall strategy in the planning and organisation of care that attempted to meet the individual needs of each resident, while also taking into account the needs of other residents, staff and families. Staff who adopted a relationship centred approach, seemed able to anticipate the needs of different residents, making sure that the right staff were in the right place at the right time to meet those needs. In most circumstances, this level of organisation enabled all staff to adopt a resident centred approach for each resident within the care routines. However, a prominent feature of a relationship centred approach was the ability of staff to facilitate a process of negotiation and compromise with other staff and with residents and their families when there were competing priorities. Furthermore, while relationship centred care was seen to start with care routines, it was not confined

exclusively to these routines as staff, residents and families found ways of making their time in the home meaningful for themselves and others within the care home community.

In the context of a relationship centred approach, staff, residents and families all spoke about the importance of seeing things from each other's perspective. This approach also required staff members, residents and families to recognise the contribution which each person could make to the life of the home, producing the potential for reciprocal exchange and contributing to reciprocal relationships. Such relationships were observed regularly at the Beeches and in more isolated examples at both Holyoake and Chestnut Lodge.

Relationship centred care seemed to involve two processes: developing shared understandings between staff, residents and families and developing an understanding of how 'we all' fit into the community.

Developing shared understandings

The process of developing shared understandings included the planning and organisation of care routines to take into account the needs of all residents, staff and families. This often resulted in negotiation and compromise between residents, staff and families when there were competing priorities.

Shared understandings emerged within the Beeches as the staff, were observed to take into account the perspectives of residents, families and other staff when making day to day care decisions within the home. For example, care routines were organised in

ways that acknowledged the personal priorities of each resident. This enabled all staff to be in the right place close to the right time when specific residents would need support:

> *'I always find with Freda if you beat her (to it) and take her to the toilet before she asks she will always remember that, 'Oh Jay has taken me to the toilet', she remembers that more and she'll say to Betty and Gwen 'Oh Jay's taken me to the toilet' and she'll remember it was at 3 o'clock and then if you say, 'do you want to go just before tea', she remembers and she appreciates that. It's as though you're looking after her which is what you are.'*
>
> *Jay- Senior care worker- the Beeches*

This particular care worker seemed to have the ability to anticipate the needs of each resident in relation to those of other residents, and always seemed to be in the right place at the right time. This enabled staff to focus on what was important for this person while also meeting the needs of other residents. Staff who worked in this way described their satisfaction in being able to achieve this with the shift running smoothly. Families appreciated the efforts of staff to meet everyone's needs and recognised that the staff were trying to do the best for all residents in the home. Therefore, anticipating each resident's needs had the potential to ensure that everyone's needs were met.

At the Beeches, this approach to the care of residents appeared to be the accepted way of working on most days:

'They'll tell you, I like to go to bed at 8 or I prefer 9-half past, so that's how you arrange things.. and we know if they prefer their baths earlier of later. For example Mary, you know to go to her on a Tuesday at 8 sharp, you just know for instance it's Mary's bath and she likes it first so you go to her first.'

Jay- Senior care worker – the Beeches

When the work was organised to take into account the personal routines of each resident, there emerged a communal routine throughout the home. Many residents were then able to see their own routine within the communal routine. This had the potential to lead to a shared understanding between staff and residents:

'Mary asked me today if Gwen was up yet, I said 'no', so she said 'fine, I know you'll come to me when Gwen is up' and went back into her room. I was surprised at that.'

Jilly- Senior care worker- the Beeches

This suggested having a communal routine allowed for acts of reciprocity on the part of residents and families that went beyond the cared-for / caregiver relationship.

Shared understandings often appeared to lead to negotiation and compromise, which had the potential to support the development of reciprocal relationships. In the Beeches, if the needs of a resident could not be met in a way they would expect, staff began a dialogue with the resident which moved beyond a simple statement such as, 'there are others I have to deal with first' to include an explanation of why the needs

could not be met at that time with alternatives being offered. This suggested a process of negotiation:

> *'They often ask me if I want to go but if they don't you can ask and you will always be taken. Just now I asked and they said can you wait until we get Gwen down and I said yes, so they got Gwen down and then they took me. I would hate to think that Gwen was stuck upstairs because I had to go to the toilet.'*
>
> *Betty- resident – the Beeches*

As the needs of both the residents and staff were identified, this enabled a compromise to be reached that provided for everyone's needs within the relationship. This comment suggested a shared understanding of the needs of others within the home, providing this resident with the opportunity to engage in reciprocal activity within the relationship. Knowing the staff would return to her next, also gave this resident the feeling she was cared for:

> *'I am very well looked after why shouldn't I be? Just about every need is catered for, in fact every need is. I can't think of one that isn't. I have no grumbles. They're (staff) wonderful here. I'm lucky to be here.'*
>
> *Betty – resident- the Beeches*

Communicating her appreciation to the staff also prompted them to go further, supporting the reciprocal nature of this relationship:

'She is nice enough to say to us that 'I'm well looked after and I know I'm very lucky' and you only need someone like that to say something like that and you think it's all worthwhile and that makes you want to go the extra mile without her having to ask for things, you want to put yourself out for her.'

Ann Marie- care worker- the Beeches

There were also times when residents initiated a process of negotiation with staff. For one resident, this took the form of giving staff advance warning of her needs:

Today seemed very busy. Staff told me there were two agency carers on. I noticed Freda had said to the carers, she will need 'to go' soon. I asked Freda about this comment. She said because they were busy, they might forget. I asked if she thought this was helping the care staff and she said 'yes'.

Field Observations- the Beeches

As individual residents and families became involved in the process of negotiation, they developed a picture of how care within the home was organised and where they fitted in. When the unexpected occurred and care was not able to be delivered in the usual pattern, staff would discuss different compromises within the care routines they could make and then discuss the options with the residents involved. For example when one resident was unable to have a bath due to staff shortages on one morning, her key worker realised the personal significance of this to the resident and negotiated changes in the schedule for the following morning. These residents and their families accepted the changed routines because they understood what was happening in the wider context of the home.

There were also situations where negotiation and compromise took place between residents and staff at Holyoake, contributing towards reciprocal relationships:

> *'I mean it's like Taylor, he smokes like a trooper he does, but he knows there are only designated smoking areas. Now he'll wait rather than lose his temper because he knows you're going back to him and if you don't go back, you apologise and he accepts it; he sees you are busy. Yesterday, he said 'is it alright if I go for a cigarette, can I borrow your lighter?' I said 'Ok, duckie, wait here, I'll be five minutes, I just have to sort these ladies out', and I did literally forget but next time I saw him, I did apologise and he said, 'no I saw that you were busy so it's alright, but can I go now?''*
>
> *Ruth – Senior care worker- Holyoake*

At Holyoake, some families also engaged with staff to support the development of shared understandings. This sometimes appeared to be a strategy to enable them to maintain a special relationship with their relative in the home:

> *'We have two chairs together but we have no divine right to that corner but it does make it nice to be like that. It's important for me to know where we are and when I go to know we will be there. There's no reason why we shouldn't be accommodated in that respect as it doesn't adversely affect the other residents.'*
>
> *Tom- husband – Holyoake*

For families to be able to maintain this semi-private space within the public domain of the home, staff needed to recognise a family's need for privacy. To facilitate this, some families in Holyoake worked hard to develop positive relationships with staff. I observed one family member, in particular, engaging regularly with staff throughout her visits. This process meant that staff developed an understanding of the routine of her visit, including the timing of her departure, which often occurred when staff were standing or sitting in the communal areas of the unit. When she came to say goodbye, many staff within this unit were aware of the significance this had to her and her husband:

> *'When it's nearing time for me to go, he carries my bag to the door and he won't let me go without that, it's our ritual it is as we say fond farewells, it's special for both of us. That's when 'our friend' can come up and be disruptive because she wants me to open the door for her. But the staff are wonderful, they guide her away and then there's no offence. Anything that interferes with this routine upsets me.'*
>
> *Elizabeth – wife- Holyoake*

Although in this unit in Holyoake, the dominant focus of care was individualised task-centred, this scenario suggested the active role this family member took, that encouraged staff to develop a shared understanding in relation to her visit. Even though the staff may have acted in an individualised task centred way to prevent a disturbance, their actions demonstrated to this family member that they understood the importance of this time to her and her husband. The family member also viewed the lack of disturbance as meeting the needs of all the residents as well as preventing a

difficult situation for the staff due to her visit. This may suggest how family members could influence staff to adopt different approaches.

Families on another unit also described how their needs were met by staff recognising the personal significance of an event to them:

> *'I think the only time I get a little bit het up was when I bought him a brand new pair of slippers in and they'd gone missing and I said 'What's happened to the slippers?' and then within seconds they'd found them.'*
>
> *Fiona -wife – Holyoake*

Staff who understood the significance of such details to families indicated that they shared an understanding of what it meant to that family member:

> *'Like the other day when Fiona came in and said one of the slippers had gone missing, So I said 'come on' and we went and found it and she was fine then- but Fi, she's really great, she understands what it's like for us.'*
>
> *Sally-care worker- Holyoake*

This scenario suggested that both the family member and staff were gaining an understanding of how they each fitted into the wider community and the reciprocal nature of the relationships that were developing.

Getting to know how we all fit into the community

A feature of a relationship centred approach was the ability of staff, residents and families to recognise themselves as members of the community within the care home. This process began with the recognition that they and others were able to make a valuable contribution to the community within the home.

While a relationship centred approach within the Beeches, was demonstrated mostly within the care routines, it was not confined to these routines. For example, I observed staff involving both residents and families in jokes and what other staff termed 'banter' within the communal areas of the homes. This supported residents in initiating humorous exchanges directed towards the staff:

> *'There's a few of them(residents) that as they've settled in, they've chilled a bit so you can have a laugh with them.. and then there's Freda, she'll be hitting my bum and I'll say 'gerroff' and it's a laugh.'*
>
> *Jay- Senior care worker the Beeches*

Staff who were involved in these episodes, suggested that the use of humour helped them deal with the stress of the work but I also observed how it enabled residents and families to contribute towards the atmosphere in the home, developing relationships at a social level.

Another feature of the relationship centred approach was staff recognising the contribution that residents were able to make to life within the home. This was

particularly noticeable when staff at the Beeches described the relationships between residents:

> *'..it did evolve, as time has gone on, Gwen's mental state has improved and obviously you want to put two like minded people together and it just crept up on us really that they could talk to each other. And then you want to put people where they can converse with each other and she can hear Freda.'*
>
> *Jane-Deputy Matron - the Beeches*

At the Beeches, this approach was observed fairly consistently with this group of residents. Staff would seat each resident in their respective seats or position their wheelchair nearby to facilitate these relationships. One of these residents commented on the importance of being sat in the same seat each day because she had a table where she could place her books and a lamp that enabled her to read at any time of the day. Another resident commented on the importance of having other residents seated nearby, due to her sight and hearing impairment:

> *'There are two people I sit near and I can hear to talk with, everyone else is so far away. I would be lost without them. I can talk to Freda because I can hear her. She keeps me up to date, I usually have to ask her what's for dinner. There can be somebody next door to Freda and I just can't hear them. I should feel lost if there wasn't the three of us. If Betty and Freda weren't here, I would be lost'.*
>
> *Gwen- resident- the Beeeches*

In this situation, staff were able to facilitate the valued contribution these residents made to their shared relationships. A member of staff at the Beeches also described how her contribution often involved organising activities that supported relationships between residents:

> *'In the summer time when they're in the garden, they were all just sat there in the sunshine and then I decided we would have a sort of flower arranging competition. So I picked all the flowers and went and got about 5 vases and got the tables in front of them and they looked at me as though to say do I have to do this? And Freda said well I've only got one hand and I said come on of course you can, you're going to be in this competition. I sorted out the colours of the flowers so they looked reasonable and I fetched them a little pot, and they were all sticking so many flowers in their little pot and they were all looking at what each other had done. Then I fetched Matron and I said 'Matron, can you come and judge this competition' and she picked out one she liked best and I think we had a little prize for who'd won. When we finished, I took each vase and put it into each of their rooms for them, so when they went back upstairs, it was there for them and it wasn't wasted. Then they got chatting and talking about it afterwards which made communication between that group and I think that's so important.'*
>
> *Ann Marie- care worker- the Beeches*

Residents, who were physically able, also contributed towards the routine activities within the Beeches by laying tables or giving out the mail. Other residents contributed to the life of the home by visiting those who seldom came out of their room:

'There is one lady, Mary who has not been there that long and she tends to go and visit Granny. She goes on walkabout and the first time, she stopped me in the corridor and introduced herself, almost formally, I'm Mary and you must be...so we had a little chat and she goes and calls on Granny when she is well enough, on a daily basis, which I think is nice for Granny, so I encourage her to do that.'

Allan- grandson –the Beeches

This example illustrates how families became aware of the valuable contribution other residents made to the life of their relative. Some families were also aware of the contribution their visits made to the experience of residents other than their relative:

'..and I bring my grandchildren, I have twins and I've been bringing them in since they were that big (demonstrating they were very small) and she will ask me about them. Whenever I come in and when Freda's got a visitor, I will hear her say,' oh that's Helen and she's got the these grandchildren, these twin little girls' so I think she must get something out of it.'

Helen- niece- the Beeches

Families on one unit in Holyoake also valued the contribution made by specific members of staff and how it benefited their visit:

'We always know when Ruby is on, there is calmness, there is less noise and we come away feeling we have had some quality time.'

Andrea - daughter - Holyoake

There were also staff who recognised how they were able to contribute to the care of residents in ways special to them, as depicted in the following scenario:

> *Johnny didn't like the hoist because he had a fear of heights from his Prisoner of War days. When he went up in the hoist, he would cry out in fear which distressed his family. Ruth knew that Johnny enjoyed singing Irish songs so would encourage him to sing with her whenever he was going up in the hoist. Sian told me Johnny used to play for the local football team and used to ask him how many goals he scored and all about a local football hero he used to play with. She said telling her this, took his mind off the hoist. Samuel told me that Johnny didn't like the hoist because he was frightened of his feet swinging because they were painful. So each time he went to use the hoist, he made sure he concentrated on Johnny's feet and this helped reduce his fear.*
>
> *Field observations – Holyoake*

Each of these care workers described the ability to see what the experience must be like for the resident and their family. Each member of staff used this ability to then identify how they could alleviate this distress in a way that was unique to them. Subsequently each member of staff brought something different to this relationship that then enabled them to effectively work together with each other, the resident and the family.

A feature of staff in this unit operating with a relationship centred approach were the opportunities taken to develop a feeling of being part of a wider community with the

residents. Examples included a Registered Nurse spontaneously encouraging a sing a long with three men who were known to enjoy singing as they walked through the unit together. The same staff member also found opportunities to encourage a group of residents to reminisce while she was doing her paperwork in a communal area. Another member of staff identified the occasion of England playing in the European Cup as a way of developing a sense of community between residents:

> *'I took a pack of lager in for all of them, all those who were allowed, cause it was the football yesterday, so Jeffrey had a glass of beer, and the other Jeff, he had a glass and David, all those who were allowed and it was wonderful watching their faces, they really enjoyed it and Ruby(RN) would come in and shout ' ENG-er-LAND'!' She got them all shouting it but it created atmosphere and they all had their tea in there and even Judith and Grace joined in.'*
>
> *Ruth- Senior care worker- Holyoake*

This scenario is an example of how individual members of staff recognised how they could make a contribution to the sense of community within the home.

Chestnut Lodge could be described as predominately resident centred in the approach to care. However, there were some staff members who described how they recognised they could make a valuable contribution to the life of the home:

'A few of us carers, we have a sense of humour and we bring that to our work. I think it is good to get the adrenaline going in older people. It shows what spirit they have left.'

Gayle – care worker Chestnut Lodge

Another care worker was particularly skilled at creating a sense of community and engagement as he went about his work. There were days when his approach resembled street theatre:

As I sat with Gina in the quiet corner, Robert came through the door in what seemed to be 'an entrance'. He looked around and began making loud and raucous comments to which other staff contributed. I noticed Dawn and Eva's eyes (both residents) light up as they followed the performance. When Robert walked past them, they responded as they were included. As this continued, Bettina joined in and this made it even more hilarious as she made pithy comments.

Field observations – Chestnut Lodge

Such engagement with residents occurred with many care workers in Chestnut Lodge as they moved across the communal areas on their way to do other things, contributing towards a sense of everyone being involved, although few had the same 'presence' as Robert.

Other staff in Chestnut Lodge also recognised how they were able to make a valuable contribution to the care routines of specific residents due to the relationship they had developed with them:

> *At lunch, Bettina was saying she didn't want any lunch. Davina had already told the other member of staff to get a plate guard and let Bettina feed herself. Bettina was still refusing, so Davina suggested they swap residents, which the other member of staff readily agreed to , with what appeared to be some relief. Davina then sat beside Bettina and started talking to her about what she used to cook for dinners and Bettina started feeding herself with support from Davina. When I later asked Davina about this situation, she told me that some people were better at doing things than others and she knew she could get Bettina to eat her meal, so it made sense to do this. That way Bettina got a hot meal and they both enjoyed the experience.*
>
> *Field observations- Chestnut Lodge*

This scenario although isolated at Chestnut Lodge suggests a similarity with the organisation of care in the Beeches to ensure the right person for the job is in the right place at the right time. However, this scenario was prompted by one care worker's understanding of the specific contribution she could make to this relationship. This suggests that one factor influencing the ability of individual staff members to adopt a relationship centred approach is recognition of the special contribution they might be able to make in different situations.

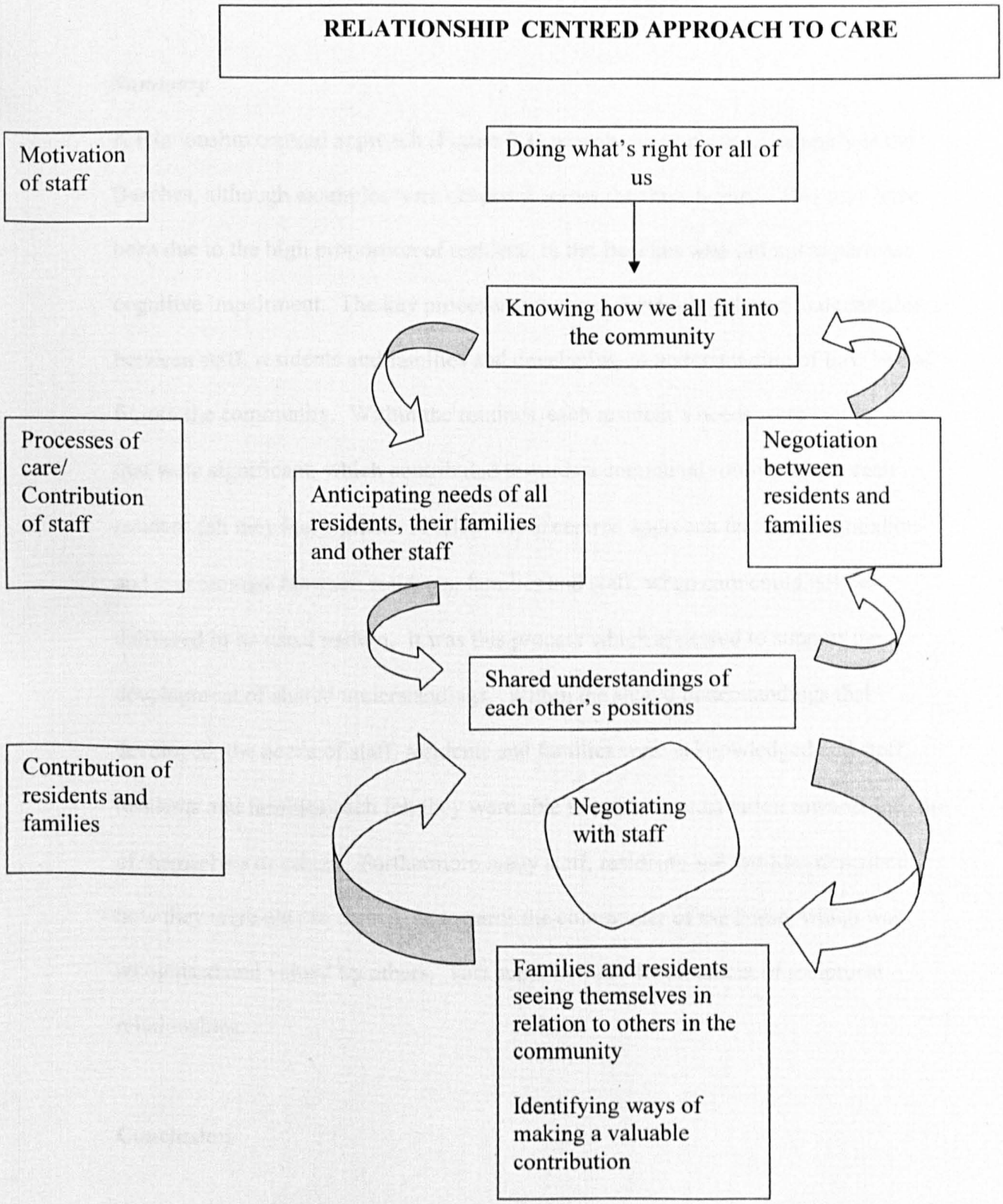

RELATIONSHIP CENTRED APPROACH TO CARE
Motivation of staff
Doing what's right for all of us
Knowing how we all fit into the community
Processes of care/ Contribution of staff
Anticipating needs of all residents, their families and other staff
Negotiation between residents and families
Shared understandings of each other's positions
Contribution of residents and families
Negotiating with staff
Families and residents seeing themselves in relation to others in the community
Identifying ways of making a valuable contribution

Figure 5.3

Summary

A relationship centred approach (Figure 5.3) was observed most consistently at the Beeches, although examples were observed across the three homes. This may have been due to the high proportion of residents in the Beeches who did not experience cognitive impairment. The key processes involved developing shared understandings between staff, residents and families and developing an understanding of how 'we all' fit into the community. Within the routines, each resident's needs were met in ways that were significant, which contributed towards a communal routine where each resident felt they had a place. A relationship centred approach featured negotiation and compromise between residents, families and staff, when care could not be delivered in its usual pattern. It was this process which appeared to support the development of shared understandings. Within the shared understandings that developed, the needs of staff, residents and families were acknowledged and staff, residents and families each felt they were able to make a contribution towards the care of themselves or others. Furthermore many staff, residents and families described how they were able to contribute towards the community of the home, which was recognised and valued by others. This supported the development of reciprocal relationships.

Conclusion

This chapter has presented a cross case analysis from the three homes. This analysis has suggested a typology of approaches to care as represented in Table 5.1. Each of these approaches to care have been described suggesting that staff, residents and families all make a valuable contribution. Furthermore, the approach adopted by staff

appeared to influence the type of relationships able to be developed by residents and families. Moreover, there were some examples that suggested families and residents also influenced the approach that staff adopted at times. This suggests that although staff have a major role to play in how care is delivered, there may be other factors that contribute to staff adopting different approaches, which also influences the types of relationships being developed. The data were further analysed to identify what factors might support or constrain relationships in care homes and these are described in the next chapter.

CHAPTER 6 – OTHER INFLUENCES ON RELATIONSHIPS

Introduction

This chapter presents further findings from the cross-case analysis. Findings from the within-case analysis presented in Chapter Four suggested that within each home, staff, residents and families all contributed to the development of relationships. From the within-case analysis, a typology of relationships emerged that were described as pragmatic, personal and responsive, and reciprocal (Table 4.3 on page 124). Chapter Five explored how the relationships that developed were influenced by staff adopting different approaches to care. These were categorised as: individualised task centred; resident centred and relationship centred approaches (Table 5.1 on page 128). Further analysis of the data suggested that there were other factors in operation that either supported or constrained staff in adopting each of these approaches, and consequently in developing different types of relationships. These factors are considered within this chapter.

Factors that emerged from the cross-case analysis and which appeared to contribute to the development of different types of relationship within each home could be broadly grouped under three headings as follows:

- **Staff-related**

  Leadership – the way we do it around here

  Continuity of staff – getting to know each other

  Teamwork – pulling in the same direction

- **Resident-related**

Getting personal

Giving something back

- **Family-related**

  Having expectations

  Making a contribution

These influences were observed to varying degrees and in various combinations across the three homes and appeared to support or constrain staff, residents and families in developing different types of relationships and are summarised in Table 6.1.

OTHER INFLUENCES ACROSSS THE CASE STUDY SITES

Table 6.1

OTHER INFLUENCES	Pragmatic Relationships Focus on the staff	Personal Relationships Between residents and staff	Reciprocal Relationships Involving residents, staff and families
Leadership- the way we do it around here	Leading from the front with formal methods of communication Followed up by senior care workers on the units	Independent working to meet resident's needs; informal pattern of communication in communal areas- sharing stories/ anecdotes	Leading by example with flexible and responsive patterns of working and communication; sharing stories and anecdotes
Continuity of staff- getting to know each other	Having staff the residents don't know and who don't know the residents	Having staff who know what is significant to the resident as a person	Staff who understand what is important to all of us
Team work- pulling in the same direction Critical mass of staff with a similar personal philosophy	Allocation by task- when all the jobs get done, there is a good team Working to the same approach of 'doing the job to the best of my ability'	Working to my strengths Working to the same approach of 'do unto others'	Negotiating workload with each other so right person is delivering the care Seeing all perspectives in the relationship
Contribution of residents: getting personal; giving something back	Pragmatic reciprocity- helping to get the job done	Responding in a personal relationship; sharing personal stories with staff	Reciprocal exchange- helping others in the community; initiating opportunities for social exchange in wider community
Expectations and contributions of families	Making sure it's done Helping with direct care	Sharing personal anecdotes or biography about resident with staff	Developing shared understandings of the situation with residents, other families and staff; trusting staff; finding ways to contribute to the life of the home

Staff-related

Leadership- the way we do it around here

Leadership, at all levels within the organisation emerged as an important factor shaping the way in which relationships developed. Across the three homes, key staff involved in the day to day care of residents were observed to provide leadership in different ways, which seemed to influence the dominant focus of care. This created a sense of the 'way we do things around here' so that staff were working to similar approaches. In the Beeches, for example, leadership was provided through example. How this was achieved was succinctly described by the Deputy Matron:

> *'..and to be caring , to be kind, to respect them and we hope to encourage that with new staff by our example and if what somebody does is not acceptable, you just pull them to one side and say we try to make it a homely environment here.'*
>
> *Jane- Deputy Matron- the Beeches*

Senior staff at the Beeches, including the Matron, Deputy Matron and senior care workers, were very clear about the importance and value of relationships and demonstrated this consistently through their own interactions and practice. The senior care workers ensured the focus in day to day care delivery by organising care according to each residents preferences and working alongside staff to deliver this. The priorities of the day were discussed at handover where all staff were able to make a contribution. If this meant that changes would be needed to the usual pattern of care, a member of staff would offer to speak to the resident who may be affected:

At handover, staff commented they were going to be short and might not be able to do all the baths. Ann Marie offered to speak to Freda as she required two people to bath her. Ann Marie looked at the work planned for the following day and negotiated with staff on rearranging the baths to give Freda her bath then. Ann Marie then went to Freda to discuss this with her.

Field Observations- the Beeches

This provided the opportunity for the resident and member of staff to become involved in a process of negotiation, suggesting a relationship centred approach to care. Registered Nurses were involved in different aspects of care across the home communicating any changes often through exchanges in the corridors. The staff would then consider how best to accommodate these changes, negotiating with each other to ensure both the needs of residents, staff and, when involved, families were met. This flexibility suggested an understanding of the communal nature of living contributing towards a relationship centred approach to care. An informal pattern of communication was observed on most days where staff shared stories about what different residents had said or done. These stories often contained information that could be used by other staff to personalise care routines. Through sharing such anecdotes about residents senior staff seemed to be encouraging care workers to see each resident as a person. For example, one senior care worker produced a photo of a resident who had advanced dementia to show new staff how this woman had been involved in the life of the home when she had first arrived some years previously. This sparked a conversation where staff shared their knowledge about how this resident now communicated with them.

In Chestnut Lodge, there was less evidence of senior staff leading by example but there was a sense that leadership happened 'behind the scenes'. For example, discussions with the owner/manager suggested she encouraged a person-centred focus that was communicated to the Registered Nurses who were responsible for the day to day organisation of the work:

> *'We allocate staff either upstairs or downstairs for about a month, that way they get to know the residents, their personal routine and what's important to them.'*
>
> *RN- Staff focus group- Chestnut Lodge*

The owner/ manager told me that she was very influential within the home and was able to encourage staff to work to her way of thinking, although how this was achieved remained unclear. At the Beeches, senior care workers had provided the day to day example in care delivery for the care staff and Registered Nurses were involved across the home. In Chestnut Lodge, there were no senior care workers and many staff I spoke to preferred this as they were able to work more independently. Unlike the Beeches, Registered Nurses in Chestnut Lodge were only seen in the communal areas at medication times, so it remained unclear what level of communication they had with care staff throughout the day. The majority of care staff were observed to focus on the individual person they were caring for and appeared to try to do the best they could for that person at that time, developing personal and responsive relationships. This dominant focus of resident centred care was supported by the informal pattern of communication between residents and staff as staff moved through the communal areas throughout the day. Staff were also seen to share stories about

residents with each other during meal times when everyone came together. This pattern of working while focussing on individual residents did not always take into account the impact that decisions made with or about one resident might have on others within the home:

> *I noticed Dorothy wasn't down to breakfast until 11am when I mentioned that she was late down today, she burst into tears and said she thought nobody had cared about her because they hadn't come. I said I'm sure that wasn't the case and she said that's what the girls had told her. One of the care workers who got her up today, Dianne, had told me that she always liked to spend quality time with the residents in the morning so wouldn't rush them. In doing this, they have left Dorothy so they can give her this quality time but it meant she was left until later than she likes.*
>
> *Field Observations – Chestnut Lodge*

This suggested there were limited opportunities for negotiation of workload between staff. Focussing on an individual resident in this way supported the 'family' ethos of making it the residents home but the competing demands created by the communal nature of living were not always acknowledged.

Due to its large size, a different style of leadership was in evidence at Holyoake. Here, the manager was more centrally located, leading from 'the front' and communicating what were considered to be priorities in making it a safe home. This emphasis on following rules made sense to many of the staff and encouraged an individualised task centred approach as they focused on the practical nature of their

work. While this style of leadership communicated what needed to be done, the manager also felt there were opportunities for staff within each unit to provide leadership in how it was to be done. She discussed with me how she was aware of the individualised task centred approach throughout the home and that she had made suggestions to registered staff about how they might move to a more resident centred approach in their allocation of work. This created a tension for the registered staff as the emphasis on safety had also increased the amount of paperwork they had to do:

> *'It's not their fault (the registered staff), they have so much paperwork to do now, so they can't be on the floor, I know they walk around but it's not the same.'*
>
> *Ruth -Senior care worker- Holyoake*

The senior staff were conscious of their lack of availability on the floor and some took steps to show the care workers they recognised their contribution:

> *'I will always ask the care staff how the residents have been and I will write what they say. If a care worker comes to me with a new idea, I will always listen and then they feel they have helped to change something, I hope that makes them feel valued.'*
>
> *Adam- Deputy Manager- Holyoake*

This meant that leadership in day to day routines was most likely to come from senior care workers within each of the units:

'I'll say I can't get on with so and so's care and Ruth (senior care) comes along and they are putty in her hands and I learn from that. She's always been there for me, showing me how things are done.'

Malcolm – care worker- Holyoake

The different approaches to care adopted by the senior care workers may account for the very different approaches that were observed between units in Holyoake.

Continuity of staff- Getting to know each other

Staff, residents and families within all three homes described how continuity of staff affected their experience of living, working and visiting in the home. Families in Holyoake for example described how having consistent staff was a key factor in whether their relative received appropriately individualised care. Similarly, residents and families at the Beeches explained how the approach of agency staff who did not know the residents differed from regular staff, resulting in a different approach to care than what was usually experienced. For example, a small group of residents shared their experiences of agency staff with me, describing how their usual pattern of getting up had been disrupted resulting in increased tiredness and irritation that had extended across their experiences of that day. Families also shared how a similar situation had resulted in their relative feeling uncared for. This suggested the high value that residents and families placed upon continuity of staff.

At the Beeches, continuity of staff was seen by many families as necessary for relationships to develop, both between residents and staff and between staff and

family members. Some families described how continuity of staff supported the development of relationships through the care routines:

> *'One of the good things about this home is that they tend to designate certain people to the same group so they get, as far as they are able, the same people, so it gives relationships a chance to develop, I think that's very important.'*
>
> *Mark- son – the Beeches*

Families in Chestnut Lodge described how having a specific nurse they could speak to about their relative, enabled them and the resident to develop positive relationships with someone who knew the needs of the residents well. A similar situation existed in Holyoake where families also felt that having continuity of staff was beneficial for residents:

> *'They understand their needs, their likes and dislikes. When it is the same staff, they (residents) may not know their (staff) names, but they recognise them.'*
>
> *Elisabeth - wife- Holyoake*

In Holyoake, there was a policy of rotating staff around the different units. Rotation occurred following staff appraisals or whenever the manager felt staff needed to develop their skills in other areas of the home. However, this policy had the potential to disrupt relationships from the families' perspectives:

'They just get to know the residents, what they like and dislike and then they are moved before they can have the benefit of that'.

Family focus group- Holyoake

Although many residents in Holyoake could not remember the names of staff, families felt they responded well to regular members of staff because they knew what to expect. The rotation of staff often placed an additional strain on family members who then needed to support the resident in adjusting to the change as the following field note suggests:

I saw Elisabeth and she was quite agitated and nearly in tears. She told me they were going to move the staff around and she was worried that it would unsettle Graham. She said' they know him and he likes them, why do they have to do this?'

Field observations- Holyoake

There was also a period at the Beeches, following the departure of the Matron, when agency staff were being used regularly resulting in lack of continuity of staff. The agency staff did not know the residents' personal routines, which impacted negatively on residents' experiences:

'On the weekend, they(residents) weren't happy because of our own staff not being on. The agency ways are different, they have no idea who the resident is or what they are all about and obviously they can't take the time out to know

the residents but it makes them very unsettled, very unhappy. Whereas we are here continuously and we know them and what they need.'

Sandra - care worker- the Beeches

This situation also placed regular staff under additional pressure to make sure that care was delivered appropriately:

'About the agency people, well we know we need them at this time and if you get one who has not been here before, you're starting again from scratch and that time you're spending on them, in effect, you are neglecting the resident to some extent which is so unfair in my mind. But it's a bit hard going for us if you get somebody who's not bothered at all, you're trying to pull them along, it does make it more difficult.'

Ann Marie- care worker- the Beeches

On these occasions, regular members of staff felt they were unable to adopt a resident centred approach and moved to an individualised task centred approach where the focus was on getting the job done.

Families at the Beeches were also conscious of the changes in staffing and how this was likely to affect their relative:

'I have noticed quite a few new faces coming and going and I think what older people like is continuity, there's nothing worse than not knowing who's coming through the door.'

Dylan- son- the Beeches

Without continuity of staff, there were days when residents at the Beeches were cared for by staff who did not know them. This situation meant that personally significant details were often omitted from the residents' care. These details had emerged through staff getting to know the residents on a personal level and were often communicated informally between staff within the home. Therefore, lack of continuity of staff, had the effect of changing the dominant approach from a resident or relationship centred approach to an individualised task centred approach to care. This situation appeared to follow the departure of the Matron, resulting in fewer staff who knew the residents well. The administrator told me how she had made the decision to employ agency staff rather than expecting regular staff to do additional hours. This was mainly for the benefit of staff but did not take into account the impact of unfamiliar staff on the approach to care and relationships with residents and their families.

The system of staff allocation in Chestnut Lodge was designed to support continuity of staff caring for residents on a regular basis. This enabled staff to understand the personal routines of each resident:

> *'Each resident is different. They like to do things in a certain order when they get up. It's easy for us to say let me do it for you, because it's quicker, but that takes away their independence, so you have to know that's what they like to do'.*
>
> *Staff focus group- Chestnut Lodge*

In Holyoake many families were concerned for the safety of residents when being cared for by staff who did not know them:

> *'It's like with Marge, she can't eat sandwiches because she chokes, but I was here the other night and someone was on who didn't know the residents and they gave her sandwiches, luckily I was there to tell them, but how can they know?'*
>
> *Family focus group- Holyoake*

While having staff who did not know the resident resulted in a focus on the task, regular staff at Holyoake who knew the residents also described how they moved from a resident centred approach to focussing on the task when there were minimum staffing levels in operation:

> *'..lack of staff is a big issue: four people to care for 23 people it's not enough and sometimes you've only got three or even two it's wrong and just because the law states it is 1 person to five residents, it's wrong. As their dementia progresses, the more you need to communicate with them, and if you don't communicate with them, they become completely cut off.'*
>
> *Ruth- senior care worker- Holyoake*

Having minimum levels of staffing in Holyoake meant that the job would get done but did not always mean that care could be delivered in a resident centred way. Some staff at the Beeches also suggested that having insufficient staff prevented them from

doing activities that were significant for the residents. One member of staff, for example, described how she had previously taken residents out for afternoon tea or on shopping trips but found that she no longer had time to do many activities with residents outside the care routines. Some staff in Chestnut Lodge also found there was limited time to involve residents in meaningful activities. One resident for example, enjoyed doing housework and while staff provided her with the opportunity to fold washing, they felt it would have been more beneficial to sit and speak with her. One member of staff described how she tried to balance meeting the needs of residents with the demands of the job:

> *'Joy likes to wash up, so I give her just a few pots, nothing she can hurt herself on and she thinks that's' wicked... and why not, she's not hurting anybody but then she might think she can do it on a day when we're busy but we try to explain to her and she accepts that. If we're busy I'll say I can do it later and now Joy will ask me 'well what time?' So I say 7, that's when we're not so busy and then I make sure I go back then even if it's for 10 minutes to give her that opportunity.'*
>
> *Diane – care worker- Chestnut Lodge*

The examples used in this section suggest that continuity of staff had the potential to support the development of relationships between staff, residents and families. Continuity of staff also affected the way in which staff worked together, which was another factor which appeared to influence the development of relationships.

Teamwork – pulling in the same direction

Personal philosophies often influenced how individual staff members approached their care as described in Chapter Four. As staff described how their different philosophies influenced their approach to care, they often referred to a 'good team' that included staff with a similar philosophy. This suggested that having a critical mass of staff with a similar philosophy appeared to be a contributing factor towards how staff worked together. This was reflected by one Registered Nurse who was responsible for allocation of staff in Holyoake:

> *'We all have our different approaches, it's about putting people together you know are going to team up and work well.'*
>
> *Ruby- Team Leader RN - Holyoake*

In Holyoake, for example, there were staff on one unit whose personal philosophy could be described as 'doing a good job'. Here, the dominant approach to care could be described as individualised task centred supporting the development of pragmatic relationships. This was reflected in the description of a good team:

> *'I'll allocate who's doing what and everyone knows what they are doing. If we've got a good team, all the jobs get done, residents get proper care.'*
>
> *Sally- Senior care worker- Holyoake*

On another unit in Holyoake, the philosophy of many of the staff could be described as 'do unto others'. When these staff worked together, there were times in the day when care moved beyond an individualised task centred approach to a more resident

centred approach. This supported the development of personal and responsive relationships between residents and staff as well as between staff:

'We know each other and when we are down, we pick each other up, we keep it light hearted.' *Ruby- Team Leader RN- Holyoake*

Many staff in this unit also recognised that they had different skills and needed to work to their strengths:

'There might be something I am better at doing than someone else and they might be better at something else than me.'

Samuel- care worker - Holyoake

There were times in Holyoake where staff with differing approaches to care might have to work together. One member of staff who had experienced this described how this influenced her relationships with other members of staff and the effect it could have on the residents:

'She was treating them (the residents) as if nothing had changed (since the last time she had worked some months previously) and that irritated me. Then her daughter (who works upstairs) came down and had 'words' with me. Now if I had to work with any of them, I would ask if there was any chance that I could be moved because it's not fair on the residents- they know when things aren't right between you (staff).'

Sian- care worker- Holyoake

Families in Holyoake also identified the potential impact that relationships between staff had on their experience:

> *I notice families looking at the board as they come in each day. Speaking to Elisabeth, she commented that she always looks on the board as this tells her what sort of visit she's going to have. She told me: 'when there is friction between carers you can sense it, when you come for four hours these things become obvious'.*
>
> *Field observations- Holyoake*

A similar situation was observed between staff in Chestnut Lodge when staff with different approaches to care were working together. One member of staff described this as not having a good atmosphere. On these occasions, the usual atmosphere of fun and camaraderie was replaced with a feeling that here was too much work to be done. Staff rarely commented on working together as a team in Chestnut Lodge. From my observations, a good team appeared to be based on personal relationships between staff who adopted a similar approach to their care:

> *'It's like with Richard, I know him better than I know my husband, I work with him so much, so I get to know him and we know how to work together'.*
>
> *Staff Focus group – Chestnut Lodge*

Staff worked primarily in pairs in Chestnut Lodge based either upstairs or downstairs. This seemed to reduce the opportunities for staff to work together as a larger team.

This was very different to the experience of staff in the Beeches where there appeared a greater level of flexibility in how staff worked together:

> *'I'd never leave anybody struggling with anything and I don't think they'd leave me struggling. If I went and said can I have a bit of help here, they would come'.*
>
> *Jilly – Senior care worker- the Beeches*

There were days in the Beeches where everyone seemed to be in the right place at the right time and this was often attributed by staff to having a good team on. A 'good team' on these occasions appeared to have staff who knew what each resident needed but could also be flexible enough when a situation changed to adapt their pattern of working.

Summary

Throughout each home, there appeared a range of staff related influences that contributed towards a dominant approach to care. The styles of leadership across the three homes were an important factor. Each leadership style reflected a different approach to communication strategies within the home that influenced the relationships between staff, residents and families. Strategies that supported the sharing of stories between staff for example, often contributed towards personal and responsive relationships. Leading by example appeared to enable flexible and responsive working patterns where staff were able to enter into negotiation with residents and other staff to make sure the right person was delivering the care, supporting the development of reciprocal relationships. Having consistent staff was

relevant in supporting all types of relationships and was highly valued by residents, families and staff. Issues in the consistency of staffing sometimes constrained staff in adopting a resident centred approach to care and some staff explained how they needed to adopt an individualised task centred approach when there was limited staff who knew how to personalise the care of each resident. Pulling in the same direction was often described by staff as having similar personal philosophies. This meant that when a critical mass of staff subscribed to a similar philosophy, this influenced the dominant approach to care and the type of relationships that developed. While these influences are not exhaustive, they provide an insight into what may contribute towards staff working in different ways at different times. However, the data presented in Chapter Five suggested that residents and families also made contributions towards how staff approached their care. The influence of resident and families will be discussed in the following sections.

Resident-related influences

Residents across the three homes, irrespective of physical or cognitive abilities demonstrated the potential to become involved in and influence relationships. There were few residents within the study who were able to fully articulate how they developed relationships; however, many residents spoke about daily activities and interactions with staff and these conversations provided insights into how residents contributed towards the relationships that developed. Some residents demonstrated through social exchanges with staff that they wished to develop personal relationships. This was described by staff as residents feeling more relaxed:

'It's like Muriel Hartley, it was very much Mrs Hartley when she came in, but now, it's Muriel and she'll have a joke with us- she's got used to us and she knows how far to push me and the same with me to her.'

Jay- Senior care worker- the Beeches

This suggests that when staff responded positively to social exchanges initiated by residents the opportunity to develop personal relationships was recognised. Residents then described their relationships with staff in more personal terms.

Getting personal

The resident's contribution in moving relationships to a more personal level was most evident at the Beeches. Here, residents actively shared personal information about their lives with staff. Some members of staff described how they used this information to introduce social conversation into the care routines. The sharing of personal information with the staff, then promoted an opportunity for social exchange within the daily routine of care that enabled the resident to contribute towards moving the relationship to a more personal level. Residents who shared their biographies enabled staff to see them as people who had done things with their lives as well as what was important to them now. These stories provided the opportunity for residents to recall their past achievements with pride:

'I went on the minibus, when I retired until I was 80 I think, there was a shortage of getting the children to school mainly.. cause they were out in the country, no transport much and they couldn't get in to do their shopping, so a group of us around.. decided to... it was all voluntary...to get a minibus.. and

(the) County said they would support us but it wouldn't last very long and it's still running.'

Gwen – resident –the Beeches

However, for relationships to develop as a result of such contributions, staff had to be able to recognise the significance of these stories:

Each time I come in, I notice Freda has a story about her family that relates to the day's events. Today she told me Jay had considered going into the police force and she had a cousin who had been in the police force who in turn had a brother who committed suicide; she then told me the effect this had on their family. It was this story that helped me realise that these stories Freda was always telling were a way of showing her relationship within her wider family, and how important her family was to her.

Field observations - the Beeches

Residents who shared personal stories contributed to the store of personal knowledge held by care workers about them. When residents were unable to do this, families often shared similar stories with staff. This appeared to support the staff in developing an understanding of what was significant to the resident as a person. Some care workers were able to use this information to create opportunities for the resident to become involved in activities that held significance to them. This signalled a personal interest in the resident as well as showing a level of responsiveness to what was important in that resident's life:

'I saw she subscribed to the RSPB and asked her about it. She told me how she used to attract birds to her garden, so now I think to do something with her like with the nuts and the bird things, it's something to do that breaks the monotony up of that day and she enjoys doing it. She'll talk to me the next time she sees me that the birds haven't come yet or I'll say to her, I'm going to put another feeder up and I've done it and the next time she comes up to the room, she's looking for it. Then she'll talk to her son and daughter in law about it when they come, and she tells them what we've been doing and that opens it up for her and it's letting them see, that her time here isn't just about being cared for physically, and in a way you could almost say it was a spiritual kind of care really.'

Ann Marie- care worker- the Beeches

Recognising the significance of this aspect of the resident's past life, provided opportunities for social exchange, which demonstrated that the staff valued the resident's identity and the contribution they were able to make to the life of the home.

In Holyoake, it was primarily activities staff who provided the opportunities for residents to make an active contribution within relationships, which could explain why relationships in Holyoake were predominantly pragmatic. The activities co-ordinator explained how she would consider the biography of the resident and then explore ways through which the resident could be encouraged to make a contribution:

'I took her (Mary, a resident) up to the Apple Tree (pub) and she had a bacon sandwich and she ate the lot, she insisted I had the other half but I said 'no,

you eat it' and we had fresh coffee but she can tell you how to make anything. She used to work at the golf club and she used to be the cook there so she knows what she's doing. I said to her, we wouldn't mind doing some baking in here but something that doesn't have to be cooked and she was coming with all sorts of ideas She was saying you don't have to cook that, you can put it in the fridge and it will set and so I said great, we'll do that next week.'

Sally- activities co-ordinator/ Senior care worker- Holyoake

This was a similar situation to that observed in Chestnut Lodge where the activities coordinator often undertook one to one activities with each resident, providing opportunities for residents to make a contribution within their relationship. This included, asking residents about photograph albums or undertaking a cooking activity with them. On one occasion, the activities co-ordinator described how she had bought a book at a book fayre for one gentleman who had an interest in antique cars. However, in Chestnut Lodge, there were also occasions when other staff initiated conversations in the communal areas outside the care routines that enabled residents to contribute towards personal relationships:

Robert, one of the care workers, sat beside Jessica who was dabbing her eyes. He asked her if she had been a nurse and if she had worked in a hospital and this started off a conversation between them. She was wiping her eyes and he offered her a tissue and then told her he had to have laser surgery on his eyes. He asked her how her vision was in respect to his and then she said she could only see three sides to that table over there. Robert replied 'well then that would give you X ray vision and I could borrow that if you could see four

sides'. She looked at him and then said 'you're pulling my leg now I know you are pulling my leg and they laughed together'.

Field observations- Chestnut Lodge

Across the three homes, it appeared to be the opportunity for residents to engage in social exchange that supported them in making an active contribution towards the development of personal and responsive relationships with staff. This suggests that while residents actively made contributions it was necessary for staff to provide opportunities for, and acknowledge these contributions in order for personal relationships to develop. When residents were unable to make personal contributions in this way, families often took on this role, which will be explored later in the chapter.

Giving something back

Many residents across the three homes actively contributed towards developing relationships, often in the context of their care routines. For example, in Holyoake, where staff adopted a primarily individualised task centred approach to care they commented on how residents might help them by co-operating in the routines of care:

'When I'm dressing John, I'll ask him to sit forward, put his arms up and that helps me to dress him and he's happy to do that as long as you tell him what you're doing.'

Sian- care worker- Holyoake

While the resident contribution was described primarily in pragmatic terms within Holyoake, a few staff also described personal and responsive relationships with residents. This suggested that residents, who might not be able to communicate verbally, were able to find other ways to make responsive contributions towards their personal relationships with staff. Similar contributions from residents were also described by staff in Chestnut Lodge:

> *'When I've been nursing people who have been ready to die, they will still look at you and no matter how ill they are, they will always say thank you and you appreciate the effort that must be for them.'*
>
> *Gayle- care worker- Chestnut Lodge*

The predominantly resident centred approach to care in Chestnut Lodge meant that staff often interpreted contributions from residents in terms of personal relationships. For example, when one member of staff returned from leave, others recognised how a specific resident noticed their return with pleasure.

As personal and responsive relationships developed between residents and staff, some residents began to engage in behaviour that demonstrated their interest in moving towards a reciprocal relationship. A feature of reciprocal relationships included staff providing opportunities for residents to negotiate changes to their care. For example, one resident described how she could support the staff in doing their work with other residents by helping the staff within her care routines. She also expressed an understanding of the impact her requests had on staff:

'As long as you are reasonable in what you ask. You can't expect to ask and for them to do it straight away. I think that's a mistake when Freda asks and expects it straight away.'

Betty- resident- the Beeches

This resident saw her requests in relation to others within the home, which influenced the development of reciprocal relationships that held benefits for everybody:

'I have always been interested in people, I still am. I try to do things to help when I can. I think it's nice to be popular and I'm vain enough to know I am popular with the staff. It makes you feel happy about it.'

Betty- resident- the Beeches

This resident also contributed towards activities that she could see staff were interested in even when she didn't share the same level of interest:

Tina was quite excited as she showed me how Betty was now walking. Tina felt she had achieved this with her recent moving and handling course she had done and felt it was quite an achievement. Later, I said to Betty she must feel that was quite an achievement but she said not really. Her sister who was two years older than her could still get in and out of the bath herself. Betty said that would be something she would like to be able to do because she didn't like being hoisted into the bath. She said she was a bit lazy really and didn't really want to walk. I was surprised by this but Betty said as nice as the staff were to say she was doing well, she didn't really believe them because of how

she used to be. She was happy to walk for them because she believed they were doing the best they could for her

Field observations- the Beeches

Some staff felt that residents who were able should understand the constraints that staff were working within:

'That's what annoys me with Freda, we're doing our best and she knows we are, she understands we are busy but she still moans about it behind our backs.'

Jay- Senior care worker- the Beeches

Many staff in the Beeches acknowledged when residents were making a contribution suggesting that for reciprocal relationships to exist, they needed to be acknowledged. This acknowledgement of reciprocity was also described by some staff in Holyoake. One resident for example, communicated how he understood the emotions being experienced by staff:

'When I'm down in the dumps even when I'm not showing it, he'll reach out his good hand and touch my hand or my knee as I walk past to show me he understands.'

Ruth- Senior care worker - Holyoake

This member of staff suggested that even with limited communication and poor cognitive abilities, residents were able to engage in reciprocal relationships that recognised the valuable contribution made by this member of staff:

> *'It's just the way he used to be, such a domineering man, he still is and he has some strength. I tell him If he was in school, they'd expel him. I think he knows what I'm saying because when I say that, I get a little grin. Had a week off and when I came back he came up to me, and I thought, he's going to hit me' and he 'loved me' he put his head on my shoulder and that's the first time he'd ever done that, it was lovely. I really felt special, it was wonderful.'*
>
> *Ruth- Senior care worker-Holyoake*

Although residents may make reciprocal contributions, it was apparent across the three homes that unless staff acknowledged the reciprocal intention of the resident, relationships tended to remain personal and responsive or pragmatic.

Summary

Residents across the three homes made active contributions towards developing relationships with staff. When staff adopted a primarily individualised task centred approach to care such as in Holyoake, these contributions were accepted at a pragmatic level. Residents who wished to develop personal relationships tended to initiate social exchanges, which when recognised by staff influenced the development of personal and responsive relationships. These were most commonly seen in the context of a resident centred approach to care as in Chestnut Lodge although there were isolated examples in Holyoake. Residents at the Beeches, who were able to

articulate the type of relationships they developed, described how they contributed towards reciprocal relationships, which they felt contributed to the wellbeing of other residents and staff. The relationship centred approach to care suggested that residents were given more opportunities to negotiate and compromise supporting the development of reciprocal relationships.

Family-related influences

Having expectations

Families across the three homes had different expectations for the care of their relative. In Holyoake, many families had cared for their relative prior to admission to the care home and described their expectations in relation to the care they had given. Often these expectations were similar in nature to those described by the residents themselves in the Beeches. Few families in the Beeches had cared for their relative and the expectations they described were based on the resident's satisfaction with the care. Families in each home conveyed that they did not want to be seen to be critical of staff but recognised that different staff had different approaches to the care of the residents. When the approach by the staff met the expectations of the families, personal and responsive relationships often developed.

Many families in Holyoake had provided direct care for their relative prior to them moving into the home and described how a deterioration in their relative's health had resulted in their admission. One daughter aptly described the feelings she and her mother experienced some years later:

'Since he's been in, we've never truly been at peace. We've become more resigned but in our heart of hearts, we've always wanted to bring him home, without a shadow of a doubt.'

Andrea - daughter- Holyoake

This experience of providing care sometimes created expectations that were not always met when the resident was being cared for in a communal environment:

'When I go and see he hasn't been shaved or he's wet or he needs a bath, then that really gets to me because of what he has had in the past. They tell me he can be very difficult and he uses bad language but I've never heard him use it.... It's not the way we would have cared for him, it's very difficult.'

Andrea – daughter- Holyoake

This created a dilemma for staff in Holyoake, who felt that families held unrealistic expectations of the care staff were able to provide in a communal environment:

'There are some families who don't realise that when they care for the residents, it was on a one to one but here we have a number of residents who all need our care, so we can't always give it the way they would have done at home.'

Adam - Deputy Manager - Holyoake

Some families expressed an understanding of the limitations of the environment and described their expectations in terms of the practical side of providing care:

'As long as he's clean fed and watered, that's all I want. The staff are busy, they can't do anything else.'

Vera- wife- Holyoake

Other families in Holyoake described different expectations. One family described staff delivering the right care when their relative needed it, which supported the development of trusting relationships with staff:

'..they were having to syringe liquid into him because he was dehydrating, they were absolutely round the clock. ..He was so ill, I thought he'd never walk again and now look at him, we were surprised, they were absolutely marvellous. ...My neighbour said to me why do you go everyday, the staff will think you don't trust them, but I said I trust them implicitly and they (staff) know that.'

Fiona- wife- Holyoake

Some staff demonstrated their awareness that how they approached the care of the resident influenced their relationships with families:

'They see me encouraging him a lot, they see me spending a lot of time with him, they see me trying to get him up, they hear how I communicate with him, they can see it, they can see that person is really spending a lot of time with my relative.'

Samuel- care worker- Holyoake

Some families in Holyoake also expressed an understanding of how staff managed care that took into account the needs of other residents:

> *'You know he's in good hands and if there's' anything wrong they'll tell us we know he needs quite a bit of time but we know he gets it that they never walk past him but not everyone's going to be the same all day every day, their needs change; like today we can see there's an issue with Ray (another resident).'*
>
> *Phillip- son- Holyoake*

This family trusted the staff to make the right decisions for their relative based on their previous experience. However, if families felt that staff were not meeting their expectations, they engaged in activities to make sure that a minimum acceptable level of care was being delivered, which tended to reduce relationships with staff to a pragmatic level. For example, some families came in without notice at different times to make sure the resident was being cared for in the right way:

> *'His daughter came in straight after lunch a couple of weeks back to take him out and, she never comes in at that time. She was mad because he had dinner down his trousers... You encourage his independence to feed himself which he does. He ..makes a right mess but he is content to do it himself. Changing him is a priority but not a priority over people who need pressure relief...it didn't take two minutes to change him after.'*
>
> *Ruth- Senior care worker- Holyoake*

This scenario suggests the difficulty in adopting a resident centred care approach when the focus of the family may be on the practical concern of having the resident ready for an outing. On this occasion, the staff member placed the needs of other residents as her priority over a task that was considered less important, causing conflict with the family. However over time, staff who were consistent in their approach felt families began to understand what they were trying to achieve because they all had the same goal – the wellbeing of the resident.

In the Beeches and Chestnut Lodge, families regularly demonstrated their awareness that the staff were looking after a group of people, not only their relative:

> *'There obviously has to be a systematic approach, people have to go to bed after lunch, people have to go to bed after tea. If people are ill, that may mean my mother may have to wait longer than usual to go to the toilet, but it's all understandable, an individual carer can't be in more than one place at a time, and there has to be prioritisation.'*
>
> *Mark – son- the Beeches*

This suggested that some families were able to see the staff perspective, moving towards shared understandings of the care of their relative:

> *I think the physical care is excellent, it all happens and happens very well, but it's difficult with the mental care because nor all of them (residents) are on a level playing field, because they're needs and abilities are so different.*
>
> *Allan - grandson- the Beeches*

There were families who described a similar understanding in Chestnut Lodge. This was supported by the layout of the communal lounge where residents spent most of their day. Many families spent their visits in the communal areas, including other residents in their conversations:

> *I spoke to Charles, while he was visiting his mother. I noticed, different residents coming up to speak with him. He knew each of them by name and engaged with them until they moved away when he would return his attention to speaking with his mother. I commented that when he visited, he was visiting all the residents not just his mother and he agreed.*
>
> *Field observations- Chestnut Lodge*

These families recognised the skills staff needed to meet the needs of the residents contributing towards a shared understanding. Families who developed shared understandings also described the contributions they made, which influenced the relationships they developed with staff:

Making a contribution

Many families across the three homes contributed towards the care of their relative in different ways. This sometimes reflected the relationship the family member had with their relative prior to moving into the home, such as providing personal care or may have signalled a new role in their relative's life. When discussing their contribution, some families described feelings of duty, to make sure that things were right for all residents:

'..it's not that I complain, I don't complain but I do get concerned and if I put those at the back of my mind, I wouldn't be doing what I saw as my duty not just for my husband but for the others. If I see something that's not right, I won't just walk past it. If you don't and you're not here, it might be happening to yours, it's not just for my husband it's for everybody.'

Family Focus group- Holyoake

Families who contributed in this way often described the relationships between themselves and staff in pragmatic terms. Some families felt they always had to make sure that their relative was receiving appropriate care and so were unable to move beyond pragmatic relationships with staff. However, when this was the family's only contribution, it could be considered as being overly critical by staff:

'It's like with some families, they are always coming in and looking for problems, little things mainly, but for those families, it doesn't matter what you do, they will always find something that's wrong.'

Sian- care worker- Holyoake

This suggested the potential for difficulties in relationships between families and staff when they were seeing the situation from differing perspectives.

Families in Holyoake who developed personal relationships with staff had a pattern of visiting that ensured regular contact with staff. One family member for example, approached staff at tea time for her husband's drink and used this time to

communicate personal information about her and her husband to staff. As she left, she made a point of thanking each member of staff for taking care of her husband, signalling the end of her visit. When I discussed this with her she provided the following explanation:

> *'..well they are friends to me, so of course I say thank you. It's like these flowers, Wendy(RN) always brings them in but I know they are so pulled out (busy). And Graham appreciates them, I know because she's told me that after she's been to see to him, he'll call her over and say 'thank you my dear'.'*
>
> *Elisabeth - wife- Holyoake*

This family member interpreted her regular contribution as developing personal and responsive relationships with the staff. However, the majority of staff on this unit were regularly observed to adopt an individualised task centred approach to care and often described their relationships with families and residents in pragmatic terms. This suggests that different approaches to care may be adopted within one unit by different members of staff, but it is the dominant approach that tends to have the greatest influence on relationships.

Some families at Holyoake also described making contributions towards the wider community within the home. One family member described her relationships with other residents like an extended family, while others described their contribution as engaging other residents in conversation or bringing sweets specifically for other residents:

'you don't only visit your loved ones, you visit the others as well. I'll go over to Judith, sometimes, she can give me a real mouthful but she's usually alright and she'll ask me for jelly babies, so I'll always bring some.'

Helena- -daughter - Holyoake

Many families expressed an understanding of the complexity of the work the staff did and for some families, this led to reciprocal action:

'I've helped with his pads before and he's always got to have two with the hoist, I've had the training with the hoist so while one's doing something else, I'm helping with that you see.'

Vera- wife- Holyoake

For this family member, supporting the staff with the practical side of her husband's care, seemed to be her way of making a contribution towards the development of reciprocal relationships with staff.

At the Beeches, relationships between families and staff were often personal and responsive and sometimes reciprocal. However there were occasions, when regular staff were not on duty, when relationships between family members and staff became more pragmatic. This was generally in response to things that had not been done. Common examples included finding their relative without call buzzers or not having a warm blanket on when the weather had turned colder. These were situations that the families concerned felt were resolved quickly with the relevant staff on duty.

However, on one occasion, after the Matron had left, some families felt they needed to assume a greater role in making sure that care was being delivered:

> *'Well we went in on Sunday and she actually said 'for the first time since I've been here, I've felt like I haven't been looked after properly'. Something she has always stressed has been the level of care, she has always said, 'I am well looked after', but she went completely in reverse, so we felt we had to speak to somebody about it.'*
>
> *Sarah- daughter in law- the Beeches*

These tended to be isolated examples and as such did not appear to have a lasting impact on their relationships with staff.

Many families at the Beeches expressed satisfaction with the contribution they felt able to make and the way staff responded to this:

> *'The staff seem to be interested in the people and they will respond to anything we ask them to consider in respect to our grandmother.'*
>
> *Allan- grandson- the Beeches*

Other families found ways of working with the staff to meet the needs of their relative, which contributed towards personal and responsive relationships:

> *'An example of something that we've thought of in conjunction with the staff was when you needed a coat (to Freda), with the disability of your left arm*

and the painfulness of putting it into a sleeve, so I did quite a lot of searching and eventually found that woollen cape which has a button on the side so you don't have to put an arm through a sleeve. So I suppose that's all part of care and before we got it we did discuss it and then when we actually got it, we brought it along and said shall we try this, is it any good? We didn't impose it and say this has got to be used. It was a case of is this something that is suitable, was it suitable for you, did you feel comfortable in it, was it suitable for the staff – did they find it better than using a coat. So these are are just things you would discuss.'

Ellen-daughter in law- the Beeches

One family member described how staff would always make sure she had a cup of coffee on her arrival. She then identified how she could make a contribution to life in the home by supporting both staff and residents in the following way:

'There's never anyone to have conversations with them, the staff are all so busy. That's why I come at dinner time because you get to know them and then if they go into their rooms. I would never see Niall if I didn't come at tea time- a different face for conversation isn't it. Well I say, I'm doing this and I'm doing that and Freda will pick up on it.. I talk about where I'm going and where I've been and then it gives them something to think about and the next time I come, they'll say oh did you so and so and they sort of remember and that's nice.'

Helen-niece- the Beeches

In Chestnut Lodge, many families were observed to be making contributions in different ways. Some discussed how they planned to take their relative out on special occasions such as mother's day other families described small regular outings when the weather permitted. These families also described personal and responsive relationships with staff who supported them in making these contributions. On occasions, shared understandings developed between staff and families as in the case of one son who came to help his mother at meal times and was also offered a meal himself. Staff explained they knew he wanted to continue to be part of his mother's life, not simply help to care for his mother.

Summary

Many families across the three homes described their expectations of care for their relative. The expectations held by families contributed towards the type of relationships families developed with staff. For families who felt their expectations were not being met, the relationships tended to be pragmatic with families 'checking' that the care had been delivered. However, families who felt their expectations of care were being met described the development of trusting relationships with staff. The contribution families made to the care of their relative, or to life within the home, also influenced the relationships they developed with staff. Some families described a range of contributions. When families wished to move towards more personal and responsive relationships with staff, they often employed strategies that brought them into regular contact with staff. However, there were also families who described their contribution towards the care of their relative as predominantly 'making sure', who tended to develop primarily pragmatic relationships with staff. Some families also described how they contributed to life in the communal environment supporting

other residents as well as their relative influencing the development of reciprocal relationships with these residents. Reciprocal relationships with staff were also influenced by these contributions to the wider community of the home as staff became aware of the contribution families made.

Conclusion

The influences described in this section were observed in varying combinations across the three homes. It was often these influences in combination that appeared to shape the relationships that developed. For example, pragmatic relationships were most apparent in Holyoake where the leadership was from the front with an emphasis on following rules. Many staff also subscribed to a personal philosophy of 'doing a good job' underlining the practical focus of care. This meant that the contribution of both residents and families were interpreted by staff as helping them to get the job done. It was this combination of influences that appeared to support the development of primarily pragmatic relationships.

This was very different to the personal and responsive relationships developed in Chestnut Lodge. The influence of leadership was less apparent here, with a greater emphasis on 'pulling together' to achieve a resident centred approach to care. Many staff subscribed to the personal philosophy of 'do unto others' which appeared to motivate them to find out what mattered to the residents. Contributions from residents and families supported the development of these relationships as biographical stories were shared informally within communal areas of the home.

Leading by example seemed to be a key feature within the relationship centred approach observed at the Beeches, with staff from all levels involved in communicating the way care should be delivered. Having a regular team that could see others' perspectives also supported this approach. The contributions of residents and families were often described in terms of supporting others within the home leading to reciprocal exchange in the wider community of the home. The combination of these influences appeared to contribute towards shared understanding of each other's experiences, enabling the needs of residents, families and staff to be taken into account. The following chapter will discuss these findings in relation to the wider literature.

CHAPTER 7- DISCUSSION OF FINDINGS

Introduction

The literature reviewed in Chapter Two of this thesis suggested that relationships influence the experiences of residents, families and staff within care homes for older people. However, little was known about how this occurred. The purpose of this study was to describe the nature of relationships between older people in care homes, their families and staff and provide an interpretive framework to understand how these relationships influence their experiences.

The findings presented from three case study sites revealed how relationships could be developed between residents, staff and families through caring practices. The contributions of staff, residents and families were described although it often appeared to be the approach taken by staff that had the most influence on the type of relationships that developed. Staff appeared to adopt an individualised task centred, resident centred or relationship centred approach and sometimes moved between these approaches (Table 5.1 on page 128). This observation supported an initial understanding of how relationships between staff, residents and families influenced the day to day experience of working, living in and visiting a care home. However, there were also a range of influences that were observed to either support or constrain the approach that staff adopted and the relationships that developed (Table 6.1 on page 173). These findings contributed towards an interpretative framework for understanding how relationships were developed within care homes.

Within this Chapter, I will attempt to provide a synthesis of how the influences described in the preceding chapters, shaped the approaches of staff and the

relationships that developed between staff, residents and families. The findings from my study will be compared to existing literature, both that considered in Chapter Two and literature that appeared during the period of data collection and analysis. I will then provide a brief overview of relevant practice frameworks, and propose the contribution which the findings of this study make to these. However, to provide a context for this discussion I will begin with a reflection on my research methods.

Reflections on the Methodology

From the outset, this study was based on constructivist principles as described in Chapter Three. However, this is a relatively new methodology for nursing research in care homes and a range of issues emerged throughout the study that suggested both strengths and limitations of using a constructivist approach. Involving older people in care homes within the research process in a meaningful way poses a particular challenge in research but is essential if we are to understand how care can be improved in these contexts (Mitchell and Koch 1995). While there have been many studies that involve older people in research (Stanley and Reed 1999), few have been undertaken that seek to develop a joint understanding between older people, their families and formal care providers. Therefore, insights gained from using a constructivist methodology are potentially of value to other researchers using qualitative methodologies within care homes.

Sampling issues

As discussed in Chapter Three a purposive approach to sampling was taken in the selection of the three case study sites and the involvement of participants within each home. It could be argued that the study may not fully represent all views across care

homes as participants were self-selecting. Involvement in research may be prompted by extreme experiences with some participants having 'an axe to grind'. Although the combination of interviews and participant observation enabled me to include participants with differing views to represent the breadth of experiences within each care home at the time. However, the views represented were those of people from white British backgrounds as there were no residents or families from ethnic minority groups within any of the care homes at the time of my study. Many staff were also white British although a number of Registered Nurses in one home were from the Asian subcontinent. Unfortunately, none of these nurses agreed to participate in the study, possibly as English was not their primary language which may have caused them to feel unsure about their participation. This conclusion is personal but suggests the need for further research into the role and experiences of overseas nurses in care homes.

As this study was concerned with the nature of relationships, the relationships which developed between myself as researcher and the participants were also fundamental to this study. Previous studies in care homes have indicated that older people tend to speak only about the positive aspects of the home rather than the negative. Through developing a relationship of trust over time, I was able to encourage older people to raise any concerns or issues that were then able to be fed into the process of the research.

Ethical Issues

Older people in care homes have the same right to contribute to development of a knowledge base that will inform and support the care they receive as others in the

health and social care services (Reed et al 2004b). However, the nature of researching within a communal environment which is home to older people requires sensitivity on the part of the researcher. Further to this, a number of issues emerged surrounding issues of privacy and confidentiality, which will now be discussed.

As older people agree to being interviewed, removing them from their usual space in order to go somewhere private, has the potential to alert staff to the activity as well as disrupting the usual pattern of the older person's day. I felt that moving to a private space would enable the participant to speak more freely about their thoughts and feelings in relation to the home. However, in the current study, residents found moving to a private space unsettling and when given the choice, preferred to remain in the public spaces. Participating in public spaces, did not appear to concern the participants within this study as my presence in public spaces had become a feature of the participant observation within the study. To ensure confidentiality, where possible, I tried to time interviews and focus groups in public spaces when I knew the staff would be busy elsewhere, so that private information could be discussed freely. Madjar and Higgins (1996) suggest that the ethic of care within a research context:

> *'requires the researcher to take on the responsibility of a moral agent, adapting approaches and actions in response to the needs of the other person (s) in the research relationships rather than adhering to a prescribed protocol'* (p.134)

This adaptation was particularly appropriate when involving participants with sensory impairment. For example, one resident who wished to be involved in a focus group

had a hearing impairment that caused her hearing to be worse on some days than others. To involve this lady, the timing of the focus group needed to be very flexible and was undertaken opportunistically when all participants were able to be involved. Such flexibility enabled a meaningful exchange of views within the focus group.

The hermeneutic circle

As discussed in Chapter Three a hermeneutic process was developed within each case study as well as across case study sites (Figure 3.2 on page 75). The purpose of this process was to share constructions from each stakeholder group to support the development of shared meanings. However it is the sharing of this information which presents real challenges in the protection of confidentiality and in some cases, anonymity. Many staff, older people and families within the study shared concrete examples which provided insights into their daily experiences. From these examples, I was able to derive more abstract terms to describe what was happening in a wider context. However, on occasion, sharing these abstract terms with participants I was required to provide concrete examples that could at times be traced back to a specific participant. When I felt there was no other way of doing this, I asked the participant involved if I could use the example offered.

The issue of confidentiality was also raised by the production of a report for use within each home at the end of the study. The use of anonymous quotation or restructuring quotations does not preclude others within the home from identification of the participants. When information was to be used in a public forum, each participant was individually asked if they were happy for the selected quotations to be

used. These quotations were also included in each participant's personal summary given out in advance of the main report.

This study suggests it may not be always possible to protect participants' anonymity within care homes research. Furthermore, there may be times when this is not desirable. Constructivist methodology seeks to share multiple perceptions between participants with the aim of creating a joint construction. This presents additional challenges to traditional notions of confidentiality and anonymity. It must be the responsibility of the researcher to undertake this aspect of the research openly and with sensitivity to local conditions so that long standing relationships within the home are not disrupted due to the research (Reed et al 2004b).

Reflections on the emergent design across the three case study sites

As constructivism is concerned with local conditions the need for flexibility across the three case study sites was reflected in the emergent design. While the principles underpinning data collection remained consistent across the three sites, how I collected the data varied and was represented in Figure 3.2(on page 75). The variations between sites are worthy of further discussion.

Case Study 1- The Beeches

From the outset of data collection, participant observation in this home was a combination of working alongside care workers and spending time with residents in communal areas. This enabled me to share my daily observations with staff and residents to develop shared meanings about the situations I was observing from the perspective of all involved. Participating in care routines supported me in

understanding how relationships between residents and staff developed. I then shared my developing understanding with staff and residents in more formal interviews providing an opportunity for them to discuss my understanding and their perspective. This contributed to developing a joint construction. Speaking with residents in communal areas provided the opportunity to ask them about daily issues that affected them. This provided me with further insights into how residents experienced relationships within this home, which I was then able to share with staff and families later in the study.

Many families lived some distance from the home and their visits were sometimes seen more as an event. This meant I had limited opportunities for informal discussions with families as the research progressed. While I was able to introduce the perspective of residents and staff into these interviews to develop a shared understanding, I was unable to share the perspective of the families with either the residents or staff outside of the main report.

Case Study 2- Holyoake

All residents in Holyoake had cognitive frailty with many having advanced dementia. As a result, families were more involved and this was reflected in their early involvement in the research process. In this home, families were among the first to be interviewed formally as well as being involved in informal conversations within the home. This alerted me to a range of issues for families that I explored in subsequent interviews with staff, supporting the hermeneutic process within this home.

I was involved more in 'hands on care' during the initial stages of participant observation as this enabled me to consider the role of care routines in developing relationships between residents and staff. Having spent time in the care routines I was able to discuss these with staff to determine how they understood the role of routines in developing relationships within the home. However, due to the pragmatic nature of the routines, my involvement moved to spending more time in the communal areas as the research progressed. It was within these areas I was able to observe the development of different types of relationships between residents, families and staff.

Case Study 3- Chestnut Lodge

Within this home, I found it much more difficult to engage staff and families in the research. In the context of research within care homes it has been noted that the manager is the key gatekeeper in gaining access to the environment although such access does not necessarily imply continued support from within the home (Reed et al 2004b). This was evidenced by the management team who were rarely available for meetings to discuss the process of the research, which has been identified as a passive blocking strategy (Reed et al 2004b). Furthermore, the degree to which staff are willing to be involved may not be known until there has been a period of observation (Normand et al 2003). On occasions, I had the impression that staff were uncomfortable as I observed them in the delivery of care. Consequently, the majority of my time here was spent in the communal areas of the home. This supported me in developing relationships with residents where I was able to observe how staff interacted with residents and families. How these relationships were developed

through the delivery of personal care was not illuminated as fully as in the previous homes.

The modifications of the research design between the three homes suggest the relevance of an emergent design that takes into account the local context of the study. However, such modifications also suggest limitations in the potential transferability of the findings, which will be discussed in the following section.

Assessing the authenticity of the research

Trustworthiness

Lincoln and Guba (1985) described the trustworthiness criteria as a way of making positivist approaches of rigour relevant to constructivist inquiries. This was considered briefly in Chapter Three and each of the elements of credibility, dependability, confirmability and transferability were considered at points throughout the current study. For example, a key feature of credibility is prolonged engagement and triangulation of data sources. Within each home, I visited at different times, on different days for periods between four and nine months. These visits included participant observation, informal conversations with residents, staff and families as well as more formal interviews and focus groups. I maintained a methodological log where I captured my decisions as the research design emerged to ensure dependability. I also returned to the participants within each home to check out my understandings of the situation with them to ensure that the product of the research captured all perspectives supporting confirmability. The opportunity for transferability has been presented to the reader through the thick description of each

case study site. However, each home had very different populations in terms of socio-economic groups and levels of physical / cognitive frailty. This raises the possibility that the three types of relationships and the approaches to care may have been an artefact of the homes and the residents within them. As all three approaches and relationships were seen within each home, this is unlikely to provide a complete explanation and further research is required in additional homes.

As discussed in Chapter Three, following the development of the trustworthiness criteria, Guba and Lincoln (1989) developed the authenticity criteria based on constructivist principles, to provide a relevant approach to assessing the quality of a constructivist inquiry. More recently, Nolan et al (2003) have relabelled the authenticity criteria to render them more accessible to research participants. With these modified terms in mind Table 3.4 (on page 63) was developed to identify relevant criteria for assessing quality at the outset of the study. Conduct of the research within each case study site was assessed for each of the elements of the 'EA' criteria (Nolan et al 2003). Therefore, I will discuss each aspect of the authenticity criteria using the nomenclature developed by Nolan et al (2003).

Equal Access

Guba and Lincoln (1989) suggested within their criterion of fairness that all groups should have the opportunity to participate from positions of equal power. However, within the care home environment, there is unlikely to be equal power between the stakeholder groups (Mitchell and Koch 1995). Within the current study, I attempted to ensure that the voices of all stakeholder groups in each care home were heard and extended a verbal and written invitation to participate to all residents, staff and

families within each home. People with hearing, sight, speech or cognitive impairment were also supported to take part if they wished to. This involved being very flexible in my research methods. For example, I was able to involve one resident with sight and hearing impairment in focus groups by keeping the group small and conducting them on days when she felt her hearing was at its optimum.

I used the hermeneutic process as a mechanism to provide all participants with the opportunity to discuss their contribution and comment on the presentation of their views. This was often achieved through informal conversations with residents, staff and families as I discussed different events in the home. I also provided participants with the opportunity to comment on at least one draft of the report where their views were represented. Residents who experienced cognitive impairment were shown key points I intended to include within the report in large print with an associated picture to act as a prompt. In Chestnut Lodge, I became involved with a small group of residents that usually met for reminiscence, so the residents felt comfortable with each other. I adopted a similar format to the reminiscence group, explaining what we were going to talk about and sharing the pictures amongst the group. This process encouraged each person to express their views on the points presented and meant I was able to share what had emerged as a joint construction in a way that was accessible to each resident.

Developing joint constructions in a fair manner is problematic as there may not always be consensus between the research participants. Where there was dissent this was identified in the final report for the readers to make their own judgement of the

views represented. One family member made the following comment to me after reading the final report:

> *'It's a very good report, very balanced. I wasn't expecting it really, I thought I might have to come to have my say here, but you've made it very balanced.'*

A member of staff made a similar comment:

> *'Well it's everyone's views, not just mine.'*

In addition to the final report, I also asked the views of residents and staff about the different approaches to care. Beneath each heading, I arranged examples of care routines shared with me in the respective homes and asked for their feedback on them. This was an attempt to enable everyone who had shared their views with me to have equal access in shaping the joint construction that was emerging within the homes. Not all participants were prepared to become involved in this process. In the Beeches, I was able to involve all staff who had participated as well as a focus group of three residents, all of whom provided further insights into how they felt about the different approaches to care. Unfortunately in Holyoake, only one member of staff saw commenting on this as relevant. This may have been attributed to the fact that many people worked to an individualised task centred approach and often did not see the need for a different approach. In Chestnut Lodge, a staff meeting was used as a vehicle to enable staff, to comment on the relevance of these approaches to their own experience. A small group of residents were also able to provide their views identifying the approaches as relevant to their experience.

Enhanced awareness of self

Nolan et al (2003) consider this aspect of quality as providing participants with new insights into their own situation, or the situation of the group to which they belong. Examples or cases that might cause participants to re-assess their experience as the same or different to others, may enhance their own awareness of the context in which they find themselves (Guba and Lincoln 1989). The interviews were conducted to encourage participants to think of what they did and what they considered to be significant in their daily experiences. Discussions with staff, for example, helped them to realise the significance of 'the everyday'. Many of the staff showed evidence of reflexivity in this process and could be described as being aware of the role they played in developing relationships. In this context, the purpose of the study was to recognise the everyday practice that largely went unrecognised. One member of staff for example, when asked about her contribution to the report, told me she was really happy with it, as it reflected what she did all the time. Another member of staff, when considering the different approaches to care, stated that she was trying to achieve relationship centred care but felt a lot of the time, she was only able to achieve resident centred care.

For residents, interviews and conversations provided opportunities to reflect on their lives, speaking of significant issues both in the past and present. For one resident this seemed to provide a renewed self-awareness as she identified that she had forgotten how interesting her life had been.

Enhanced awareness of others

This criterion is related to the increased understanding and respect for the other groups' values, beliefs and perspectives, not necessarily agreement with them (Guba and Lincoln 1989). Rodwell (1998) also believes there should be increased understanding and appreciation of what causes other groups to see or do things differently. The interview process supported an enhanced awareness of others as participants were encouraged to say how they felt their actions impacted on others. Staff were encouraged to comment on resident responses identified in field observations. This provided an opportunity to add their perception to the situation. Guba and Lincoln (1989) describe a process of negotiation that provides a publicly available account of whether or not this criterion has been achieved. However, within my research, negotiation between stakeholder groups to achieve consensus was not always possible. Therefore I used the circulation of the final report within each home as a focal point for discussion with residents, families and staff. I received a range of responses to this:

- One staff member, after reading the report, stated she was surprised to read about the type of activities families engaged in to keep their relationships special with the residents;
- One senior member of staff shared an observation with me, that if the report had revealed something she did not already know, then she wouldn't have been doing her job properly;
- A family member felt the report had confirmed to him what he thought already happened between staff and residents within the home.

- Residents' comments primarily focussed on the significance of their own experiences rather than the experience of others. This suggests that often the resident perspective captures the immediacy of their experience on the day. If the awareness of others is not relevant to that day, then it will not emerge within the research process.

These examples suggest it is not always easy to ascertain if all participants have developed an enhanced awareness of others through the research process. They do suggest that an enhanced awareness of others was raised for some participants.

Encourage Action

Guba and Lincoln (1989) first described this criterion in the context of developing a new model of evaluative research where there is a need for change as a result of the evaluation. Rodwell (1998) suggests that constructivist research creates knowledge for action. However, in a constructivist inquiry change may be secondary to the creation of joint accounts with the potential for change arising if these accounts encourage action by providing the impetus for change (Nolan et al 2003). Within my study, there was no explicit rationale for change. I did not see it as my role or as ethical conduct, to jeopardise what may be considered by all stakeholders as effective working relationships. If change was desired, it needed to emerge from the developed awareness of the participants involved in the research. In this sense, participants had the potential to produce new ideas within the ongoing hermeneutic process, acting on them where possible. One example of this was a Registered Nurse explaining how during the time of the research, she had changed how she approached her paperwork. At the outset of the research, it was evident that most of the paperwork was being

done in the office, with limited opportunities to interact with residents. This observation had been shared with this nurse, who then had found an alternative approach to her paperwork, which had resulted in the opportunity for social exchange with residents, contributing towards more personal relationships.

After the report was circulated within each home, I approached key participants and had informal discussions about what they felt could come from the research or how they might use the suggestions for improvement that had been included in the final report. These informal discussions could be described as one way of encouraging action. This approach reinforces the importance of the product of the research process being accessible to all stakeholders using ideas that are meaningful to them (Nolan et al 2003). The report to each home had the potential to be used as a vehicle to stimulate action as it included suggestions for change from participants.

Enable Action

Guba and Lincoln (1989), propose that involvement within the research should empower stakeholders to make changes. The question could then be asked, has the research been impoverishing or empowering for the participants and can they demonstrate they are better off for being part of the inquiry (Rodwell 1998). Nolan et al (2003) suggest that enabling action comes by providing the means to achieve or at least begin to achieve change. Within my study, the managers in each home described to me how they intended to use the suggestions made in the report at the next meeting of residents, relatives or staff. This suggests the potential for the research to influence others outside the immediate context of the study. The typologies of relationships and approaches to care have both been based on everyday

practice and interactions between residents, families and staff making them accessible to each of these groups. I intend to use a conference style event to disseminate these findings to residents, families and staff from care homes local to the study to highlight positive practice in the different approaches to care and explain how relationships are developed in this context. This may provide insights to encourage those working, living in, and visiting care homes to develop different ways of working with each other.

There is little guidance within the literature as to how the authenticity criteria can be achieved (Rodwell 1998) and the extent to which I am able to demonstrate this within the current study is perhaps limited. Within each home, only a small number of participants commented on the report in ways that demonstrated an enhanced awareness of self or others, or suggested that the research had encouraged action. The use of the grid developed by Nolan et al (2003), in the planning stage of the research alerted me to the opportunities of integrating the authenticity criteria into the research process in an accessible format (Table 3.5 on page 63). This supported me in utilizing all opportunities in conversation with residents, families and staff in evaluating the authenticity of the research as it appeared relevant to the respective participants. The use of the authenticity criteria to assess the quality of qualitative research is relatively new, and as such presents its own challenges in its application within the research process. Utilizing the EA criteria meant I was able to integrate the authenticity criteria in a way that was meaningful to both the participants and myself. As a relatively new methodology, it is important that researchers document their experiences, highlighting the challenges as well as the benefits of the different ways in which the authenticity criteria may be used.

Having reflected on the methodology, I will now discuss my findings in relation to other literature in the field, establishing how these findings can support the development of theory and practice.

Synthesis of findings with other literature

The original aim of this study was to explore relationships in care homes by describing the nature of relationships and developing an interpretive framework to understand how relationships influence the experience of residents, families and staff. The findings described three types of relationships in care homes, which appeared to directly influence the experiences of staff, residents and families (Table 4.3 on page 124). There was some evidence to suggest that these relationships were not mutually exclusive as some participants were observed to engage in different types of relationships. Further analysis presented in Chapter Five suggests that these relationships were often dynamic, influenced by the approach to care taken by the staff. These three approaches to care were also arranged as a typology (Table 5.1. on page 128)

Relationships emerged as an integral part of working, living and visiting a care home and were described by staff, residents and families in the context of everyday events. Relationships between residents and staff most commonly developed during the care routines within the home. Moreover, it was sometimes observed that different approaches to care may be adopted but it tended to be the dominant approach that most influenced the type of relationships able to be developed. While residents, families and staff actively participated in these relationships, it was more difficult for

residents and families to alter the relationships that existed if staff did not see the need for a different way of working. However, there was some evidence to suggest that other influences working in combination also supported or constrained the relationships that developed. These influences included leadership, team working and the contribution of residents and families (Table 6.1 on page 173). The following section of this chapter will discuss these relationships and the influences that supported or constrained them in relation to the wider literature.

Pragmatic Relationships

Pragmatic relationships focused upon the practical aspects of care giving and usually developed between staff and residents or staff and families when communication revolved primarily around care giving tasks. Maintaining a routine that focused on the routines of care, for some residents, families and staff meant that they were giving or receiving good care. Staff who developed pragmatic relationships described how they got to know the individual needs of each resident and used this information to get the job done, in a way that was individual to that resident. The pragmatic relationships that developed were then focused on how to gain the co-operation of the individual in the task and their knowledge of the resident was used to get the job done. This sometimes meant that staff used trial and error to make decisions or that residents were kept waiting without negotiation or explanation due to other priorities. It was generally the focus on what needed to be done rather than the significance of the task to that person that resulted in this situation. For some staff these were the only type of relationships developed, while other staff described these relationships as a starting point before they moved on to personal and responsive relationships. When involved in pragmatic relationships staff tended to accept contributions from residents

and families in a practical manner as they strove to get the job done. The key processes and influences which contributed to pragmatic relationships included: creating an individualised routine of care, the personal motivation of staff to do a good job and the dominant focus of making it a safe home.

Creating an individualised routine of care

Within the current study, new staff described how they became familiar with the routine of caring and used this time to get to know the residents as individuals. 'Routine' is a term often used in research and practice but with no consensual understanding (Zisberg et 2007), which has been used to describe a range of behaviours from rigid and maladaptive to a necessary part of functioning and stability in life (Bouisson and Swendsen 2003). In a recent concept analysis, Zisberg et al (2007) propose the definition of routine as:

> *'a concept pertaining to strategically designed behaviour patterns (conscious and subconscious) used to organise and co-ordinate activities along the axes of time, duration, social and physical contexts, sequence and order' (p.446).*

Across the care homes in my study, routines were described by many residents and their families as markers in the residents' day providing structure and organisation. When residents need to get up, when morning coffee is, when lunch will be served, when baths are given, when afternoon tea is served, when tea is provided and when people begin to go to bed all mark the rhythm of life within a care home (Green and Cooper 2000). It is thought that the need for structure and routine is in part

personality driven but may also reflect an individual's lifestyle or identity (Zisberg et al 2007).

Creating an individualised but practical routine of care was most evident in Holyoake where staff identified the value of being able to meet the complex needs of the residents through having a clear structure to the day. Routine has been described as a means of coping by allowing efficient allocation of resources and so can be a useful resource conservation strategy (both physical and mental) when there are limited resources available (Zisberg et al 2007). Indeed, having a structure to the day has been described elsewhere as enabling staff to focus more on the individual needs of residents (Haggstrom et al 2005). It was noticeable from the examples in the current study that the focus of individualising care routines remained on the practical nature of the care giving task. This suggested that staff developed practical knowledge derived from everyday events within the home that enabled them to see each resident as an individual who required care in a particular way.

Individualised care has a strong tradition in nursing as a means of humanising care and increasing job satisfaction of nurses (Reed 1992). This study would suggest that the importance of treating residents as individuals reflected in the National Minimum Care Standards (DH2001a) has been transferred into the individualised task centred approach to care. However, Reed (1992) also raised concerns about the need to prioritise workloads and patient needs as standing in the way of individualised care. In the current study, staff used the routines as a way of prioritising the workload, ensuring the work got done in a way that recognised residents as individuals. This reflected a pragmatic but individualised approach to care.

In care homes, getting to know the person has been identified as important in being able to individualise care (Evans 1996). A common way of describing the process of getting to know the resident was through trial and error. Staff who used this strategy described how it helped them make rational decisions with residents who had limited communication and was most noticeable in Holyoake. Corazzini et al (2004) describe a framework of decision making employed by Certified Nursing Assistants (CNA's) in the US that results in either rational or intuitive decisions. Rational decisions were seen to be based on the personal priorities of the CNA while intuitive decisions were characterised by subconscious processing of previous experience of what worked with similar residents (Corazzini et al 2004). The current study would suggest that the use of trial and error as a strategy enabled the care staff to develop individualised knowledge of the resident, which contributed to a store of knowledge of what worked for that resident, enabling them to move from rational to intuitive decisions on future occasions.

Many families and staff in Holyoake suggested that a focus on the practical nature of care was necessary to provide a structure that the residents could identify with as their cognitive abilities declined. However, the focus on the practical nature of getting the job done, tended to limit the opportunities for conversation and was observed most clearly in the focus of interactions between staff and residents in the early morning routines. Wadensten (2005) described how the content of morning time conversations, chosen by staff, created the climate for work that day. In Holyoake information shared between residents and staff in the early morning routines, tended to focus on gaining the co-operation of the resident, which enabled the staff to get the job done. A similar strategy was described by Gibb and O'Brien (1990) where

nurses' focus on the task, influenced the nature of their social interaction with the resident. DePoy and Archer (1992) found that limited personal interaction between staff and residents contributed towards functional relationships described as 'those in which the residents and staff interact within the domain of a care-giving function' (p.69). Furthermore, these authors contend that functional relationships also meant that assistance was provided with minimum effort and limited interaction. In my study, the focus on the practical nature of the care giving task also shaped the pragmatic relationships that developed. A major difference with my study was that even though staff remained focussed on getting the job done, they also recognised the practical contribution of the resident and families in helping the staff. This contribution was often used to individualise the care being given and interactions would encourage this level of involvement in an individualised task centred approach. This focus on the practical nature of care giving often stifled opportunities for social conversations, which contributed towards the development of primarily pragmatic relationships.

The families, residents and staff in my study all wanted good care, which was often described in terms of the residents' needs for personal hygiene and support with eating and drinking. This has been found in other studies (Rantz et al 1999) with Rantz and Zwygart-Stauffacher (2004) describing a quality institution as one where visible care such as ambulation and toileting is seen to be happening. Certainly in Holyoake, there were families and some residents who appeared to favour this pragmatic approach with difficulties arising when personal routines were not followed. Bowers et al (2001a) also describe how some residents focus on the technical aspects of care and judge the quality of the care in terms of their own

expectations of how care should be delivered. This suggests that to individualise routines in the way some residents and their families would like, may require a focus on the practical nature of caring.

Many residents across the three homes in my study used the care routines to provide information about themselves to staff. Those residents who were able, shared personal stories with staff, often using the task that was being undertaken as a starting point. Some residents used these stories to communicate to staff what was important to them. This information appeared to contain what was important to maintain their 'self' in light of changing physical and cognitive abilities although it was unclear if this was done consciously. These stories suggested that some residents were keen to develop more personal relationships with staff. There were residents and families who actively contributed towards care. When staff were focused on the practical nature of the caring tasks, these contributions were interpreted as helping them to get the job done. This continued to focus the relationships on the practical nature of the job to be done, further influencing the development of pragmatic relationships.

Personal motivation of staff- 'doing a good job'

Within the current study, some staff described a personal motivation of 'doing a good job' as the reason they were in care work. The sense of being able to do a good job has been described as enabling staff to retain a feeling of control over their work (Secrest et al 2005). 'Doing a good job' in my study involved undertaking the tasks of caring to the best of their abilities, which they believed had positive consequences for the residents. Anderson et al (2005b) contend that mental models are used to explain and predict events and suggest that CNA's use mental models that have been

successful in their personal lives and previous experience. 'Doing a good job' in this study could also be described as a mental model and was described as a personal philosophy by care workers, which gave them a sense of pride in 'a job well done'. Furthermore, Anderson et al (2005b) describe how these mental models support non professional staff in making sense of residents' behaviour and guide the decisions they make. The mental model of 'doing a good job' described by staff in this study involved individualising care in a way that enabled them to get the job done. This was markedly different from the 'mother wit' described by Anderson et al (2005b) where staff saw residents with child like tendencies requiring the staff to make decisions for them. The current study suggests a mental model described by staff, which supports decision making that respects the individuality of residents, while still being able to get the job done.

Staff who described their work in terms of 'doing a good job, also described a pragmatic approach to the relationships they developed. Boeje et al (1997) refer to this as a 'Martha' response based on the biblical character who focussed on the practicalities of Jesus' visit, rather than engaging with him on an emotional level. Boeje et al (1997) suggest that such a response is designed to provide emotional distance for the care worker. My study would also suggest that not all staff in care homes may wish to, or feel able to, engage in personal relationships with residents or their families. However, many of the staff who described their motivation as 'to do a good job' also spoke about individualising care and were praised by some families for their practical approach. This suggests there may be times when this approach is the right one for some residents and their families.

The dominant focus of making it a safe home

The dominant focus of making it a safe home appeared to influence the relationships that developed within Holyoake. Minimising risk tended to maintain the focus throughout the home on the practical nature of the care routines. There was a clear hierarchy of leadership here with the dominant focus influenced by the Manager. This style was described as leading from the front where staff knew what was expected and structured the individual routines around the risk management requirements for each resident. Managers' leadership in the interpretation of new policy or care regimes has been found to be a key factor in implementation (Jeong and Keatinge 2004, Swagerty et al 2005). For example, leading from the front provided a clear structure in what was required with a focus on the practical nature of what needed to be done. Anderson et al (2003) suggest that care home managers commonly use rules because the industry is highly regulated with a predominately semi-skilled workforce. They conclude that when rules exist, there is no need to talk to decide what action to take and everyone is encouraged to think and act in a similar manner (Anderson et al 2003). Within the current study, this contributed to a dominant individualised task centred approach to care which supported the development of primarily pragmatic relationships.

The teams in Holyoake were quite hierarchical with a clear demarcation of responsibilities. The focus on getting the work done, meant that senior care staff allocated work primarily by task. The manager felt that Registered Nurse's on the units should encourage a different approach and although she suggested this, the approach did not change. This could be due to the reliance on formal rules and procedures as the usual way of working across the home. Anderson and McDaniel

(1998) found that an over reliance on formal mechanisms gave Registered Nurses less influence in decision making than more informal mechanisms, which could account for the perpetuation of the dominant approach to care across the home. Furthermore, Anderson et al (2003) suggests this reliance on rules and enforcement may reduce positive relationships between staff, with team work being characterised by cliques. There was evidence at Holyoake that staff allocation was done according to those who were known to work well together, which could at times resemble cliques.

Relationships with families were also influenced by the dominant focus on the tasks of caring with many families describing how they made sure care was delivered. This is not unusual as Shield (2003) described relationships between staff and families in similar terms. Some families in Shield's study identified how seeing that care was delivered consistently enabled families to trust staff over time, which was also reflected by some families in Holyoake who suggested the care met their expectations. Alternatively, when the expectations of families were not met they spent much of their time making sure care was delivered similarly to families in the study by Sandberg et al (2001). My study would suggest that when this was the main activity of families, primarily pragmatic relationships with staff developed. The formal communications strategies between families and staff in Holyoake also seemed to perpetuate these pragmatic relationships as care workers were not allowed to give information about residents to families. This created an over riding focus on when things went wrong but many families felt that their concerns were being acted upon. Train et al (2005) found that it was important for families and residents to be able to relay concerns or suggestions to staff and feel they were acted upon. There was some evidence in the current study to suggest that for some families pragmatic relationships

were the relationship of choice. Shield (2003) concluded that task centred approaches in nursing homes work against the development of personal relationships between staff and families. However my study would suggest that even with a predominantly individualised task centred approach to care, there was also evidence of families developing personal relationships with staff when the staff recognised this as part of their role.

Personal and Responsive Relationships

Personal and responsive relationships developed through the sharing of personal information between residents, families and staff. These relationships were focussed on the well-being of the resident and existed primarily between residents and staff, although contributions could also be made by families. Personal and responsive relationships went beyond the practical nature of care giving to focus on the significance of the routine for that person. Residents and families often described the small but important details that went into their care. Staff who described personal and responsive relationships recognised the life the resident had led and who they were now, which often enabled them to take the right action at the right time for that person. For many residents, this responsiveness supported their well-being or alleviated distress. For personal and responsive relationships to develop, communication needed to involve social conversations between staff, residents and their families. For residents and staff, many of these social conversations occurred during the care routines. Gaugler and Ewan (2005) suggest that positive relationships between staff and residents influence relationships between staff and families. Social exchanges were also observed within the communal environment of the home involving residents, staff and families, which further contributed towards personal and

responsive relationships. The key processes and influences which contributed towards these relationships included: finding out what matters to the resident as a person, the personal motivation of staff to 'do unto others', consistent staff and the dominant focus of making it the resident's home.

Finding out what matters to the resident

The residents who were able to articulate what was significant to them described how they attempted to develop relationships with staff. This involved sharing personal information, which encouraged staff to see what mattered in their lives, both in general terms and on a day-to-day basis. For individual residents in all three homes, changing abilities or changing routines could have a dramatic impact on how they approached their day. Residents in the Beeches for example, described how they made choices about what was important to them on different days, communicating this to the staff. For example, when staff appeared busy, one resident would give them advance warning of her toileting needs on that day. Cook (2006) suggests that it may be difficult for residents with complex health care needs to always enact their choices or decisions independently, as they often need the support of staff. This might explain why relationships with staff have been described by residents as making the difference between positive or negative experiences (Grau et al 1995).

In order for personal and responsive relationships to develop, care workers needed to recognise what was important to each resident. Many staff in the Beeches and Chestnut Lodge used the care routines to develop knowledge about who individual residents were and what was important to them, incorporating these details into the care routines. Thorman Hartig (1998) described how expert Nursing Assistants

(NA's) encouraged residents to reminisce as a way of developing personal knowledge that could be used in personal care routines. This was described as individualising care through combining functional care activities with a resident centred care approach, which led to positive relationships (Thorman Hartig 1998). Staff who described a resident centred approach in my study implied a focus that moved beyond the instrumental notion of individualised care to understanding the implications of care for that person. Bowers et al (2001a) describe a similar level of personalisation as 'care as relating' where care workers' used their personal relationships developed in the care routines to attend to the little things residents found important. Jackson (1997) described a similar approach as 'emotional' care that was more personal and over and above what was described as 'routine caring'. Thorman Hartig (1998) also describes expert NA's buying gifts or doing 'little things' for the residents that demonstrated personal relationships. In my study, when staff developed care routines that took into account what mattered to the resident, residents and families were encouraged to take an active role in the sharing of stories about their lives supporting the development of personal and responsive relationships. This contributed towards staff developing an understanding of what had been important in someone's life and how such knowledge could be used to inform their care. Residents who experienced attention to these significant details also described personal relationships with these members of staff framed in terms of friendship, love and caring.

Developing a more resident centred approach to care, suggested that staff began to understand the significance of personal care routines to the resident as a person. Zisberg et al (2007) suggest that personal routines may comprise an individuals' world, lifestyle or identity and that maintaining personal routines at a time of major

life change is a challenge for nursing that could have positive benefits for people requiring care. Understanding what is important for a person in their care has been described in the literature as being 'person centred', a term that has been used to identify an approach that values people as individuals (Coyle and Williams 2001). Resident centred care, in my study, moved the focus from the task towards valuing what was important to the resident as a person. When staff worked in this way, some residents described how they felt encouraged to make a contribution towards their care according to their abilities. Bowers et al (2001a) describe this as a feature of 'care as relating' where residents found ways to help the staff.

Staff who developed personal and responsive relationships with residents also demonstrated awareness of situations that held significance for a resident and responded in ways that affirmed the experience for that person. Kitwood (1997) termed this validation, a response that accepted the power of an experience for an individual. Staff who did this in my study seemed to be looking beyond the immediate needs of each resident to how a changed situation might impact on them. On these occasions, these members of staff responded in a timely action to promote the well-being of the resident. However for personal and responsive relationships to develop there needed to be consistent staff.

Consistent staff

Both resident and families commented on the value of regular staff so they could get to know the important details in the care of the residents. Burgio et al (2004) found that consistent staff assignment had positive effects on residents, and relationships

have been found to be enhanced for residents and families if caregivers are reliable, empathic and consistent in their approach (Sandberg 2002, McGilton et al 2003). Residents and families in my study described how they developed confidence in staff members who did what they said they would do. When staffing was consistent, residents and families felt they could rely on staff to work in this way. Developing confidence in staff was generally based on their past experience and contributed towards the development of trusting relationships. Hertzberg et al (2003) suggest that trust develops over time but can be interrupted by increased staff turnover when staff leave the home.

In the current study, there were periods of inconsistency in staffing in both Holyoake and the Beeches. In Holyoake, there was a practice of rotating staff, both to cover sickness and as a means of staff development, which was felt by families in particular to disrupt relationships that had been developed between staff and residents. Bowers et al (2003) described how nursing assistants felt that good quality care, meant good relationships that were built up over time but also felt that the decision to rotate staff meant their commitment to residents in this way, was neither understood nor valued. (Bowers et al 2003).

Patmore and McNulty (2005) in a review of home care services found that person centred care was based on relationships between care providers and those they cared for. In this report, consistent staff who knew the aspirations of the person they cared for and became motivated to fulfil these aspirations were able to provide person centred care in ways that often required little extra time (Patmore and McNulty 2005). In care homes Flesner and Rantz (2004) suggest that giving direct care staff the

authority to make decisions about how to spend their time enables them to support residents in meeting life preferences and goals. However, there have been few studies that explicate how consistent staffing may influence the type of relationships able to be developed in care homes.

Personal motivation of staff- 'do unto others'

The personal motivation described by staff in this study appeared to be a key influence in how staff made their decisions. Staff who were motivated by a 'do unto others' philosophy described themselves as being interested in the resident, providing care in a way they would like for themselves or a close family member. Anderson et al (2005b) describes a similar mental model held by nursing assistants as 'the golden rule', where decisions would be made according to the way they would like it to be done but did not always take account of the resident's values. Anderson et al (2005b) suggests that although these mental models have potential benefits for residents, they could also lead to inappropriate actions due to the lack of communication between professional and non-professional staff. This was very different to the staff in my study who described how they would find out what mattered to each resident as this was how they would like care delivered for themselves or a close family member. For this to occur, staff needed to understand what each resident valued.

In the home, where this approach was most prominent, there was also regular and informal communication between families, residents and staff, where the values and knowledge of all were assimilated in the everyday interactions. This could account for why for these members of staff, 'do unto others' meant 'as the resident wanted it'. Staff recognising the values of those they care for has been described as a prerequisite

for a therapeutic relationship to develop (McCormack 2003). The staff who subscribed to a 'do unto others' approach appeared to move their focus of care from the individualising of the task of care to performing care in a way that valued each resident as a person leading to personal and responsive relationships.

Many staff who held the personal philosophy of 'do unto others' also believed this approach made a difference to the lives of the residents and was the reason they chose to be in care work. These members of staff often discussed what residents had done with their lives prior to moving to the care home suggesting respect for the resident's previous life. Older people have described demonstrating respect as being treated as an individual with a unique history and identity (Bayer et al 2005). Smith (2005) found that residents described respect as being given choices and being treated with dignity, which reflected how routines were enacted in resident centred care. Staff who often demonstrated this respect also described a resident centred approach to their care.

The dominant focus of making it the resident's home

The dominant focus of making it the resident's home appeared to influence the personal and responsive relationships that developed between residents, families and staff. Unlike Holyoake, in Chestnut Lodge there was limited evidence of a specific style of leadership with Registered Nurses describing a more 'behind the scenes' approach. This approach to leadership was reflected in discussions with other staff who suggested they understood the importance of personalising care routines for individual residents. A key feature of Chestnut Lodge was the informal and frequent interactions that occurred between staff over the course of the day. Anderson et al

(2004) suggest that informal interaction patterns suggest a process known as self organisation. Self organisation is where workers are able to respond flexibly to a situation and does not necessarily require a specific management or organisational process but is influenced by the willingness of staff to develop relationships that support the flow of information (Anderson et al 2004). The current study would suggest that increasing the pattern of communication to include residents and families as part of the information network in care homes, encourages the development of a dominant resident centred focus supporting personal and responsive relationships.

Building personal and responsive relationships with families was also evident in Chestnut Lodge with many families feeling content that the right care was being delivered to their relative. The families I spoke to felt the staff understood their relative as a person and so were able to give personalised care. Shield (2003) suggested that families often watched staff with other residents which enabled them to trust staff that the right care was being delivered when they were not there. Having a critical mass of staff with a similar personal philosophy facilitated informal and personal interactions between residents, families and staff throughout the day. Davies (2003) found that residents choosing to stay in a central communal area facilitated interaction between residents, visitors and staff. In the current study, many staff were often observed to share personal anecdotes about the residents with families in the communal areas over the course of the day. This led to many informal exchanges building personal and responsive relationships.

This study suggests that resident centred care routines influenced the development of personal and responsive relationships but there were examples in Chestnut Lodge

where staff were unable to maintain the personal care routines for every resident, all of the time. On these occasions, some residents in the current study described a poor experience of that day. This could be described as the personal routine colliding with the organisational routine (Zisberg et al 2007). Furthermore this exclusive focus on the resident as person did not always support the recognition of the needs of others within the community, which suggests the values of extending the notion of person centred care (Nolan et al 2006). Therefore, this would suggest there may be occasions when it might be preferable to move from a dominant focus on this as the resident's home to the idea of the home as a community as proposed by Davies (2003).

Reciprocal Relationships

Reciprocal relationships signified a move towards understanding the communal nature of living, working and visiting in a care home. These relationships moved beyond the single focus on the resident as a person to recognise the needs of families and staff as people within the relationship. Recognising the needs of others in this way, often supported the development of shared understandings between the resident, the family or staff as they saw themselves and others as part of a community. Reciprocal relationships were ones where staff, residents and families recognised and valued the contribution of others. Care routines were seen to be organised to meet the needs of all residents creating a communal routine where everyone felt they had a place. On days where care might not be going as planned there was often a form of give and take within these relationships where residents were able to show their understanding of the wider context of the situation. Staff recognising and valuing this contribution became part of the reciprocity that developed. Staff who developed reciprocal relationships often created opportunities for reciprocal exchange outside the care

routines. Similar exchanges were then initiated by residents or families with staff recognising the value of such contributions. Residents and families also described how they contributed to the life of the home which was valued by other residents and staff. Influences and processes that supported the development of reciprocal relationships included: recognising everyone in the relationship, valuing each other's contribution, developing shared understandings and the dominant focus of 'making it our home'.

Recognising everyone in the relationship

Reciprocal relationships were characterised by a recognition that the experience of staff, residents and families all needed to be taken into account. This was different to the previous relationships in the typology, which appeared to favour either the staff experience (pragmatic relationships) or focus on the needs of each resident as a person (personal and responsive relationships). Reciprocal relationships developed when staff, residents and families were able to see themselves in relationship to others (people in the relationship or wider community) and understand how they or the physical and social environment may have affected others. For example, in Holyoake some staff spoke about residents and families understanding the pressures they as staff faced, and some families described how they felt the staff recognised what it was like for them.

As with both pragmatic and personal and responsive relationships, reciprocal relationships were also observed to develop through personal care routines. Ronch (2004) suggests that reframing the emphasis from the task of care onto the relationships between residents and staff has the potential to benefit those in the

relationship. This was apparent between residents and staff at the Beeches who often spoke about their relationship in terms of the care being provided and what each participant brought to the relationship. One resident for example recounted how she would remove her jewellery to help the staff get her ready for bed while another resident waited to go the toilet to enable her friend to be brought downstairs. Staff at the Beeches spoke about how each resident's needs were being met in relation to other residents and the needs of staff. This resulted in a flexible and responsive way of working that was observed by most, if not all of the staff on duty that could be equated with self organisation (Anderson et al 2005a). Self organisation has been described as a process where people mutually adjust their behaviour to meet the demands of a changing environment (Cilliers 1998), and this was evident to some extent in Chestnut Lodge. Self organisation in the Beeches however, seemed to result in a more co-ordinated response across the home ensuring all residents' needs were being met. McDaniel and Driebe (2001) suggest that people self organise to create new behaviours to meet the demands of the relationships they have with each other and their environment.

A key difference in behaviour in the Beeches was the regular and informal interaction between staff where there was a sense of senior staff leading by example. Relationship oriented leadership (Anderson et al 2003) has been described as fostering interconnections and enhancing the information flow needed for self organisation, which could account for this key difference between the homes. Anderson et al (2005a) suggest that diverse interactions produce a better understanding of a situation. In the case of the Beeches, this diversity included professional and non-professional staff as well as the involvement of residents and families, ensuring that the

information shared, included all perspectives. While the staff were observed to deliver care in a resident centred way, they were also anticipating what was required in the wider context of the home, foreseeing issues with other residents, staff or families that might prevent resident centred care. This was then communicated to each other, the residents and if necessary the family. Effective communication has been described as open, timely and accurate (Anderson et al 2004), and this was evident at the Beeches. Anderson et al (2005a) suggest that organisations should recognise the importance of the nature and quality of relationships between staff although my study would suggest that this should be extended to include the nature and quality of relationships between staff, residents and families.

Within the current study, staff who developed reciprocal relationships with residents were also adept at recognising the needs of family members. Staff members shared examples of everyday interactions with families, revealing how they understood the changing perspective of each family member and how they accommodated this into the decisions they made. Davies and Nolan (2004) found that, as families and staff interacted more regularly, they developed a respect and appreciation for each other's contribution signalling a move towards 'working together.' Brereton (2005) found that family caregivers were more likely to trust staff when they felt their needs were also taken into consideration. In my study the reciprocal nature of these relationships developed as families recognised that their contribution was valued.

Valuing each other's contribution

The nature of reciprocal action suggests that all involved in the relationship need to be aware of the meaning within the action (Kitwood 1997). A feature of reciprocal

action, observed primarily at the Beeches was that the contribution of the other person was valued within the relationship. Grasser (1996) discusses the importance of staff recognising the reciprocal intention by residents in their communication providing opportunities for reciprocal behaviour within the relationship. Opportunities for social exchange between residents, staff and families in communal areas were a common example. Humour has been described as a way that residents can express their individuality (Burgener et al 1993). Staff also appreciate the opportunities to laugh and joke with residents and other staff (Astedt-Kurki and Isola 2001, Haggstrom et al 2004). At the Beeches, humour played a key role in the development of reciprocal relationships as staff recognised and valued the contribution made by residents and families in either the initiation of, or response to humorous situations. Reciprocal relationships were also developed as families initiated social exchanges with staff through the course of their visit, giving the families a sense of feeling welcome and part of the home.

While some families came to visit their relative 'in their home', there were other families who recognised the communal nature of living in the home and made contributions to the experience of other residents and staff. A common example was families helping out with the tea trolley when they could see staff were busy. For the contribution of families to be valued, staff needed to be aware of the contribution and its intention. What became apparent within my study was the appreciation by staff of the reciprocal intention of these families. Some families also made a contribution that was intended to benefit other residents as well as their relative, describing the recognition they received from residents other than their relative in affirming the

value of their contribution. This suggested that a shared understanding of these situations was developing

Developing shared understandings

Reciprocal relationships appeared to develop when residents, staff and families described shared understandings of their situation. In my study, shared understandings appeared to emerge through a process of negotiation and compromise. Slettebo and Haugen Bunch (2004) found that Registered Nurses engaged in a range of strategies including negotiation and explanation when struggling with the issues of meeting residents needs in their day to day work. In my study, when care might not able to be delivered in the usual way at the Beeches, there was usually discussion between professional and non-professional staff, between staff and residents and on occasions families. Ronch (2004) described this process as improvisation, which involves residents, staff and families in creative ways of problems solving. This suggests the complexity of decisions often made by non-professional staff (Anderson et al 2005a). Staff who worked in this way described how they 'weighed up' the needs of each resident, the needs of the staff and the needs of the family according to the situation. Haggstrom et al (2005) described how staff felt stimulated when they needed to think of new ideas or solutions in their practice. The reciprocal relationships in my study suggests a process that enabled all perspectives within a situation to be considered, which implies staff, residents and families working in partnership to achieve shared goals.

Staff who described reciprocal relationships were also conscious of the needs of other members of staff, which could result in negotiation between them to ensure the person

with the right skills and approach for each resident had been allocated to that person. Jeong and Keatinge (2004) suggest that shared cultural values were a key aspect of promoting a collaborative team approach. Furthermore, shared values have been described as an integrating force enabling team members to work towards common goals (Haggstrom et al 2005, Swagerty et al 2005). In my study, shared understandings between staff were often communicated through stories or anecdotes. Ronch (2004) describes narration or telling stories as a powerful tool in communicating the values within a home. In my study stories were also shared by residents and families contributing towards a shared understanding that emerged over time as residents and family members appreciated the demands made on staff by the communal nature of the care home. Many of these residents and families also described an appreciation of how the decisions made by staff might also influence other residents, families and staff within the relationship.

The dominant focus of making it 'our' home

In the Beeches flexible and responsive working patterns that supported a communal routine with informal and responsive patterns of communication and leadership from all levels of the organisation were often observed. This process has been referred to as self organisation which is a property of all social systems that occurs whether or not it is recognised (Anderson et al 2003). Anderson et al (2003) suggest if it is recognised, then it can be influenced to improve resident outcomes. It has been suggested that the nature and quality of relationships between staff is integral to self organisation (Anderson et al 2004). From my study, the concept of self organisation could be extended to include relationships with residents and families as part of the interconnections throughout the home, expanding the diversity of interactions and so

helping staff to understand the situation taking all perspectives into account. In this way, self organisation between staff, residents and families could explain how care homes might work as communities to meet the needs of all within them.

Davies (2003) proposes care homes as communities where the type of community suggests the organisational values and the relationships that develop between residents, families and staff. Within my study, the recognition that a care home could be home to a community of people was reflected in how staff in the Beeches arranged care routines to meet the needs of each of the residents in the context of other residents. In one organisation staff described how everyone was willing to go beyond their usual duties to get the care right for the residents, doing 'whatever it takes' (Swagerty et al 2005). In my study, the relationships that developed between residents, families and staff also provided residents and families with opportunities where they could support staff, and other residents within the home. It was through these reciprocal relationships that shared decision making could occur. A 'complete community' has been described as one where everyone's contribution is valued and residents, families and staff all have a part to play (Davies 2003). For example, in the Beeches, staff and residents were observed to regularly contribute to decisions as they shared information with each other throughout the course of the day. This has been described as participatory decision making, which supports people in an organisation in considering a broader range of strategies which may make it more adaptive (Ashmos et al 2002). This was observed on occasions in Chestnut Lodge where staff negotiated with each other and residents to ensure that the right person was delivering care in the right way for the resident and the staff, taking into account the influence of this situation on other residents.

At the heart of community lies the understanding of relationships in care homes (Davis 2000, Davies and Brown Wilson 2007). This thesis adds to this body of literature by describing how relationships are enacted within care homes and how they influence the experience of residents, families and staff. The specific examples from everyday occurrences described in this thesis suggest how contributions from residents and families may support the development of a sense of community. Furthermore, it has been recognised that care homes develop a distinctive 'culture, which creates and shapes the experiences of residents, families and staff (Anderson et al 2003, Davies 2003, Rowles and High 2003). Wilkerson and McDonell (2003) draw on the anthropological literature to suggest that culture involves shared meanings, beliefs and activities which become the norm for that group of people. Davies (2001a, 2003) suggests that culture within care homes is influenced by relationships between staff, residents and families as well as organisational and environmental factors. Cultures, within institutions such as care homes, have been described as the operating systems the institution develops to perpetuate itself:

> *'The traditional culture of nursing home care then communicates what it values and how it ascribes meaning to the various aspects of residents' lives. The 'culture' accomplishes this through the ways it is organised and staffed.'* (Ronch 2004 p.69)

How care is organised has been found to be a contributing factor to the culture that develops (Boyd 2003). Furthermore, this thesis adds to our understanding of how issues such as the organisation of the care routines and consistent staffing within care homes influence the approach to care that staff adopt and the relationships developed

with residents and families. I propose that understanding how these factors influence relationships is the first step towards promoting a positive culture and improving the experience of residents, families and staff.

Developing Frameworks for practice

Transforming findings from research into clear messages for staff, residents and families is necessary if we are to influence experiences within care homes. How relationships are developed, is often difficult to articulate and placing this into an everyday context is the first step in making the findings from this study accessible. This has been achieved in the preceding chapters. The intention of this section is to consider how the findings of this study might contribute to current frameworks for practice. In particular, I will aim to demonstrate how an understanding of relationships in care homes can support the development of person centred practice and relationship centred care.

Person centred practice

Relationships in caring for older people have been identified as central to positive care experiences (Brooker 2004; McCormack 2004, Dewing 2004). However, it is not always clear how enabling relationships are developed (Dewing 2004). My study suggests that enabling relationships begin to develop through the sharing of personal information between residents, families and staff. This may occur as part of the care routines but also extends into social conversations between residents, families and staff in the communal areas of the home. Individual staff members may use these opportunities to find out what matters to residents and transfer important details for

that person, into their care routines. This approach supported the development of personal and responsive relationships (see figure 5.2 on page 149).

Brooker (2004) suggests that developing person centred care for people with dementia, requires valuing the person and those who care for them, looking at the world from the person's perspective and promoting a positive social environment that supports the well-being of the person. These principles have also been identified as having relevance to all older people in care homes (Ashburner 2004) although my study would suggest that these principles also need to include the resident and family contribution, which is reflected in the resident centred approach to care (Table 7.1).

Table 7.1 Summary of resident centred care

Role of staff	**Contribution of residents**	**Contribution of families**
Respecting the person and valuing their sense of identity	Communicating choices in daily care routines	Observing staff responding to other residents
Understanding the significance of the biography to that person in their current place- Finding out what matters	Telling stories about their life during care routines	Communicating to staff things that matter to the resident through stories and anecdotes
Transferring 'personal' knowledge to specific actions in care routines- attention to significant details	Resident contributing towards what is important for them in their daily experience	Providing little things that help the staff in attending to significant details
Responding to small signals to promote resident well-being	Recognition of staff on a personal level	Recognition of the personal relationship staff have with the resident
Understanding the resident's behaviour in the context of their changing abilities/ needs	Demonstrating personal responsiveness	Recognition of the staff knowledge of the resident's changing needs

In a review of the nursing literature, McCormack (2004) described key themes within models of person centred practice as: knowing the person; the importance of values; biography; relationships, and seeing beyond the immediate needs.

My study would suggest how these themes can be applied in everyday practice. For example, as staff engaged with residents through care routines, they shared information which contributed towards knowing the person and understanding their biography. When staff described their values of respect for the resident as a person they listened to the stories people told and used these to improve the experience of the resident in ways that were meaningful to them. This supported the development of personal and responsive relationships, which enabled staff to see beyond the immediate needs of residents. Previously, models of person centred practice have been criticised for lack of guidance in how these principles are transferred into everyday care (Dewing 2004). In Long Term Care, it is often non-professional staff who provide direct care to residents, usually without the benefits of a professionally developed model of practice. Examples from everyday care routines described by staff, residents and families revealed how the principles of person centred practice could be embedded in the daily care routines of care homes (see Chapter 5 for examples). The resident centred approach to care (Table 7.1) provides accessible guidance to non-professional as well as professional staff in how to incorporate the principles of person centred care into everyday care routines. This would enable staff to see person centred care as part of their everyday care rather than doing anything 'extra', which has been considered an issue in the implementation of person centred practice (McCormack 2004).

Resident centred care, as with person centred practice, focuses on the individual resident as a person. However, this thesis has identified that within a care home, the

experience of others visiting and working within the home is also important for positive relationships within care homes to develop. Furthermore, the communal nature of living in a care home means that not all residents will be able to experience resident centred care, which suggests a limitation for current conceptualisations of person centred practice.

In a community, there may be times when the focus needs to extend beyond an individual resident to consider everyone in the home, in relation to each other. For example, making decisions in the interests of one person may, through the communal nature of living, have an impact on other individuals within the community. While there is a need to nurture respect of the 'personhood' of older people, there also needs to be respect for the 'personhood' of staff and families. By their very nature, care homes are communities based around a collection of individuals for whom we are all trying to adopt a person centred approach. Therefore, each person centred approach needs to be seen in the context of others. Within this study there were tentative suggestions that staff moved between different approaches to care dependant upon their motivation and the contribution of residents and families. This suggests that the approaches of care could be considered as points along a continuum although further work is required to explore this aspect further. Nolan et al (2006) present a cogent argument for expanding the context of person centred care to enable the development of effective care environments for older people. While person centred practice remains a relevant concept for older people in care homes the communal nature of care delivery also suggests the need to extend the model of person centred practice to consider all the relationships within care homes.

Relationship centred care

Reciprocal relationships within my study were often based on shared understandings of a situation that emerged from the recognition and valuing of all contributions to the relationship. The practical outworking of these relationships involved negotiation that took into account the needs of everyone involved, as well as the context of the wider community. Each person also recognised that they were able to make a contribution to the wider community of the home. This suggested interdependence between resident, families, staff and the wider community of the care home. Nolan et al (2004) suggest that interdependence, rather than independence is an appropriate goal when caring for frail older people, although opportunities for reciprocity may diminish with deterioration of a person's ability. Reciprocal relationships were often described by staff, residents and families using examples from personal care or communal routines and were also observed in social exchanges throughout the home. The range of reciprocal exchange within my study suggests that even those who are very frail may still be able to enter into reciprocal relationships should they choose. Furthermore, residents and families appeared to be encouraged to enter into reciprocal relationships when staff adopted a relationship centred approach to care (Table 7.2).

Nolan et al (2004) suggest that therapeutic nursing is dependant upon a network of relationships that involves others in the wider community and moves beyond the focus on the individual and their needs (Kitwood 1997) or the nurse -patient relationship (McCormack 2001).

Table 7.2 Summary of relationship centred care

Staff role	Contribution of residents	Contribution of families
Anticipation of individual residents needs in the context of the needs of other residents and organisational demands or constraints	Seeing themselves as part of a wider community with other residents	Seeing themselves as part of the wider community
Valuing the contribution of other staff, residents and families Reflexive recognition of own contribution	Valuing the contribution of staff, families and other residents	Valuing the contribution of others- staff, families and other residents
Negotiation – valuing all perspectives	Being prepared to give and take	Negotiation – valuing all perspectives
Recognising reciprocal action as valuable	Initiating and engaging in social exchange	Finding ways to make a valuable contribution to the life of the home
Developing knowledge of how each individual influences the communal environment leading to shared understandings with others	Developing shared understandings of other residents, staff and family members all having needs	Developing shared understandings of other residents, staff and family members all having needs

Using the principles of person-hood and valuing interdependence, Nolan et al (2006) propose the Senses Framework (Table 2.4 on page 41) alongside relationship centred care as an appropriate philosophy to underpin future developments for the care of older people:

> *'the Senses Framework captures the important dimensions of interdependent relationships necessary to create and sustain an enriched environment of care in which all participants are acknowledged and addressed. This lies at the heart of our vision of relationship centred care and illustrates the delicate interactions necessary to achieve truly collaborative care.'*
>
> (Nolan et al 2006 p.124)

The Senses Framework has been developed to encompass the views of older people, staff and family caregivers in different care environments (Nolan et al 2006). It has

been acknowledged that different contexts would create the 'Senses' for people in different ways (Nolan et al 2001) but would contribute towards an enriched environment where positive relationships may develop (Nolan et al 2002). Starting with the care routines is essential if staff are to be encouraged to move beyond an individualised task centred approach to care to resident centred or relationship centred care. I suggest the current study provides an example of how the Senses can be created within care homes through the delivery of resident centred and relationship centred care supporting the development of reciprocal relationships (Table 7.3).

Table 7.3 The Six Senses in the context of caring relationships (adapted from Nolan et al 2006)

The Senses	Resident centred care	Relationship centred care
A Sense of Security For older people: attention to physiological and psychological needs. To receive competent and sensitive care	Being seen as a person	Involved in negotiation and compromise when care can't be delivered as expected
For staff: to feel free from physical threat, rebuke or censure, to have emotional demands of the job recognised and feel supported	Recognition by the resident	Feeling contribution is valued by residents families and other staff
For family carers: to feel confident in knowledge and ability to provide good care. To be able to relinquish care when appropriate	Sharing personal information about the residents and possibly themselves	Feeling their knowledge is being used in the care of their relative
A Sense of Continuity For older people: recognition and value of personal biography; skilful use of knowledge to contextualise present and future; consistent care delivered within an established relationships by known people	Communicating what matters to the staff who then attend to significant details	Involved in negotiation and compromise when care can't be delivered as expected- being prepared to give and take
For staff: positive experience of work with older people, exposure to good role models, expectations of care communicated clearly and consistently	Using informal sharing of stories and anecdotes between staff and with families and residents to find out what matters and then using this in the care routines of the resident	Leading by example, flexible working patterns
For family care givers: to maintain shared pleasure/ pursuits with car recipients, to maintain involvement in care as desired/ appropriate	Keeping it special	Making a valued contribution
Sense of Belonging For older people: opportunities to maintain or form meaningful and reciprocal relationships to feel part of a community as desired	Developing personal and responsive relationships with staff	Feeling their stories are valued and making a contribution to their care; developing relationships with other residents

The Senses	Resident centred care	Relationship centred care
For staff: to feel part of a team with a recognised and valued contribution	Working with other staff who value the resident as a person	Flexible approach to care being able to negotiate with other staff
For family care givers: to be able to maintain / improve valued relationships, to be able to confide in trusted individuals	Keeping it special Developing relationships with staff	Being seen as an individual within the relationship with personal concerns and worries
Sense of Purpose For older people: opportunities to engage in purposeful activity, facilitating the constructive passage of time	Being involved in activities that hold significance Developing goals/ aspirations	Having relationships with other residents that enable you to pass the time. Staff facilitating these relationships
For staff: to have a clear set of gaols	Personalising the care of each resident using a 'do unto others' philosophy	The development of a shared understanding of how residents, families and staff fit into the community
For family care givers: to maintain the dignity, integrity and well being of the care recipient, to pursue reciprocal care	Sharing personal information with staff, including staff in visits	For this to be part of the shared understanding
Sense of Achievement For older people: opportunities to meet meaningful and valued goals, to make a recognised and valued contribution	Staff finding out what matters and using this information to create opportunities for meaningful activity	For their contribution to social exchange to be recognised and valued by other residents, families and staff
For staff: to be able to provide good care: to feel satisfied with one's efforts	Achieving the little details of care for each resident	Anticipating residents' needs in the context of all residents – being in the right place at the right time
For family care givers: to feel you have done your best, to develop new skills and abilities	Contribute to care of resident in ways they are comfortable with	Making a contribution to the life of the home and feeling it is valued
Sense of Significance For older people: to feel recognised and valued as a person of worth, to feel that you matter	Time taken to attend to the details, knowing when something has changed	Contributions are being valued by staff, residents and families
For staff: to feel that your work and efforts matter	Residents responding positively	
For family care givers: to feel that ones efforts are valued and appreciated	Staff having time to talk	

Relationship centred care emerged from the Pew Fetzer Task force on how to develop the education of community medical practitioners and advocated that relationships were at the heart of any therapeutic activity (Tressolini et al 1994). They suggested an alternative training programme that addressed values, knowledge and skills that medical practitioners required to achieve relationship centred care. Nolan et al (2006) noted from this report that further work was needed to explicate the dimensions of relationship centred care. I would suggest my study goes some way to progress our understanding of how relationship centred care might be operationalised within care homes for older people.

Tressolini et al (1994) identify three key relationships between the health care practitioner and: the patient, the community and other practitioners with the areas of knowledge, skills and values necessary to create relationship centred care (see Appendix 1). This resulted in a practitioner focused model to support the education of health care practitioners. There appear some differences between my study and the Tressolini et al (1994) model such as in the areas of knowledge and skills but there are also many similarities between the skills and values required in relationship centred care. However, a major limitation in using this model would be the lack of recognition of the contribution made by the residents and families within my study. Using a framework based on Tressolini et al (1994) I have applied the findings from my study to further develop our understanding of how relationship centred care could be created when the care home is seen as the community (Table 7.4). For ease of reference, I have highlighted major developments with blue shading.

Table 7.4 Developing the dimensions of relationship centred care ('adapted from' Tressolini et al 1994, with my additions in bold)

AREA	KNOWLEDGE OF STAFF	SKILLS OF STAFF	VALUES OF STAFF	CONTRIBUTION OF RESIDENTS AND FAMILIES
Self Awareness	Knowledge of self Knowledge of self as a resource to others	Reflect on self and contribution to work	**Recognising what I bring to the relationship that is unique to me**	**Recognising what they bring to the relationship that is unique to others' contribution**
Resident experience of living in the care home	**Knowledge of the person and what is important to them**	**Recognising the residents life story and its meaning** **Attending to significant details in their care routines**	**Do unto others** **Valuing the contribution of residents**	**Sharing stories about their life and what is important to the resident and family**
Family experience of visiting the care home	**Personal knowledge about the family member and what is important to them in their visit**	**Recognising the contribution of families and what it means for them, making them feel welcomed and involved**	**Do unto others** **Valuing the contribution of families**	**Finding ways of giving something back in a way that is valued by staff, other residents or families**
Staff experience of working in the care home	**Knowledge of all residents needs** **Knowledge of organisation**	**Negotiation and explanation**	**Willingness to see the other perspectives in the relationship**	**Providing positive reinforcement that their contribution is valued, understanding when things change, engaging in negotiation**
Developing and maintaining caring relationships	Understanding the potential for conflict and abuse	**Attend to the changing needs of residents and families**	Respect for resident's dignity, uniqueness and integrity **and the values of**	**Showing respect for staff and an interest in their welfare,** understanding

	Understanding when residents **or families** may feel disempowered **Understanding the need of residents for social relationships with others**	Accept and respond to distress in resident, self and family Respond to moral and ethical challenges	**the family** Respect for self determination of resident **Respect for families' needs**	when staff may feel disempowered, **sharing personal information, developing relationships with other residents**
Effective communication	**Knowledge of how to communicate in ways appropriate to resident, families and other staff**	Listen **and share information, learn from residents, families and other staff,** promote and accept the emotions of others	Being open and non judgemental **Valuing social exchange with residents and families**	**Initiating and being involved in social exchange , showing staff they understand the pressure staff may feel**
Traditions of knowledge **between staff, residents and families**	**Understanding how the dominant focus in the home influences the contribution of residents and families**	**Accepting you don't know it all and that others may have different knowledge**	**Valuing knowledge of others**	**Sharing personal knowledge and respecting knowledge of staff**
Building teams and communities	**Personal knowledge of team members, residents and families across the home**	Communicate effectively Collaborate with others Work co-operatively **Negotiate workload to ensure right person for the job**	Acknowledge the values of others when different (affirmation of diversity)	**Find ways to support what is happening in the wider community and understanding the impact of the contribution being made**
Working dynamics of teams	**Knowledge of how other staff approach care Understanding of the impact of different levels of staffing on residents**	**Recognising what other staff are good at and when I have something special to contribute** Share responsibility	**Recognition of the value of self and others** Openness to others ideas **including residents and families**	**Recognition of special contribution from staff Sharing insights when things may not be working well**

	and families	Resolve conflicts Flexibility	Mutual trust and empathy	**Trusting staff to make right decisions**
Working dynamics of the organisation	**Understanding how events in the home impact on themselves, other staff and residents and their families**	**Being able to anticipate issues that may arise and acting to promote well being of residents, families and other staff**	**Awareness of congruence between personal and organisational values**	**Understanding how the organisation works and its impact on the care of self and others, willingness to negotiate and compromise care needs**
Meaning of community	**Understanding what contributes towards community in the home**	Participate within community **external to the care routines**	Respect for the integrity of all in the community Respect for cultural diversity	**Willingness to participate in the social life of the home, initiating social exchanges**
Multiple contributions to **life** within the community	**Developing shared understandings**	**Recognising everyone's contribution**	**Valuing everyone's contribution**	**Developing shared understandings**
Developing and maintaining community relationships	**Understanding social relationships between all members of the community** **Understanding what could potentially disrupt these relationships**	**Recognition of how actions can support or constrain relationships being developed** **Encourage opportunities for social exchange**	**Acknowledging personal responsibility in the development of reciprocal relationships**	**Participation within the community in ways that promote reciprocal exchange**

Developing the dimensions of relationship centred care (Table 7.3) from the findings of this study provides an accessible framework to explicate the knowledge and skills staff need to support the development of relationship centred care in care homes. Furthermore, it identifies the values required by staff, which are seen as central to both relationship centred care and person centred practice. In addition, this framework maps the contribution of residents and families to the same areas as the knowledge, skills and values of staff. This makes explicit how the contribution of residents and families supports relationship centred care and may also enable care providers to involve residents and their families in developing the practice of staff in care homes.

Conclusion

The findings from this study provide evidence that the relationships developed between staff, residents and family members are an important influence on experiences of life within a care home. Three broad types of relationship were identified: pragmatic, personal and responsive and reciprocal, with evidence to suggest that personal and responsive and reciprocal relationships lead to more positive experiences for residents, their families and staff. These relationships were mainly influenced by the approach to care adopted by staff. Individualised task centred approaches tended to keep the focus on the tasks of care and so developed primarily pragmatic relationships. While some residents, families and staff felt these were appropriate, others preferred the personal and responsive relationships apparent when staff adopted a resident centred approach, which valued the person. There were occasions when this approach might not meet the needs of all residents in the community and on these occasions a relationship centred approach was often seen to

address this as it developed reciprocal relationships that featured negotiation and compromise. There were also other influences that combined to support or constrain the types of relationships that could be developed. These influences included the style of leadership, the approach of staff working together and how the contribution of residents and families was interpreted. This chapter located these findings in respect to the current frameworks of person centred practice and relationship centred care. By aligning what was known about person centred practice with resident centred care, this study suggests how enabling relationships may be developed through everyday practice, which had been a criticism of these frameworks. Furthermore, this chapter has developed the current conceptualisation of relationship centred care by extending it to a new community, that of the care home. The development of reciprocal relationships also suggests the importance of the contribution made by residents and families in this context. Aligning my findings to the areas of knowledge, skills and values required by practitioners, has created an inclusive framework to develop practice that values the perspectives of those who live, work and visit in care homes. The concluding chapter of this thesis considers the implications of my work for policy, practice, education and research.

CHAPTER 8- CONCLUSION

TOWARDS CREATING COMMUNITY IN CARE HOMES

Reflections on policy, practice, education and research

Introduction

This study emerged from personal concerns that care homes were often judged to be the 'last resort' rather than an active choice. This may be that the concept of 'home' is a powerful symbol of autonomy and independence, with institutions such as care homes representing a loss of these attributes (Wiles 2005). However, for some older people care homes are a positive choice as they reconstruct their lives in ways that are meaningful in the context of their personal biography (Cook 2006). People's perceptions of places such as care homes are largely influenced by their experiences, both past and present (Wiles 2005). My motivation in undertaking this study was to better understand how relationships influenced the experience of people living, visiting and working in care homes. This thesis, has considered the views of residents, families and staff, acknowledging the complexity of these relationships. Furthermore, the findings presented suggest how the staff approach to care and the contributions made by residents and their families can support the development of positive relationships in care homes. This chapter will consider the implications of these findings for policy practice, education and research.

Policy context

As I commenced this study, the National Service Framework for Older People (DH2000) was beginning to influence the choices available to older people in long term care, with a growing emphasis on maintaining people in their own homes. Four years, later, the emphasis remains on supporting people within the community to 'age

in place', as this is the stated preference of many older people (Audit Commission 2004, Wanless 2006). Furthermore, a recent report by the National Director for Older People (DH 2007) maintains this emphasis on intermediate care as a means of enabling older people to continue to live in their communities, with limited reference to the role of continuing care. Even the most optimistic forecasts of age-related disability suggest that many people over 85 years will continue to experience physical and cognitive impairment (Wanless 2006). To enable older people to remain in the community it is estimated that informal family care would need to increase by 45% (Wanless 2006) given that the support of informal care givers remains the first line of support for older people in the community (DH2007). There are concerns that this may not be possible as the pattern of family life continues to change (Wanless 2006).

There is sometimes conflicting evidence on the effectiveness of intermediate care due to the variations in practice (Carpenter et al 2002) with some evidence that admission to long term care remains unchanged with the introduction of intermediate care (Young et al 2005). Furthermore, Young and Stevenson (2006) suggest that many intermediate care services are too small, inadequately targeted or insufficiently integrated to achieve a whole system change for the care of older people. This suggests that demand for care homes will be maintained in order to provide care for an increasingly older and frailer population, with more complex health needs. The continued emphasis on community based models of care in the policy agenda raises concerns that the perception of care homes as the 'last resort', when all other forms of care have been tried, will be sustained.

It is estimated that 50% of the social care workforce is located in private sector care homes and that these workers have minimal qualifications (Wanless 2006). Concerns over an unskilled work force in care homes has raised the profile of training in these environments with 50% of the care workforce expected to be qualified to NVQ 2 or its equivalent by 2005, although it is unclear whether these targets have been met (Wanless 2006, Meyer 2007). While there have been service improvements, nearly 20 % of residential providers still do not meet the National Minimum Care Standards (Commission for Social Care Inspection (CSCI) 2005). Furthermore, the areas where there has been least improvement are those that support independence and choice; areas valued by older people as affecting their quality of life (CSCI 2005). Domains that older people themselves see as relevant to their quality of life in care homes include autonomy, dignity, privacy; individuality; relationships and meaningful activity (Kane et al 2003). Help the Aged have also collected narratives from older people living in care homes that underpin similar themes. These narratives reveal both positive experiences and experiences that could be readily improved (Owen et al 2006). Concerns over standards and the lack of respect for dignity in a range of care settings were identified as key drivers for the NSF for older people (Philp 2006). Therefore 'Dignity in Care'(including residential care settings) has been identified as the first programme of the 'New Ambition for Old Age' the report that seeks to take the National Service Framework for Older People forward (Philp 2006).

The study reported in this thesis suggests that relationships in care homes are integral to the experiences of residents and their families. Such issues were not addressed in the Care Standards (DH 2001a) with the emphasis being on maintaining independence and promoting choice for residents. The Care Standards are currently being replaced

with a new 'Outcomes Framework for Performance Assessment' , which will include monitoring of indicators relating to health and emotional well-being, quality of life, making a positive contribution and exercising choice and control (CSCI 2006). While this development in the regulation arrangements is intended to take into account the subjective experience of residents and families, there is scant reference to the significance of this within the new framework and it remains unclear how this will be achieved. The findings within this thesis suggest that the process of care is integral to developing relationships within care homes. To support staff, residents and families in developing positive relationships, practical suggestions are made in the following section under the following headings:

- Promoting effective leadership
- Sharing information
- Ensuring continuity of care
- Developing a learning culture in care homes

The chapter will conclude with a discussion of the implications for education and research.

Promoting effective leadership

Dewar (2007) suggests there is a need to develop strong and effective leadership within care homes with the potential for this to encourage practitioners to understand different perspectives and deliver person centred care. However, there remains a need to support Registered Nurses in developing leadership skills (Milisen et al 2006, Dewar 2007). The current study suggested that, for relationship centred care to be

enacted, relationship-oriented leadership was necessary. Anderson et al (2003) describe this style of leadership as giving constructive feedback, helping staff to resolve conflict and generating trust. This would suggest that any leadership programme in care homes would need to support Registered Nurses in developing these skills.

Creating opportunities for effective communication

Andrews et al (2005) argue that if nurses are to challenge their traditional roles in perpetuating institutional practices, they need to alter their interactions with clients. Explicit and tacit knowledge in an organisation is conveyed through a system of open communication and interaction, which generates new knowledge (Anderson et al 2003). This suggests the value of creating opportunities for effective communication.

In the current study, residents, families and staff meeting together in communal areas, enabled the sharing of personal information and anecdotes, which suggests that the use of communal areas has a part to play in supporting effective communication. This has implications for the building of continuing care environments to provide a more central communal space where people can choose to congregate and that enable staff to traverse throughout the day as they continue their work. This could potentially increase the frequency and intensity of interactions, supporting a more resident centred environment.

A key feature in communication in a relationship centred environment was the informal and frequent interactions between residents and staff, between staff and between staff and families. The nature and content of these interactions varied but a

common factor was the level of personal information shared. Providing opportunities for staff to do this over the course of the day would demonstrate that this knowledge is valued. For example, encouraging staff to share 'what works' for different residents during 'hand over' periods could be one way to validate the importance of personal information gained.

Within this study, an over reliance on rules and procedures tended to limit the need for communication between staff, residents or families and communication was characterised by formal channels. When this communication strategy was coupled with a philosophy of getting the job done, a culture based on complaints and problems developed. This suggests that formal channels of communication would also benefit from a relationship centred approach, taking into account the needs of residents, families and staff. For example, involving the staff, residents and families in suggesting solutions to problems that are being experienced could be one way to remove the emphasis on complaints. This would have the benefit of families and residents feeling their complaints were being recognised but would also facilitate their involvement with staff in identifying ways of doing something differently when needed. This could contribute to shared decision making within the home.

Facilitating shared decision making

The way in which decisions are made within care homes provides an important focus for attempts to promote high quality care and quality of life (Davies and Brown Wilson 2007). Indeed, it has been suggested that it is the myriad of decisions that create the culture within a home and ultimately determine each resident's daily lifestyle and quality of life (Rowles and High 2003). A feature of relationship

centred care described in this thesis was the process of negotiation and compromise that occurred between staff, residents and families that took into consideration the needs of others within the relationship. Opportunities for involvement need to be continuously negotiated both with residents and families. In the current study, this was generally achieved using the care routines as a starting point. Developing resident centred routines contributed to the development of personal and responsive relationships. As relationships developed, staff were able to enter into negotiation with residents and families contributing to shared decision making in these routines. This approach contributed towards reciprocal relationships which encouraged residents and families to become involved in the wider community of the home.

In this study, there were no formal mechanisms within the homes that supported the involvement of residents and families in this way. Aveyard and Davies (2006) found that encouraging relatives to contribute to wider decisions about the home through the mechanism of an action group helped relationships to develop, and as a consequence, staff became more aware of the contribution that relatives made to care. This suggests that the development of resident or family groups can provide a forum for shared decision making that moves beyond individual care routines. Creating an environment that encourages collaboration and negotiation between staff, residents and families to find solutions to problems that emerge could also be a mechanism to ensure that everyone feels valued.

Ensuring that everyone feels valued

This study has suggested that the contribution of residents, families and staff is integral to the development of personal and responsive or reciprocal relationships.

For example, adopting a relationship centred approach to care recognises the communal nature of living, visiting and working in a care home where residents, families and staff all have a valued contribution to make. To achieve this, staff need to demonstrate respect for what residents have done in their lives in how they speak with them and the choices they provide in day to day care routines. Greeting families and making them feel welcomed is a small but valuable contribution that staff can make and taking the time to meet with families, even briefly, suggests their visit is valued. It is also helpful if residents and families are able to communicate that they value the contribution of staff and are interested in their experiences by initiating personal exchanges. For example, Campbell (2003) suggests that staff experience a sense of empowerment when residents and families communicate their appreciation.

In this study, when staff adopted a relationship centred approach to care, opportunities for reciprocal exchange were created. This was often achieved through social interaction where both residents and families could also make a contribution. For residents and families to feel this is valued, their role in this needs to be acknowledged and reciprocated by staff. For example, Grasser (1996) describes how some residents offered to pray for staff as a means of reciprocity but found this could go unrecognised by staff. In the current study, there were examples of staff acknowledging the little things that residents and families did to help or responding to the initiation of humorous exchanges. When their contributions were valued, residents and families were encouraged to find ways of becoming involved in the wider community of the home which provided opportunities for meaningful activity.

To achieve relationship centred care in practice, staff require knowledge and skills to be able to negotiate with each other, residents and families and be flexible in how they approach their work. This suggests the need for a relevant approach to the training and education of staff, which will be discussed later in this chapter.

Sharing information

Many communication models have been developed for staff within organisations (Anderson et al 2003), which fail to acknowledge the contribution of residents or their families. In a previous section, informal and frequent communication between staff and with residents or families suggested a more responsive way of working. In this section, I consider the contribution made by residents and their families in more detail.

Encouraging story-telling

Story-telling has been described as a process through which people make sense of events that have happened to them and is central to involving older people in decision making (Barnes 2005). In the homes where I observed resident centred and relationship centred care taking place, communication occurred informally based on the sharing of stories between residents, families and staff. This contributed towards flexible working practices that enabled staff to make decisions based on personal knowledge of the residents and families. In a resident centred environment, these stories were used primarily to inform the personalisation of care routines for each resident. For example, photos, personal belongings or stories shared by families could be used by staff as triggers for conversation during personal care routines. Staff should invite residents who are able, to share stories about their lives if they would

like to do so. Families could also be involved in this process, with staff similarly sharing stories or anecdotes during their visits. This communicates to the families that staff are interested in the life the resident has led. Within this study, staff also shared information and anecdotes about their own lives, contributing to feelings of mutuality. However, it is important to acknowledge that not all individuals may wish to share details of their lives in this way and this must be respected.

In a relationship centred environment, stories may support the development of shared understandings as they communicate the values of the community within the home. This calls for a re-evaluation of communication strategies in care homes so stories between residents, families and staff are encouraged and valued.

Creating opportunities for information sharing

Recognition of the contribution of the residents and families was a key feature in staff developing personal and responsive relationships. Providing an environment where staff can informally discuss day to day care routines and share insights with each other may contribute to a greater recognition of the residents' and families' contribution. Ronch (2004) terms this 'collaboration' where staff pool their knowledge, creating an inventory of solutions that everyone can draw on. Regular meetings where staff feel valued also have the potential to build trust and commitment (Moyle et al 2003). Williams (2002) suggest that regular and frequent community meetings are central to thriving relationships:

> *'With residents, families and children in attendance, community meetings provide new knowledge and foster mutual understanding. A new*

consciousness of self and community develop that will promote not only individual relationships but a sense of community identity and aspiration.'

(Williams 2002 p.6)

Gilbert and Bridges (2003) also describe the development of neighbourhood teams that comprised residents, families and staff to support the sharing of information. Supporting residents in attending meetings is not without its challenges and the impact of frailty needs to be addressed if participation is to be meaningful (Reed et al 2004a). In particular placing strategies in place that facilitate the involvement of residents with hearing and visual impairment and being aware of relationships between residents within meetings would support meaningful engagement.

Ensuring continuity of care

Continuity of care was valued by staff, residents and families throughout this study. The lack of continuity in care described by staff, families and residents often demonstrated how the organisational values differed from their own and contributed towards poor experiences. Therefore, this would suggest the value of involving staff, residents and families in developing strategies to ensure continuity of care.

Consistency in staff allocation

Numerous studies have considered staffing and skill-mix within care homes, often with conflicting results (Lankshear et al 2005, Bostick et al 2006). Studies have demonstrated that more staff may improve some outcomes, but not others (Bostick 2004, Schnelle et al 2004a, Bostick et al 2006) with inconclusive evidence on the adequacy of staffing (Harrington et al 2000, Mueller 2002). This thesis suggests that

relationships in care homes are influenced by the approach staff adopt in the care routines. For example, when a resident centred approach to care was adopted, staff exchanged personal information with the resident and their family to personalise the daily care routines in ways that mattered to each resident. Personal knowledge about residents was developed over time, which suggests the need for consistent staff assignment within homes if resident centred care is to be achieved. Involving staff in the process of resident allocation enables them to show the value of their knowledge and how they develop relationships. Furthermore, by acknowledging this aspect of work, workload can be adjusted to reflect the ongoing demands experienced by staff in developing relationships with residents and their families. This would also convey to staff that this aspect of their work was valued (Bowers et al 2003, Campbell 2003). Primary nursing and key worker systems are two strategies that could also be used to promote relationships and continuity of care.

Development and use of care plans

Residents have been found to adopt a range of strategies to maintain their sense of identity and to (re) construct their lives in the context of their biography, which may go unrecognised by staff (Cook 2006). Bridges (2007) suggests that staff need to learn about individuals in the context of their whole life development so that care can be tailored accordingly through a person centred approach. Within my study, care plans were rarely used or discussed, which would suggest that the information in care plans was not considered relevant to care staff, residents or families. Care plans have been criticised for reinforcing the stereotype of residents as recipients of care rather than acknowledging their goals and aspirations (Cook 2006). Biographical approaches to care planning are beginning to be developed (Clarke et al 2003)

although their effectiveness is yet to be evaluated. To achieve resident centred care in practice, staff, residents and families need to understand the value of the stories they share and be active in using this information. It would seem that the transfer of this information to the formal process of care planning may support the development of person centred and relationship centred care. However, residents and families need to be supported in seeing the relevance of their involvement.

Enabling residents and their families to make a contribution

Within the current study, the formal philosophy of the home, although written down and readily accessible was not discussed by any of the participants. The contributions of many of the residents and families were a product of the development of personal and responsive or reciprocal relationships. However, a clearly stated and accessible philosophy that openly values the contribution of residents and families could provide an opportunity for residents and families to discuss their expectations of involvement within the home.

When residents and families first move into a care home, the recognition of the biography of the resident and inclusion of the family into the admission process would communicate the value placed on the contribution of residents and their families. Integration of the biographical details into the care planning process could also support residents and families in seeing the relevance of their involvement with this process.

Developing a learning culture within care homes

To create a learning environment in care homes it has been suggested that key values, roles, knowledge and skills must not be assumed but must be actively modelled and taught (Hurtley 2003). Furthermore, staff themselves recognise the learning opportunities within continuing care environments but need the support of managers to realise these (Moyle et al 2003, Train et al 2005). However, the majority of studies that describe learning initiatives in care homes are a product of staff perception of needs and rarely includes the voices of older people or their families (Meyer 2007). Ronch (2004) argues that involving residents and their families in identifying different ways of doing things may bring in a different perspective. This suggests that strategies involving residents, families and staff may have the potential to create an effective learning environment.

Encouraging Mentorship

There was some evidence within this study to suggest that role modelling good practice was becoming the responsibility of care workers. Care workers predominately learn through experience. Fraser and Greenhalgh (2001) suggest a range of process oriented learning methods that support practitioners in dealing with complex situations. For example, new staff could shadow more experienced staff learning how to adopt a resident or relationship centred approach. In this way, learning is embedded into the normal routine (Dixon 2003). As discussed in a previous section, providing regular meetings for staff to discuss the care of individual residents may support ongoing learning opportunities. Hansebo and Kihlgren (2004) describe an intervention that created care giving teams which, provided regular opportunities to share experiences, discuss and reflect on the care of individual

residents. These meetings were facilitated to emphasise personal knowledge about residents and carers were more inclined to see each resident as a person in a close relationship following this intervention (Hansebo and Kihlgren 2004). Moyle et al (2003) suggest that developing an understanding of older people and their behaviour assist staff to be empathic and provide a more holistic approach. This suggests the potential of facilitated team meetings to support the development of a relationship centred learning environment.

Involving residents and families

If residents and families are to be enabled to make a meaningful contribution to the learning environment of the home they may also need training or guidance. Dewar (2005) describes a programme that enables older people to explore different ways of expressing themselves, seeking the views of others, influencing change and valuing their contribution. These are skills that older people and their families are likely to find useful in becoming part of the learning culture in care homes.

Care workers tend to learn on the job from senior or experienced carers who demonstrate what needs to be done. By involving residents and their families, in supporting new members of staff, a relationship centred approach to care could be encouraged. Residents and families could be invited to share their stories with new members of staff as part of their induction to the home as an innovative way of introducing new staff to residents' biographies. This study would suggest that involving staff, residents and families in the process of staff development has the potential to ensure that everyone has the opportunity to make a valued contribution.

Implications for education in care homes

There is wide variability in education and training in care homes (Aylward et al 2003, Fitzpatrick and Roberts 2004) and in a recent review of the literature in this field Meyer (2007) concludes:

> *'the emerging evidence seems to indicate the need for education and training to be relationships centred and concerned with developing the whole of the care home workforce on-site, as part of an overall quality improvement initiative rather than bite size educational inputs.'* (p.147)

I propose that the articulation of resident centred and relationship centred care in the context of everyday care routines may be used as a mechanism to support staff in thinking beyond the 'what' of care to the 'how'. Learning how things are connected and understanding the interactions and relations between the knowledge gained supports practitioners in applying their learning to new contexts (Fraser and Greenhalgh (2001). Gaugler (2005) argues that conceptual models are key in guiding the development of effective programmes to improve relationships between residents, families and staff. Based on the conceptual framework of relationship centred care, Table 7.3 explicates the knowledge, skills and values staff need to develop positive relationships in care homes. Therefore, this could provide a useful framework for a coherent strategy of staff education that includes the perspectives of staff, residents and families. The inclusion of the contribution of families and resident could encourage staff to think reflexively about how they influence the development of relationships and may contribute towards care homes as learning environments. To date there has been limited evaluation of learning programmes in care homes

(Aylward et al 2003) which suggests the need for further research on the implementation and evaluation of future programmes.

Implications for research in care homes

Much of the research aimed to improve quality of care in care homes has been based in the United States and has concentrated on the measurement of the outcomes of care; often from what have been considered erroneous sources (Schnelle 2004b). However, Gaugler (2005) argues that considering the dynamic between residents, families, staff and the organisation could be key in improving outcomes in long term care environments. While outcomes of care are important, the relative neglect of the process of care by researchers risks ignoring what older people, families and staff see as relevant to their experiences in care homes. This study suggests that further research is required to see how resident centred and relationship centred care may contribute to positive and relevant outcomes for residents, families and staff. Furthermore, the contribution of residents and families warrants further investigation.

In the UK, there is increasing emphasis on involving older people in practice development and also in developing the knowledge base that informs their care (Reed et al 2004a, Dewar 2005, Reed et al 2005). Care homes have an increasingly frail population of older people experiencing fatigue, hearing and speech difficulties or poor health, which raises concerns in relation to their involvement in the development of the research agenda (Kane 2001, Quadagno and Stahl 2003). This study suggests that older people, families and staff need to be consulted on what questions have relevance to them in their experience of living, visiting and working in care homes.

Participatory models of research with those living, visiting and working in care homes have been found to be of value in supporting a change process involving residents, families and staff (Chenoweth and Kilstoff 2002, Asburner et al 2004). This study also suggests that research methods which enable the voices of all stakeholders to be heard may also have the power to change practice in care homes.

Using a constructivist approach enabled the perspectives of residents, families and staff to be heard, creating a joint account of the significance of relationships to their experience. This required continuous negotiation of consent and flexibility within the research process to ensure the meaningful engagement of older participants in the research process. Further research within care homes should consider how consent is negotiated, and should aim to create a more meaningful approach than results from the current emphasis on written consent as the only valid method. This would require the development of positive relationships with participants in care homes, suggesting longer periods of engagement, which would need to be costed into any funding proposal and supported by funding bodies.

Promoting a culture of community

To date, the most effective methods of change in care homes have been reported from the 'culture change 'movement in the United States, and feature participatory approaches that include everyone involved within the care home (Boyd 2003, Gilbert and Bridges 2003). Ronch (2004) suggests that putting the spotlight on the everyday practice of staff has been found to be a powerful way of setting the process of change in motion. This study suggested that the personal philosophy of staff also influences the approach to care and relationships that develop, which could indicate that

understanding the mental models staff use in their day to practice is a useful starting point in supporting staff to develop their care and so contribute towards a change in culture. Creating opportunities for residents and families to become involved in the development of caring practices would mean that any changes were also grounded in their expectations, supporting their contribution to the process.

Recently, Help the Aged have launched the 'My Home Life' Programme, a major campaign to support and develop quality of life in care homes (Owen 2006). Based on a major review of the literature (NCHR&D Forum 2007), this programme considers how a positive culture can be developed considering the views of older people, families and staff. The value of maintaining a person's sense of identity, creating a community, sharing decisions and the complexity of workforce issues have been described within this review (NCHR&D Forum 2007).

This thesis considers the value of developing relationships in care homes and proposes a typology of approaches to care as a means of explicating the processes involved in developing positive relationships between residents, families and staff. It is proposed that the findings of this study are very relevant to the 'My Home Life' Programme. Grounded in the everyday experience of residents, families and staff, the findings have the potential to inform the development of person centred practice and relationship-centred care in care homes. Furthermore, in developing the current framework for relationship centred care to include the contribution of residents and families, the potential to support a participatory approach to the development of practice in care homes may be realised. This framework has the potential to recognise the needs of residents, families and staff within care homes as they build

caring communities. However, it would be unrealistic to expect this level of change to occur independently within many homes without reference to the wider policy agenda. Policy makers and regulatory bodies need to understand and value the process of care and provide support to enable changes in practice to be realised. Furthermore, managers and owners of care homes need to engage in practices that enable care staff, residents and families to become involved in decision making. All have a part to play in improving the experience of those who live, visit and work in care homes. I hope this thesis provides a useful starting point to achieve this.

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