

What makes a real difference to resident experience? Digging deep into care home culture: The CHOICE (Care Home Organisations Implementing Cultures of Excellence) research report.

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INTRODUCTION

This is the report of the Care Homes Organisations Implementing Cultures of Excellence (CHOICE) project. This research project was developed by a network of university teams working with the Preventing Abuse and Neglect in the Care of Older Adults (PANICOA) programme. The UK based collaboration involved teams from University of East Anglia, University of Stirling, Cardiff University and University of Worcester. The research examined the relationship between good and poor care experiences in care homes, particularly of residents with high levels of complex needs, and the organisational culture of the care homes. The research design of comparative case study combined structured observation using the PIECEdem tool and ethnographic case study research. This report sets out the background, rationale and context of the research, details the methods used, presents the findings, discusses the implications and draws conclusions.

KEYWORDS

Care experience, dementia, complex needs, care homes, organisational culture, care home culture.

EXECUTIVE SUMMARY

This is the report of the Care Homes Organisation Implementing Cultures of Excellence (CHOICE) project to examine the relationship between good and poor care experiences in care homes, particularly of residents with high levels of complex needs, and the organisational culture of the care homes. This report identifies key elements of care which are relevant for care home organisational culture in providing high quality care

Introduction

This research project was developed by a UK-based network of university teams (from the University of East Anglia, University of Stirling, Cardiff University and University of Worcester) working with the Preventing Abuse and Neglect in the Care of Older Adults (PANICOA) programme.

The research used a comparative case study design combining structured observation using the PIECEdem tool and ethnographic case study research. A linked series of 11 case studies of care home settings were carried out across the United Kingdom. Data was collected from a purposive sample of homes varying in terms of their characteristics as types of provider, 'locale' and resident population', which included 6 homes in England, 3 homes in Scotland and 2 in Wales.

The study aimed to analyse positive and negative care experiences, the contexts in which they occur and the factors positively or negatively pre-disposing to their occurrence through:

- Examining the experience of residents with characteristics that make them particularly vulnerable to the effects of mistreatment to highlight key practices and organisational features implicated in positive and negative experiences.
- Determining the individual circumstances, organisational cultures and practices most likely to encourage, or inhibit, the provision of high quality of care for older people living in care homes.
- Analysing the relationship between experience of care and the recording of measurable indicators of quality (e.g. inspection reports, complaints, safe-guarding issues).
- Identifying examples of empowering practice including between individuals and at an organisational level.

Key findings of the case study research

Theme One: Shared purpose in providing the best person-centred care

Findings show that having a shared purpose in a care home can have a bearing on the quality of care. Shared vision and understandings of the purpose of the home and the aims of care among management and staff that put the needs of residents as paramount were associated with positive care experiences.

These findings suggest that having a shared understanding of the purpose of a care home is an essential component for creating positive care experiences for residents. This shared purpose needs to exist across all levels of staff in an organisation and be evident in both articulated values and values demonstrated in practice. However, having a shared purpose is unlikely, in and of itself, to create the cultures necessary to achieve good care if intrinsic and extrinsic values are brought to bear which conflict with outcomes of positive care for residents or if the workforce is not adequate and stable enough to enable shared values become embedded. In exploring the circumstances within which shared values are associated with positive care experiences, other aspects of care home culture are implicated, such as the sense of community within the care home and impact of external factors on the life of the home.

Theme Two: A sense of community between all involved in the care home

The sense of connectedness within a care home impacts on care quality. An active facilitation of this connectedness is required to create a sense of community and positively impact care experiences.

Where there was a strong sense of connection across all involved in home life, care experiences appeared to be on the whole, positive for all concerned, and the care home was described and experienced as a community. For care homes that did not demonstrate connectedness, a sense of community was not present and care was observed and reported to be more inconsistent in quality. A sense of community seemed to be features that were

actively facilitated by the home, and sometimes enhanced by an external community to which the home belonged, such as a religious faith

Theme 3: Managers ensure external pressures do not have a negative impact on care delivery

The forces and factors from outside of a care home such as those from the regulator, from owner organisations and from families can impact on the care experience in a negative way even when they are meant with good intention. Managers can mediate these pressures so that they do not have a negative impact either by taking on the responsibility for them or by interpreting them into meaningful types of activity.

External factors could influence the care experiences of residents. By examining what occurred in care homes in response to these pressures, we identified that when care homes (and particularly management of the homes) sought to mediate their impact on the day to day work of staff and daily life of the home, then residents reported and were observed to experience a preponderance of positive care. Mediation was still required even when external factors were initially intended to benefit residents. However, when mediation did not take place (or failed due to the nature/weight of external pressure) then care experiences appeared to be poorer. Mediation occurred in a variety of ways, not simply to prevent impact but to translate the ways in which factors had effect. However, such mediation was only found possible when the external factor (whether regulatory, owning organisation, family, or financial factor) was receptive to such mediation, which was not always the case.

Theme Four: Staff are empowered to take responsibility for resident well-being by active management processes

The findings show that the extent to which care staff were empowered to be effective in their practice had an impact on care experiences for residents. Supportive management; responsive management; present leadership; leading by example; defining boundaries and expectations; united leadership; and strong management all served to increase staff taking responsibility in their work with residents and families

Those homes that appeared to achieve a predominance of positive care experiences for their residents evidenced frontline staff who demonstrated autonomy and responsibility in their day to day actions within clearly defined boundaries. This effective staff action appeared to be crucially facilitated through the actions of management and leadership in a variety of different dimensions to facilitate and empower frontline staff. In homes that were inconsistently successful or poor in providing positive care experiences for residents, staff autonomy and responsibility was often absent or inconsistent, dependent on the will and skill of individual staff members and some or all of the facilitative aspects of management and leadership were partly or wholly absent.

Theme Five: Openness to Change for the benefit of residents

Findings suggest that way in which a home views and pursues change impacts on care quality. Change pursued in a gradual and on-going way, towards a resident-oriented (rather than organisation-oriented) goal, appeared to be associated with positive care experiences.

Change in care homes impacts on care quality; whether in response to changing resident needs, policy directives or in recognition of changing focus of care. Change may be implemented immediately or gradually and it may be instigated from above (the organisation) outside (local authorities or regulation) or from within the care home itself. Our case studies illustrate the negative impact that change imposed for the sake of organisation-oriented needs as opposed to resident focussed needs can have on care practices and thus the care experiences of residents. Conversely, when a care home does not value change or recognise the need for it this can also impact negatively on care experiences. When a care home is responsive to the need for change, sensitive to the impact of change on staff and residents and puts the residents' welfare at the centre of change then care experiences are more likely to be positive. Management mediation of the impact of change caused by external factors (such as organisational or regulatory requirements) is highly relevant, but also dependant on the management being recognised and being enabled to mediate.

Theme Six Using the care home environment to the benefit of residents

The findings suggest that the ways in which the environment is used in care homes is shown to have an impact on the quality of care experiences. Where conscious reflection on the environment and its use is evident in a home, it can contribute to positive care experiences.

There is a complex relationship between design, space and practices within that space. The degree to which staff are able and are willing to reflect (whether holistically or in relation to residents' perspectives) on the use of space within their homes and on its environment, was found to have an impact on the quality of care experiences of residents. In homes where we found such staff reflection on the environment and how it may impact on residents' care experiences then care experiences appeared to be more positive. Where a home demonstrated shared values related to person centred care, then this value shaped reflection on the environment within that home. Moreover, the extent to which care staff were enabled to be effective in their role also appeared to determine the extent of their reflection on the environment of the home and its impact on resident experiences. Here, actions such as reflection on environment in relation to values or as an action of effective staff was required to be on-going rather than a one-off event if it was to lead to good care experiences.

Theme Seven: Person centred activity and engagement is integral to care work

The extent to which activity and engagement are viewed as care work impacts on care quality. When activity and engagement are embedded and integral to care work then the impact on care experiences of residents is positive.

For residents to experience a predominance of positive care experiences, care homes must enable activity and engagement to be embedded into their staff's work. This required a shared understanding across the home of its importance, of whose responsibility it is and, crucially, the practical circumstances (such as sufficient staff and resources) to make it happen. Where homes were inconsistent in providing positive care experiences, or exhibited a preponderance of poor care experiences, activity and engagement were not integral to care work and to an extent depended on the availability of sufficient staff and the abilities and skills of individual staff. Care staff shortages impact on the provision of structured and one-to-one activities but positive care experiences can still predominate if activity and engagement is integral to care work.

Conclusions

The case study approach taken in this study enabled the examination of 'circumstances, organisational cultures and practices' in context, and in relation to the experiences of people with very high levels of need for care. Each aspect of care home culture could be seen to interact with and be interdependent on other themes. This examination indicated that, rather than there being one 'right' culture a culture that supports positive care can combine important elements in varying ways.

Implications

Shared purpose

- It is important for care home managers and staff to be aware of inconsistencies in values of a care home. The values of a care home overall and those which guide how staff work if different can cause difficulties. Identifying discrepancies in values held between management and staff or between different groups of staff, is required. If managers are more aware of the values and assumptions that guided staff in their work, these insights can be used to help staff to think about how they work and ultimately to change the way they work.

Sense of connectedness

- The facilitation of connectedness between residents, relatives and staff in a care home is an important part of good practice. There is not one particular method for facilitating connectedness. Rather such practices may include a range of ways of valuing and supporting working together, interacting and shared activity that helps to develop meaningful relationships between people both inside and outside of the care home.

Mediating external pressures

- Some managers were shown to be knowledgeable about how to mediate the external forces and factor that impact negatively on care homes. The way such mediation is

carried out can be similar across care homes but also can vary depending on the particular set of circumstances of each care home. The knowledge, approaches and strategies is an untapped resource that could be shared with managers across the care home sector.

Empowerment of staff

- Understanding how to balance the autonomy and empowerment of care staff and to manage the running of a home efficiently is an important skill. Managers and other staff would benefit from training and support in developing their knowledge and skills in leadership approaches and activity. It is important for managers to understand what kind of leadership is effective in what kind of setting.

Openness to change

- It is important to clearly identify which goals may be more organisationally orientated and which goals are resident-orientated. One approach may be to 'resident proof' proposals for change, that is, to consider in advance the particular impacts of any change for residents and also to monitor impacts for residents as change is taking place. This approach would help alert managers to any unintended consequences and adjust plans accordingly.

Environment and its uses

- The environment in care homes and its uses in the every-day routine and life of the home must be considered in terms of whether this is the best use for meeting residents' needs. It is important to constantly review and question how the environment and spaces can be better used to meet the needs of every resident.

Activity and Engagement

- The way in which care jobs are designed and care work is organised requires attention. It is important for jobs in care homes, particularly care work to be designed to ensure that person centred activity and engagement are integral part of that role.

BACKGROUND /RATIONALE

This section of the report will locate the work in relation to relevant evidence and policy, in particular in relation to: the provision of residential and nursing care, regulation of care provision, mistreatment and safeguarding in care, the quality of the care experience and organisational culture in relation to the care experience.

Positive public messages about institutional care are rare with a perception that mistreatment is commonplace (Hussein 2007), but providing robust research evidence in this field raises challenges of definitions and obtaining robust data. From the small amount of research into mistreatment in institutional settings some indicators, markers and risk factors have been identified. Commonly occurring organizational features associated with reduction in care quality have been identified (Killett et al 2012). Both concrete behaviours and subjective experiences of residents are important in understanding the prevalence of mistreatment and experiences need to be understood in the context of reasonable expectations of trustworthiness in relationships (Dixon et al 2009)

The research brief and the research question asked ‘What are the individual circumstances, organisational cultures and practices most likely to encourage, or inhibit, the provision of high quality of care for older people living in residential and nursing homes?’ The study examined, in context, experiences of care that reflected both high quality care and also poor care including mistreatment.

Provision of residential and nursing care for older people

As older people are supported to remain in their own homes longer the needs of the population of care home residents have become more complex; an estimated 60% of the care home population have dementia (Alzheimer’s Society 2010). Older people with dementia are recognised as particularly vulnerable to poor care with continual monitoring of provision needed (Goergen 2004, Benbow 2008).

Residential care in the UK is currently provided by a combination of for-profit organisations, which range from individuals owning one care home to corporate organisations with many care homes, and not-for-profit organisations, including local authorities, charitable organisations and housing associations. Care home registration types are now described in England as ‘care’ and ‘care with nursing’. There are then additional specialist categories of provision, and those relevant to this research are dementia, mental health condition and caring for adults over 65. The payment for residential care for individuals by the state is subject to needs assessment and means testing. These are the responsibility of Local Authorities, who operate under national guidance. Individual local authorities have different ceilings of the fees they will pay. Where there are individual health related needs, the NHS may have a responsibility to contribute to fees. The majority of care is purchased by local authorities, with the local authority having a contract with the provider and collecting a contribution according to means from the resident (Hancock and Hviid 2010). Few local authorities still directly provide care homes but their purchasing power and decisions have implications for the care of both those for whom they purchase care and people who purchase their own care (Hancock and Hviid 2010).

This research was carried out in England, Scotland and Wales. While having many aspects of care provision in common there are key differences. In Wales 22 local partnerships between health and social care providers are charged with provision of the National Service

Framework (NSF) for Older People. The partnerships vary in their size, constitution, frequency of meetings, reporting arrangements and internal cohesion. All of these factors may influence the NSF implementation. Partnership working between health and social care, however, may be more embedded in Wales than in England, and the possibilities for coordination of services may be pertinent to care provision in relation to older people and their decisions to move into care, and to the health care they receive in care.

In England in 69% of residential homes and 88% of nursing homes are in the for-profit sector (CQC 2010a). Within this varied sector, encompassing venture capital activity and small family run businesses, ethos and values of the particular organisation are likely to be pertinent to the resources available to care for residents and the terms, conditions and support available to staff (Moriarty, 2012). Local authority provision accounted for 7% of residential care homes in England (CQC 2010). The distribution of the market between the independent and local authority sectors in Wales is similar with a trend for increase in the proportion of independent sector providers. The independent sector accounts for 87% and local authorities for 13%. In the past few years there has been a decrease in the number of small care homes across Wales (Chief Inspector's Annual Report 2010). Scotland has the highest proportion of local authority provision. In Scotland at the 2010 census the majority of care homes for older residents (67.6%, n=637) were privately owned. Of the remaining homes, 174 (18.5%) were owned by Local Authorities/NHS and 132 (14%) were in the voluntary sector (ISD Scotland 2010: 3).

In the for profit sector in England in 2008, 52% of the independent sector market was occupied by corporate and larger owners defined as providers with three or more facilities. (CSCI, 2008a). Under the now discontinued CSCI ratings system, excellent ratings were achieved by 29% of third sector providers compared with 18% of private sector providers. This has been associated with a tendency for smaller homes to provide better quality care and for the third sector to have smaller homes than the private sector.

The Convention of Scottish Local Authorities (COSLA) developed the National Care Home Contract (NCHC) and this has been in use by local authorities since April 2007. The aims of the contract are to standardise arrangements, across local authorities, for procuring care home places for older people and to govern/evidence additional investment in the sector provided by the Scottish Government. As such, the NCHC applies principally to services procured from the private and voluntary sectors. The National Care Home Contract includes a series of quality payments. These are intended to provide care home providers with financial incentives to raise standards of care. Until recently, the NCHC has operated these payments on a deficit model, where the poorest performing homes are denied additional payments should they fail to meet grades 3 or above in the relevant area of the Quality Assurance Framework. Recent versions of the NCHC offer additional payments (Enhanced Quality Award) to care homes which perform at the top of quality framework.

The implications of the constrained market in care provision include limited specialist provision in certain areas of the country, for example specialist dementia provision. There is great regional variation as to the number of dementia registered care home places available per 100 population predicted to have dementia (and aged over 65). The highest is 55 places available per 100 in the North East, with the lowest being 30 in the South West. West Midlands stands at 38 and Eastern region at 42. There are very tight financial margins for care homes providing places purchased by the Local Authority.

Regulation of care provision

Each of the three countries covered by the research has a regulatory body: Care Quality Commission (CQC, England), Social Care and Social Work Improvement Scotland (SCSWIS) and Care and Social Services Inspectorate Wales (CSSIW).

The Health and Social Care Act, 2008 created the Care Quality Commission (CQC) as the responsible body for the registration, regulation and inspection of all health and social care providers in England. This new regime replaced, from October 2012 onwards, the national minimum standards and associated regulator (Commission for Social Care Inspection, CSCI) of The Care Standards Act, 2000 & Health and Social Care Act (*community health and standards*) 2003.

Pre-October 2010, CSCI used National Minimum Standards with an input and systems-based approach to monitoring compliance. Inspections produced a system of quality star ratings, (CQC, 2010e). In October 2010 this was replaced by the CQC & Essential Standards of Quality and Safety. Quality star ratings were discontinued, replaced by 28 regulations governing the standards of quality and safety in a care provider. An outcomes approach is used and the standards are grouped under 6 headings: Involvement & information; Personalised care, treatment & support; Safeguarding & safety; Suitability of staffing; Quality and management; Suitability of management (CQC, 2010d). CQC monitors both providers (who may operate across many different locations and operate different types of service), and specific service locations. CQC is also taking on the monitoring of a much wider range of provision than CSCI, including for example dentistry, ambulance services and home care agencies.

In the CQC process of regulation a 'quality and risk profile' (QRP) is first established. These are so far done for NHS Trusts only. CQC is in the process of developing QRPs for adult social care. The QRP is based on information from users of services, other agencies and the provider themselves through the registration process. QRPs are not available to the public, although the reviews of each location run by a provider are available and listed under each provider. CQC commits to conducting a 'planned review' of each location at least once every two years, but not at set intervals, and these may not necessarily include a visit to the location. Locations/Providers are not informed in advance. Planned reviews focus on all standards and begin by reviewing the quality and risk profile. If this does not demonstrate compliance other measures may be used such as contact with service users and partner agencies, location visits, or completion of a quality audit by the location. In addition CQC conducts responsive reviews of locations, in response to specific information received by CQC or to follow-up on previous enforcement actions. They can take the same format as planned reviews, but focus on specific standards of concern. It is not specified what type or source of information would provide sufficient enough concern to prompt a responsive review, or when actions would take the form of a location visit rather than other action. In response to reviews, a location (and provider) can be judged as compliant with standard/s or as noncompliant with minor, moderate or major concerns. CQC can issue improvement actions, (if it judges a location as being compliant, but unlikely to remain that way), compliance actions (if it judges a location to be noncompliant) and enforcement actions (if it judges a location to be noncompliant and high risk). Compliance Reports are publically available for specific locations if a review has been conducted since 2010(CQC, 2010e & 2010f). At the time of writing, CQC has experienced a recent change of chief executive and suggestions of a change in focus with regards to its work with residential care providers.

In Scotland two key pieces of primary legislation currently guide the registration and inspection of care services: The Regulation of Care (Scotland) Act 2001; and, The Public Services Reform (Scotland) Act 2010.

The Regulation of Care (Scotland) Act 2001 established an independent commission to register and regulate care services in Scotland (The Scottish Commission for the Regulation of Care) as well as a professional body for registering and regulating social services staff and professional training (The Scottish Social Services Council). The Act led to the creation of Scottish Statutory Instruments (No. 113 and No. 114), which outlined the legal requirements for care homes when registering and providing care services.

The 2001 Act introduced the National Care Standards for Scotland. These outline minimum standards for the quality of care that service users can expect. Care standards are not legally binding but are used by inspectors, as benchmarks, to monitor services (see below). The National Care Standards are designed to be accessible and are written from the point of view of service users. There are 20 minimum standards relating to care homes for older people and are based (as are all National Care Standards) on 6 key principles: dignity; privacy; choice; safety; realising potential; and, equality and diversity.

The Public Services Reform (Scotland) Act 2010 was introduced in order to reform and simplify the landscape of public bodies in Scotland. The Act led to the creation of two new bodies: Social Care and Social Work Improvement Scotland (SCSWIS) and Healthcare Improvement Scotland (HIS). These replaced the Scottish Commission for the Regulation of Care (established under the 2001 Act) as well as NHS Quality Improvement Scotland.

Several organisations play a role in regulating care services in Scotland, and in investigating allegations of mistreatment. In accordance with the Public Services Reform (Scotland) Act 2010, the regulation of care service providers is the responsibility of Social Care and Social Work Improvement Scotland (SCSWIS), which became operational in April 2011. Care services previously registered with the Care Commission automatically transferred to SCSWIS on 1st April 2011. Providers of independent healthcare services are regulated by Healthcare Improvement Scotland (HIS), which also became operational in April 2011. Centres which provide care services *and* independent healthcare services are regulated by both agencies (SCSWIS 2011a). SCSWIS regulate care services according to: the regulations laid out in the 2010 Act; the National Care Standards; and, 'other agreed benchmarks' (SCSWIS 2011a: 3).

The Scottish Social Services Council (SSSC) continues to register and regulate the social services workforce in Scotland. According to the National Care Standards, 50% of staff working directly with residents within the care home should have obtained a minimum of SVQ level 2 or equivalent, or be working towards achieving the relevant qualification required for registration with the SSSC. In addition to regulating professional education and training, the SSSC is responsible for developing codes of practice and can investigate/take disciplinary action against registered workers whose conduct is suspected or known to fall short of the codes. In addition to the above bodies, The Mental Welfare Commission and the Office of the Public Guardian (Scotland) have statutory powers to investigate allegations of mistreatment in relation to *individual* residents.

Since 2008, registered care services in Scotland have been inspected using a framework of quality themes and statements, informed by National Care Standards (SCSWIS 2011b). Care services are graded on a six-point scale according to four quality themes. Themes are: the quality of care and support; the quality of the environment; the quality of staffing; and, the quality of management and leadership (SCSWIS 2011b). Each quality theme is comprised of a series of quality statements. Providers are required to assess their service against all the quality statements and themes, providing evidence of their performance. Inspectors then assess the performance of the service against a selection of the quality statements contained within a select number of quality themes. A grade for each quality theme is calculated based on the inspected quality statements; grades range from 6 (Excellent) to 1 (Unsatisfactory). According to SCSWIS, Grade 3 represents a 'tolerable level of performance for the purposes of regulation' (SCSWIS 2011b: 14). Grades 1-2 therefore result in the service receiving improvement orders, and the imposition of enforcement action if improvement is not evidenced. Key evidence used by inspectors to assess performance include: upheld complaints; incidents; feedback from service users; evidence that previous action plans have been implemented; and, information in the annual return (SCSWIS 2011b). Inspection reports are published and are available on-line.

The inspection of care services has been highlighted as a key priority for SCSWIS for the period 2011-2012 (SCSWIS 2011a). In contrast to provisions made under the 2001 Act, however, the Public Services Reform (Scotland) Act 2010 does not stipulate how often care services must be inspected (SCSWIS 2011c). Following the introduction of the 2010 Act (and the transfer of regulatory powers from the Care Commission to SCSWIS) the grading system will continue to be used to monitor and inspect care services. However, it is anticipated that key changes to the existing system of inspections will include: the use of unannounced/ random inspections; greater maximum periods between inspections for better performing /low risk services; greater frequency of inspections for poor performers/high risk services; and, more emphasis on self-evaluation using validated methods (SCSWIS 2011a; 2011b).

Out of the three devolved nations Wales shares many similarities with policy and legislation that is applicable in England, for example the Mental Capacity Act, 2005 and the Deprivation of Liberty Safeguards, 2009. However, there are specifics for the Welsh environment in relation to workforce, demographics and policy that should be considered in any analysis of elderly care provision in Wales. In Wales, with a population of just over three million residents, since devolution in 1999 there has been a transfer of a range of policy responsibilities, such as that for the National Health Service (NHS), to what has recently been rechristened the Welsh Government (WG). In Wales the WG has sought to improve the cohesion between health and social care by developing policies that seek to encourage different organisations that contribute to service delivery to work more closely together. Wales has been particularly innovative in developing policies in relation to the provision of services to older people including the implementation of the ten year NSF for Older People and introducing a Commissioner for Older People.

Under this devolved administration the two main regulatory agencies working in the field of eldercare provision are: the Care Council for Wales (CCW), the main regulatory body that regulates the social care workforce, and Care and Social Services Inspectorate Wales (CSSIW) which is the main regulatory body in relation to social care provision.

In summary, in England, Wales and Scotland there are moves to less frequent inspections, supplemented by self-rating. There is a message that compliance is increasing but also concerns that for residents and their family carers it is difficult to get information about the quality of care in different care homes.

Mistreatment and safeguarding in care

There is limited research into the mistreatment of older people resident in care homes. A systematic review of studies examining the prevalence of mistreatment (Cooper et al, 2008) reported studies where 16%-40% of care staff reported committing serious psychological abuse, 10% physical abuse and 79-99% had observed the occurrence of abuse. Cooper's hypothesis uses an individual psychology model to explain abusive behaviour but there is a lack of research examining such behaviour in context. Examination of definitions and descriptions of mistreatment in care homes emphasised the importance of considering expectations of trust, including the organisation being in a position of trust, and relating characteristics of residents, perpetrators and care homes in further research (Dixon et al 2009). Studies examining mistreatment in care homes have relied wholly on carer report, excluding the perspective of those most vulnerable to abuse. A focus upon those who have the highest level of need for care and support is likely to assist us in examining the organisation of care.

In England, practice for safeguarding vulnerable adults is not on a statutory footing but reliant on multi-agency guidance in the 'No Secrets' report (DH 2000). No Secrets defines the following categories of abuse: physical, sexual, neglect, financial, psychological, discrimination and institutional abuse. Few adaptations have been suggested, although the inclusion of self-neglect and harm is suggested in the Law Commission review (The Law Commission 2011). 'No Secrets' does not set specific thresholds of harm for intervention. It asserts that harm does not only include ill-treatment but also "*impairment of or avoidable deterioration in a person's physical, intellectual, emotional, social and behavioural development*" and determines that intervention is a judgement based on vulnerability, nature, extent and time frame of the abuse, and its impact. ADASS affirmed that good practice is evidenced by transparent, consistent decision-making by local authorities in this regard and that poor understandings or experiences of thresholds and intervention by care services increase vulnerability of service users, (ADASS, 2005).

The **Mental Capacity Act, 2005** (MCA) covers both England and Wales. The MCA and its Code of Practice (Department for Constitutional Affairs, 2008) provides a statutory framework for engagement with people who may lack capacity. It provides for protection from liability for acts in connection with care and treatment carried out by health and social care staff in accordance with the Act, and it introduced two new criminal offences: ill-treatment and wilful neglect of a person who lacks capacity. Professionals and paid carers are under a statutory duty to comply with the Code of Practice. CQC regulations reference the MCA throughout and demand evidence of outcomes in accordance with the Act, (CQC, 2010c; CQC 2010d; CQC 2010e; CQC 2010f).

The **Deprivation of Liberty Safeguards, 2009** (DoLS) are an amendment to the MCA and clarify the boundaries of lawful restriction and restraint under the MCA. Restriction and restraint is lawful under the MCA providing a person lacks capacity, it is in their best interests and is carried out in the way least restrictive of the person's rights and freedoms. If such an act is severe enough to constitute a deprivation of a person's liberty (under the meaning of Article 5 of the European Convention on Human Rights) it is not lawful unless a DoLS authorisation is sought and granted from the Supervisory Body, (the local authority of the resident concerned). Managing Authorities (care homes) are legally responsible for requesting and complying with DoLS authorisations for all residents in their care for whom they may be required.

The practicalities of Supervisory Bodies, (whether they sit within the local authority or PCT; their staffing; the use of dedicated assessors; and their screening of DoLS referrals prior to assessment) vary across locality. Therefore the experience of care homes of the process, and any potential impact on care quality impact may differ as well.

The **Safeguarding Vulnerable Groups Act, 2006** (SVGA) outlines the pre-employment checks required of people employed or volunteering in positions with vulnerable adults. For care homes, it requires that all staff in 'regulated' and 'controlled' activity (as defined by the type of contact and frequency/intensity of contact with vulnerable adults) have an enhanced Criminal Records Bureau (CRB) check prior to starting work. The Independent Safeguarding Authority (ISA) holds the list of people banned from work with vulnerable adults (previously known as the POVA list) and this is checked through the CRB process. In practice, this means the vast majority of staff in care homes must have an enhanced check. In urgent situations, staff can begin work under supervision prior to receiving a satisfactory CRB check, if the provider seeks an ISA Adult First check. Employers also have a duty to refer a member of staff to ISA if they have reason to believe they are unsuitable to work with vulnerable adults. This would include situations where someone is dismissed (or would have been dismissed but they resigned) on grounds of abuse.

Aspects of the SVGA were put on hold by the incoming Coalition government. Likely changes for care home practice include: The removal of controlled activity from the check requirements, (meaning domestic and administration staff and volunteers may be exempt from requirements); the portability of CRBs so they transfer with the individual; and the removal of requirements for staff to be registered with the ISA Vetting and Barring Scheme (in practice, this system was never fully implemented).

In Scotland three key pieces of legislation currently outline the principles and procedures for safeguarding vulnerable adults: The Adults with Incapacity (Scotland) Act 2000; The Mental Health (Care and Treatment) (Scotland) Act 2003; and, The Adult Support and Protection (Scotland) Act 2007.

The Adults with Incapacity (Scotland) Act 2000 established a set of general principles upon which decisions made on behalf of an adult with impaired capacity must adhere. Specifically, the Act states that all such decisions must: benefit the adult; take account of the adult's past and present wishes; restrict the adult's freedom as little as possible while still achieving the desired benefit; encourage the adult to use existing skills or develop new skills; and, take account of the views of others with an interest in the adult's welfare. The Act makes provisions for a variety of interventions made on behalf of adults with impaired capacity, such as: continuing and welfare power of attorneys; intervention and guardianship orders; and, the management of residents' finances. The Act provides the Office of the Public Guardian (Scotland) and the Mental Welfare Commission with powers to oversee and investigate potential infringements of the rights of vulnerable adults, as outlined under the Act.

The Mental Health (Care & Treatment) (Scotland) Act 2003 outlines how individuals with a 'mental disorder' should be treated both in the community as well as inpatient settings. The Act is based on the principle that any intervention made under the Act should: be non-discriminatory; promote equality; respect diversity; be based on reciprocity; encourage informal care; facilitate participation; respect the role of carers; follow the least restrictive alternative; be of direct benefit to the service user; and (where applicable) treat as paramount the welfare of children of those individuals who are affected by a 'mental disorder'. The Act outlines the various ways in which individuals with 'mental disorders' may be assessed and treated, as well as the processes of formal appeal against compulsory intervention (e.g. via mental health tribunal). The Act also provides the Mental Welfare Commission with powers to investigate cases where individuals with a 'mental disorder' are/may not be being treated in accordance with the Act.

The Adult Support and Protection (Scotland) Act 2007 places a legal duty on local councils to investigate allegations of abuse in relation to vulnerable adults, and to determine whether further action is needed. The Act outlines a range of adult protection orders (assessment orders, removal orders, and banning orders). The Act established multi-disciplinary Adult Protection Committees (responsible for overseeing local adult protection policies) and places a legal duty on statutory bodies to co-operate in cases where the risk of harm to vulnerable adults is known or suspected.

In Wales, national guidance for safeguarding vulnerable adults was issued in 2000, which was reviewed in 2010. The guidance was brought in under the powers of the Local Authority Act 1970 and required social services departments to coordinate processes to 'prevent, identify, respond and ameliorate' abuse of vulnerable adults and to take action against perpetrators (HIW 2012). The Care Standards Act (2000) placed requirements around safeguarding procedures on care providers.

The quality of the care experience

In England, according to CQC/CSCI inspection reports there is a tendency for better performing care homes to be of smaller size. Of care homes (all adults) rated poor or adequate, 15% were large, 14% medium and 10 % small (CQC 2010b). The average size of nursing homes (all adults) is 46 beds, with private providers averaging 48 beds and third sector providers 36 beds. The average size of residential homes (all adults) is 19 beds, with private providers averaging 19 beds and voluntary providers 14 beds (CQC 2010b). In Wales in the past few years there has been an 11 per cent decrease in the number of small care homes (care homes with three or fewer places) across Wales with there now only being 14 left. There has been a small (two per cent) decrease in the number of small care homes across Wales between 2009 – 2010.

Person-centred dementia care

Approximately 250,000 people with dementia live in care homes (Alzheimer's Society, 2007) representing approximately 37% people with dementia living in the UK, costing in excess of £9 billion per year in social care (Alzheimer's Research Trust, 2010). This group of people have the most complex needs and the highest levels of dependency of all those with dementia, often having multiple physical, cognitive and functional mental health difficulties (Fossey and James, 2008). Behavioural and Psychiatric Symptoms of Dementia such as aggression, agitation, depression and psychosis (Margallo-Lana et al, 2001) are widespread and these difficulties are exacerbated by the inappropriate long-term use of antipsychotic drugs (All Party Parliamentary Group, 2008). One of the key goals of the National Dementia Strategy (DoH, 2009) was to improve the quality of care for people with dementia in care homes. A review of antipsychotic prescribing (Banerjee, 2009) recommended a substantial reduction in unnecessary prescribing. This adds further weight to the recommendations of the NICE/SCIE (National Institute for Health and Clinical Excellence/Social Care Institute for Excellence) dementia guidelines (NICE/SCIE, 2007) to improve the treatment and care for people with dementia in care homes.

Over the past 30 years there has been a sea-change in how we view the lives of people with dementia. In 1986 in the UK the Kings Fund published "Living Well into Old Age" which provided an explicit statement that people with dementia had the same rights and value as anyone else in society. Kitwood (1993a) described the person with dementia as:

"a person in the fullest sense: he or she is still an agent, one who can make things happen in the world, a sentient, relational and historical being" (p541)

Kitwood (1997) said that he used the term 'person-centred' in the context of dementia care to bring together ideas and ways of working with the lived experience of people with dementia that emphasised communication and relationships. The term was intended to be a direct reference to Rogerian psychotherapy with its emphasis on authentic contact and communication.

The disability rights movement and the growing dissatisfaction with institutionalised care led to various codes of practice from the Kings Fund in the UK during the 1980's that emphasised the rights of people with dementia to live well. The work of Steven Sabat (Sabat, 1994) was influential in shaping thinking about the impact of social environments on people with dementia. Kitwood brought together a theoretical framework for understanding the experience of care in his most well-known book *Dementia reconsidered: The person comes first* (1997). He focussed on the maintenance of personhood as being central to person-centred care. He defined personhood as:

"a standing or status that is bestowed upon one human being, by others, in the context of relationship and social being. It implies recognition, respect and trust" (Kitwood, 1997 p8)

The primary outcome of person-centred care for people with dementia is to maintain their personhood in the face of declining mental powers. There is an assumption in person-

centred care that people with dementia have the capacity to experience relative well-being and ill-being. Kitwood's view of person-centred care for people with dementia was that it took place in the context of relationships. He wrote a great deal about this and the way in which the social psychology could be supportive or damaging to people with dementia. As verbal abilities are lost, the importance of warm, accepting human contact through non-verbal channels becomes even more important than before. With the onset of dementia, individuals are very vulnerable to their psychological defences being radically attacked and broken down. As the sense of self breaks down, it becomes increasingly important that the sense of self is held within the relationships that the person with dementia experiences. These relationships cannot be developed through the traditional therapy hour as in person-centred psychotherapy. Rather the development of relationship occurs through the day-to-day interactions.

In communication and interactions, personhood is undermined when individual needs and rights are not considered, when powerful negative emotions are ignored or invalidated and when increasing isolation from human relationships occurs. Kitwood described the various common ways that he had observed personhood being undermined in care settings, coining the phrase 'Malignant Social Psychology' (MSP) as an umbrella term. MSP includes episodes where people are intimidated, outpaced, not responded to, infantilised, labelled, disparaged, blamed, manipulated, invalidated, disempowered, overpowered, disrupted, objectified, stigmatised, ignored, banished and mocked.

Very few people would wish to deliberately subject other people to MSP. Kitwood was at pains to say that episodes of MSP are very rarely done with any malicious intent. Rather, episodes of MSP become interwoven into the care culture. Kitwood also described what a positive social psychology might look like for people with dementia. If personhood is undermined by MSP then it should also be possible to describe the sorts of everyday interactions that would promote the maintenance of personhood. He used the term 'Positive Person Work' to describe ten different forms of interaction that would maintain personhood. These were labelled recognition, negotiation, collaboration, play, stimulation (engagement through the senses), celebration, relaxation, validation, holding and facilitation (Kitwood, 1997 p90-93)

The writings of Tom Kitwood have been enormously influential in the dementia care. The NICE/SCIE Guideline on Dementia (NICE/SCIE, 2006), built on Kitwood's work and further definitional work (Brooker, 2004) which defined the principles of person-centred care as asserting:

- The human value of people with dementia, regardless of age or cognitive impairment, and those who care for them;
- The individuality of people with dementia, with their unique personality and life experiences among the influences on their response to the dementia;
- The importance of the perspective of the person with dementia;
- The importance of relationships and interactions with others to the person with dementia, and their potential for promoting well-being.

Person-centred care and the ideas that influence it continue to grow. In many respects, these ideas no longer seem radical. The challenge now is how we get these principles into everyday practice. There is a particular challenge of how we assess the impact of person-centred care culture in care homes for people living with advanced dementia. People with advanced dementia face enormous challenges with having their personhood needs met.

Arguably, they are the people who most need regular nurturing contact from their care givers, but they are those who are least likely to receive this.

Intertwined and in parallel to the sea-change in how the lives of people with dementia are construed, there has also been a shift towards more positive constructions on how we view care home cultures. Tobin's (1999) work about the preservation of the self highlighted the importance of the psychosocial aspects of the care environment. According to Tobin, it is the warmth of staff in relationships, the availability of personally meaningful activities and stimulation, the tolerance for resident deviance and the extent to which residents are perceived and treated as individuals that define quality of psychosocial care. Sabat's (2001) demonstration of social positioning with respect to people with dementia lends empirical support to the manner in which interactions enhance or diminish a person's sense of self. His work also provides evidence of the way people with dementia actively cope with how they are treated.

The centrality of the relationships between care staff, residents and families as maintaining well-being of all these groups was brought together in the model of 'relationship centred care'. Through a series of interviews and observational studies Mike Nolan and others (Nolan et al, 2001, 2008) provided the Senses Framework demonstrating that quality of care is dependent on the relationships between the older people, care staff, and family carers. Good quality in the relationships was conceptualised by achieving a sense of security, continuity, belonging, purpose, achievement and significance for each party. The Senses Framework and relationship centred care was the conceptual framework for the "My Home Life" (Help the Aged, 2006) Programme. Following on from the publication of this report My Home Life was set up as a collaborative programme aimed at improving the quality of life of those who are living, dying, visiting and working in care homes for older people by sharing best practice and enhancing quality of care.

This approach addresses the larger organisational context of care provision. The practice of caring for very vulnerable people in large groups with low staffing levels can place care workers in an intolerable bind when trying to provide person-centred care. If care homes are to deliver person-centred care in anything but a non-trivial manner, the rights of all people regardless of age and cognitive ability has to be driven from the top down. The person-centred approach is about the building of authentic relationships. Organisations that adopt a person-centred approach to care also recognise the need to work by the same set of principles with their staff. If the personhood of an individual member of staff is not respected then they in turn will find it difficult to maintain respect for those they care for over a sustained period of time. Direct care workers for older people are one of the lowest paid groups in health and social care, often working in poor conditions with high risk of injury (Noelker and Ejaz, 2005). Providing care in a humanistic and person-centred way is a challenge where front-line care staff often feel under-valued (Skills for Care, 2007). Consequences for staff can be demoralisation, burnout and stress, lower work satisfaction or job clarity, lower psychological well-being and high workforce turnover (Moniz-Cook et al, 1997; Cole et al, 2000). Staff burnout has been shown to be associated with less willingness to help residents, low optimism and negative emotional responses to their behaviour (Todd and Watts, 2005). High levels of staff turnover, staff shortages and poorly trained staff exacerbated feelings of depression in care home residents (Choi et al, 2008). Empowering direct care staff through adequate induction and training is a crucial first step towards improving the lived experience of care for people with dementia.

Likewise, building relationships with families of residents is important in the life of any care home. Actively encouraging families to maintain relationships with their loved ones can make a positive impact on the lives of residents and staff (Woods et al, 2007). Without active encouragement family members or people with dementia can often feel marginalised, confused and excluded (Hennings et al, 2010). Family carers often struggle with their own

overwhelming feelings when the person they care for moves into a home. Where care homes do not understand and accept these feelings and carers are not made to feel welcome, they may be increasingly reluctant to visit. This can deny residents an important link with the past and their core identity.

There is a significant subset of people living with dementia particularly in long-term care settings, however, who find it very difficult to express themselves verbally. In some respects, this would not be so much of a problem if the experience of those who could speak out was similar to those who cannot. For example, in care homes where some of the residents who can take part in interviews are reporting high levels of satisfaction then it might be reasonable to assume that people with advanced dementia were also happy. There is evidence to suggest, however, that residents who are able to participate in interviews may have very different experiences of care than people with advanced dementia (Thompson and Kingston, 2004). Within a care home setting for example, those residents who are more socially able are likely to have more staff and visitor contact. The person who finds it difficult to achieve eye contact and who has very limited capacity for speech is likely to attract less attention.

When people have difficulty speaking for themselves about their situation it is common practice to ask someone who knows them well to speak on their behalf. In the case of people living with dementia this is often the person's next of kin or, failing this, a health or social care worker who has knowledge of their current situation. This is generally known as a proxy opinion. Some of the structured quality of life instruments have versions of the same instrument that can be completed both by the person with dementia and their proxy – either family member or key worker. Whilst proxies may be able to provide answers that would concur with the person with dementia on some occasions, there are others where they would not. Within the current study we were keen to utilise the perspective of those who cannot speak out for themselves. This was the rationale for commencing each case study with PIECE-dem (Brooker et al, 2011)

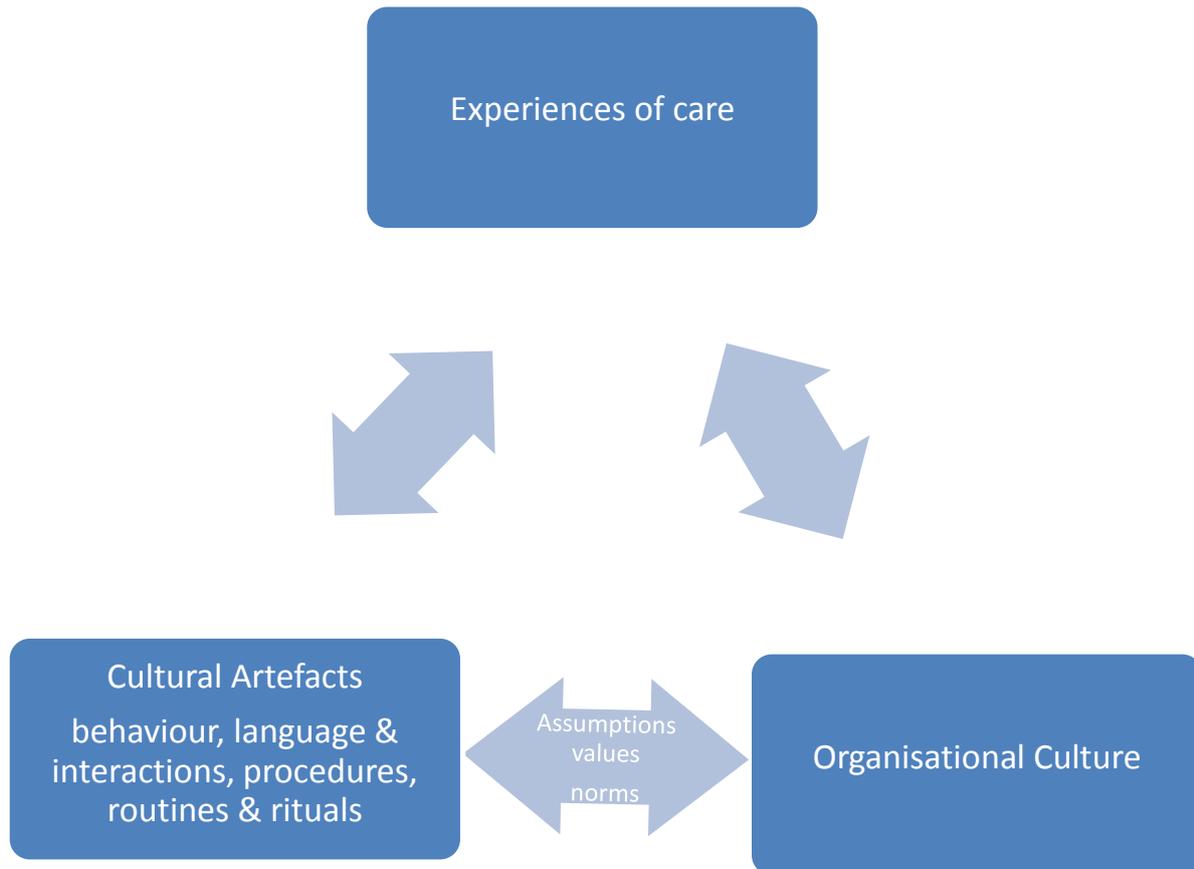
Organisational culture

The 'My Home Life' programme has identified 'positive culture' as an important element in the complex work of providing high quality care (NCHR&DF 2007). The CSCI (2008) report 'See me, not just the dementia: Understanding people's experiences of living in a care home' also argued that 'a culture within a care home of respecting and treating people as individuals', along with good leadership and staff support, was an essential component of good quality care, and that training alone was not sufficient.

In organisational studies culture refers to the basic assumptions, values and norms shared by and influencing how members of an organisation behave and interact (Schein 1985). Assumptions are often unconscious and taken for granted while values in organisations inform members about what is important. Assumptions and values shape the norms within an organisation; the unwritten rules that guide how members should behave in particular situations (Schein 1985).

Espoused values are an organisation's stated values and rules of behaviour (Schein 1985). It is the espoused values that often guide how care home staff represents the organisation both to themselves and to others. The values of a care home are usually written into organisational documents such as the philosophy of care and the statement of purpose within a care home. It is suggested that problems may arise if espoused values by organisational leaders are not in line with the general assumptions of the culture in a care home (Schein 1985).

Figure 1: Representing relationship between experiences of care, organizational culture



The influence of culture on performance, including the care experience, in health and social organisations has been the subject of debate for many years. Care homes are particular organisations, they are institutions in which people both live and work. Goffman (1968) illuminated the impact of institutionalisation, including on the development of abusive practices, and following this attempts were made to change practices in institutions including creating smaller organisations, personalising possessions and changing the staff experience (Goffman 1968, Miller and Gwynne 1972). Kitwood (Kitwood & Bredin, 1992, Kitwood & Benson, 1995) contrasted the New and Old Cultures of Dementia Care detailing the underlying beliefs and assumptions about the nature of dementia and the behavioural norms these related to in day to day practice. Scott et al reviewed (2003) the evidence for a relationship between organisational culture and health care performance. They argued that in health care simple relationships, such as for example that 'strong culture leads to good performance' were not supported by the evidence at that point, rather the evidence indicated that culture, performance and the relationships between them were multi faceted. In the USA social movements supporting 'Culture Change' first emerged in 1991 gaining further momentum in 1997 with the establishment of a professionals' network to promote resident centred care (Banaszak-Holl et al 2012). Within the broad movement of nursing home culture change in the US a range of models or locally developed practices are used (Stern et al, 2010). As this has gained momentum a body of research has grown using a framework (Competing Values Framework, CVF) and associated tool to establish an organization's culture in relation to four core cultural types (Cameron and Quinn 2006). Scott-Cawiezell et al (2005) hypothesised that nursing homes with a 'group' culture and 'flexible' orientation

would have the best outcomes, and found that nursing homes with lower 'flexibility' were more likely to report issues with team morale. Although this work was based on over 1700 staff questionnaires, these were drawn from only 31 nursing homes. Banaszak-Holl et al (2012) surveyed 1056 nursing homes with a CVF instrument and argue that the cultural value of recognising employee contributions is quite wide spread in the industry, even though most nursing homes do not report that they are affiliated to the culture change movement. They conclude that the translation of employee involvement into new work practices and staff's responses to the culture change values promoted by top managers are likely to be key issues.

Meyer and Owen (2008) aligned the My Home Life movement in the UK with the culture change movement in the USA, arguing that the development of leadership, management and expertise to facilitate a culture in which care homes are seen as a positive option is one of 8 themes of what residents want and what works in care homes. Kirkley et al (2011) have carried out one of the few UK studies examining organizational culture and care provision. They examined the role of organisational culture in supporting or undermining person centred care for people with dementia in short term care settings. They identified 5 aspects of organisational culture influencing person-centred care (understanding of person centred care, attitudes to service development, service priorities, valuing staff and solution-focussed approach). They argue that person-centred approaches are far from embedded in that setting and that a valuable step would be for providers to develop a shared culture consistent throughout the levels of the organisation.

Organisational culture is therefore understood to be a powerful influence on the care provided in a home. This study illuminates links between positive and adverse care and the context and culture, bringing increased understanding of culture to inform organisational development.

AIMS AND OBJECTIVES

The central focus of the study is 'to determine the individual circumstances, organisational cultures and practices most likely to encourage, or inhibit, the provision of high quality of care for older people living in residential and nursing homes.' (PANICOA 2010). The central research question is therefore:

What are the individual circumstances, organisational cultures and practices most likely to encourage, or inhibit, the provision high quality care for older people living in residential and nursing homes?

In order to address this question it is necessary to examine in context experiences of care that reflect both high quality care and also poor care including abuse, neglect and loss of dignity. In order for the research to be carried out in a respectful way that does not replicate disempowerment commonly experienced by residents (and also in different ways by staff) it is important to understand the meaning and importance that individuals give to their own experiences. These experiences then need to be related to analysis of the organisational cultures and practices. From ongoing PANICOA research projects the preparatory network hypothesised that the organisational features likely to impact most on the practice culture are type of provider, locale, and characteristics of the resident population. These features were therefore used to structure a sample frame to develop a purposeful sample of case studies.

The study aimed to analyse positive and negative care experiences, the contexts in which they occur and the factors that positively or negatively pre-dispose to their occurrence through the following:

- Examining the experience of residents with characteristics that make them particularly vulnerable to the effects of mistreatment to highlight key practices and organisational features implicated in positive and negative experiences.
- Determining the individual circumstances, organisational cultures and practices most likely to encourage, or inhibit, the provision of high quality of care for older people living in care homes.
- Analysing the relationship between experience of care and the recording of measurable indicators of quality (e.g. inspection reports, complaints, safe-guarding issues).
- Identifying examples of empowering practice including between individuals and at an organisational level.

The objectives to meet the aims were:

1. Focus on those residents with difficulty in communication through use of in-depth case studies that give sufficient time for:
 - a. development of relationships of trust between researchers, residents and staff,

- b. development of shared understanding between researchers and residents with difficulty in self expression
2. Use PIECEdem Observation Process (Brooker et al, 2011 access at http://www.worc.ac.uk/documents/PIECE-dem_Final_report_June_2011.pdf to examine the experience of residents who have dementia and a high level of complex care needs in order to focus case study data collection on key practices and organisational routines.
3. Conduct focussed ethnographic observations of routine care and interviews with residents, relatives, care staff, managers and owners in order to examine key aspects of care and the positive or negative experience of that care.
4. Use panel group consultation at key points in the study to ensure research questions and practice are highly sensitive to the perspectives of older people resident in or concerned with the experience of institutional care, and are not disempowering.
5. Position and contextualise the sample of comparative case studies to support relevance of the findings to the sector as a whole.
6. Understand from residents and staff what constitutes empowering care practice, and examine the relational aspects of such practice.

METHODS

Study design

The study adopted a comparative case study design, incorporating an element of participative research. The case study approach was intended to provide a method for examining activity in context, using multiple methods and data sources (Stark and Torrance 2005) to triangulate data and interpretation of experiences of care, care-giving, organisational cultures and practice from key perspectives (Stake 2005). Case study methods structure systematic collection of a range of data from different sources and analysis of that data to provide in-depth understanding of context and relationships (e.g. Wright et al 2009, Colon-Emeric 2010). The sample of cases was strategically selected (Hammersley and Atkinson 2007) to examine the impact of type of provider, locale and characteristics of resident population. Previous research in the PANICOA programme (e.g. Killett et al 2012, Bowes et al 2011) pointed to these as potentially significant components in the development of culture and practice in care home settings. Comparative case study design supports the development of knowledge and theory through an iterative process of within-case analysis and analysis between different cases (Eisenhardt and Graebner 2007). The design used in the CHOICE research involved four research teams each carrying out a series of case studies with substantial comparison from an early stage as cross case analysis took place between the teams. Data collection included a focus on capturing the experiences of those people whose communication was limited by cognitive, neurological, sensory or physical impairment: such limitations were considered to significantly affect needs of people living in residential settings, and we anticipated that their experiences were likely to be affected by communication issues. Ethical and reflexive research practice were emphasised as integral to the conduct of the study throughout.

Participative research approaches aim to actively involve the group of people most affected by a research topic so that their priorities, insight and experience can shape the research, leading to research that is relevant and respectful (Burns et al in press). This study included involvement of older people with experiences of care, and care staff and managers, in refining the focus, methods used, analysis and findings through the use of a panel group at key stages in the work.

The study had three phases: contextualising work, case study data collection and cross case analysis. Ethical review took place prior to fieldwork, and is discussed below. The cross case analysis commenced after the first round of case studies had been completed, and informed subsequent case studies.

Contextualising work

A series of 34 key informant interviews were conducted to position the study in relation to the wider context of developments in care home policy, regulation and practice. These interviews sought contextualising information which explored constraints and affordances of

current policies and practices of regulation, commissioning and labour markets, and care was taken to examine trends in each of the devolved jurisdictions responsible for health and social care (England, Scotland and Wales - Northern Ireland was not included for reasons of research resource). For a schedule of the topics covered in the interviews see Appendix 2. Interviewees are listed in the table below

Table 1: Participants in contextualising interviews

Category	Number interviewed
Care-home provider organisations	10
Regulators	4
Policy influence	3
Campaigning/representative organisations (service users)	9
Campaigning/representative organisations (for care providers and staff)	4
Safeguarding of vulnerable adults/care quality leads/local authority commissioners	4

Respondents were identified through purposive sampling to ensure coverage of issues. The purpose of these interviews was to highlight current and upcoming issues: we did not attempt a systematic overview of perspectives from these organisations, but to ensure that our work was informed by current thinking and issues. The interview data were summarised by researchers and the Findings chapter, page xx, provides an account of the issues highlighted.

Further contextual information was collated through a review of public domain documentary information profiling the care home sector, assembling an overview of key policy, practice and regulation trends, as well as statistical information about the sector, with particular reference to service improvements and their implementation. This desk based exercise produced summaries of policy and practice trends in the devolved administrations which ensured that the case study work proceeded with this knowledge (Appendix 1)

Participatory consultation through Panel Group

Two panel groups consisting respectively of 4 people either living in or caring for a relative living in a care home setting and 4 people involved in providing residential care were set up and functioned as a reference group for the research. The resident and carer panel group met twice, once prior to the fieldwork and once during the data analysis phase. The provider panel met once, prior to the fieldwork. It was not possible to convene the provider panel in

the data analysis phase¹. At their first meetings, the panels discussed their experience around care homes and at the second, they reviewed emerging findings.

The residents and carers group spoke about positive and negative aspects of care homes from their experience, and provided advice about approaching care homes, the need for people in care homes to have time to get to know the researchers to ensure the ethnographic data collection would be as good as possible, and about care home routines and staff shift patterns, and how these could be problematic for residents who might prefer a different routine.

The service provider group discussed good and bad care practice from their experience and about the challenges of running and working in a care home. They provided views on how the researchers might be received in the care homes and noted the need for researchers to understand what would be typical and what might be less usual. They spoke about their experiences of aggressive behaviour from residents, and about how difficult this could be to deal with, especially if someone was waiting for a move to another facility having been assessed as needing additional help. They highlighted that lack of staff training was a continuing problem in care homes.

At the second panel group meeting, carers and researchers reflected together on the fieldwork process, with carers raising several issues that the research team were able to confirm had been covered, such as the need to note how inspections operate, and the need to ensure interviews with sufficiently relevant senior people to ensure a picture of the aims and drivers of the home was built up. All participants agreed that the factors used in the sample framework (see below) were important, i.e. profit/not for profit, size, provision and what care was offered. Key questions raised concerned the level of training received by managers and their qualifications. Amenities in the care home, relatives' involvement and residents' meetings were highlighted. The group reviewed the 'propositions' (see below) that were being used to guide the analysis and discussed each one. They provided advice on improved ways of expressing the propositions, improving their clarity. The Panel Group discussions were fed back to the researchers, and used to inform the fieldwork and the data analysis.

Case studies

A linked series of 11 case studies of care home settings were carried out across the United Kingdom, between September 2011 and August 2012. The protocols for conducting these case studies were agreed between the teams, and the work coordinated to ensure consistency of approach for each case study. Data analysis, as we will describe below, included both within case and cross case analysis of the case study sample.

¹ It was not possible to find a time at which enough panel group members were available during the period in which the analysis was carried out.

Sample

Sampling was purposive and strategic with a view to taking account of type of provider, locale and characteristics of resident population. Previous research in the PANICOA programme had suggested that these three characteristics were likely to influence the individual circumstances, organisational cultures and practices implicated in the quality of the care experience. 'Type of provider' relates the nature of the organisation providing care, e.g. independent private business, large corporate business, not for profit. 'Locale' refers to features such as socio-demographic make-up, rurality, workforce availability. 'Resident population' includes attention to category of registration, funding of places and needs of residents.

The sample size of 11 was intended to allow in-depth study of each setting, involving respectful engagement with individuals living and working in each setting, their needs, perspectives and experiences, to gain in depth understanding of the relationships between key indicators, organisational features and the experience of living in that setting. The sample of care homes included 6 homes in England, 3 homes in Scotland and 2 in Wales. The sample included a care home in a predominantly Welsh speaking area of Wales with approximately 80% of the residents first language Welsh speakers. The sample also included a case study of a care home in London and another in outer London. This was to ensure that the research was informed by issues pertinent to care home provision in these areas including particular recruitment issues related to cost of living, and ethnicity and language of residents and carers. The principle of purposive sampling was used. The sample is not intended to support statistical generalisability of the findings, but instead purposively selects cases to provide data that is relevant to key issues of care home provision. Table 2 lists the care homes involved in the study and their key characteristics.

Table 2: Showing sample of care homes taking part as case study sites, and their key characteristics

Care Home Pseudonym	Sector	Size of organization	Number of residents	Provision	Fee band charged per resident
Mantle View	Not for Profit	Large, national	49-69	Care with nursing	Res Band C Nurs/Dem Band F
Chamomile Place	For Profit	Small, local	25-49	Care	Band B
Sage Court	For profit	Single	Under 25	Care, specialist dementia	Bands C-D
Lovage View	For profit	Large, national	49-69	Care with nursing	Band C
Marjoram Place	Not for profit	Large, national	Under 25	Care, specialist dementia	Band D
Chives Court	Local authority	Medium	25-49	Care	
Tansy View	Not for profit	Large, national	25-49	Care	Band B
Bergamot Place	For profit	Large, national	Under 25	Care with nursing, specialist dementia	Band I
Thyme View	Not for profit	Small, national	49-69	Care with nursing, specialist dementia	Bands B to G
Hyssop Place	Not for profit	Large, national	49-69	Care, specialist dementia	Band A (Local authority funded) Band D (self funded)
Angelica Court	Not for profit	Medium, national	49-69	Care with nursing	Bands B -F

Table 3: Showing key of fee bands

Band	Fee per week in pounds
A	300-400
B	401-500
C	501-600
D	601-700
E	701-800
F	801-900
G	901-1000
H	1001-1200
I	1201-1400

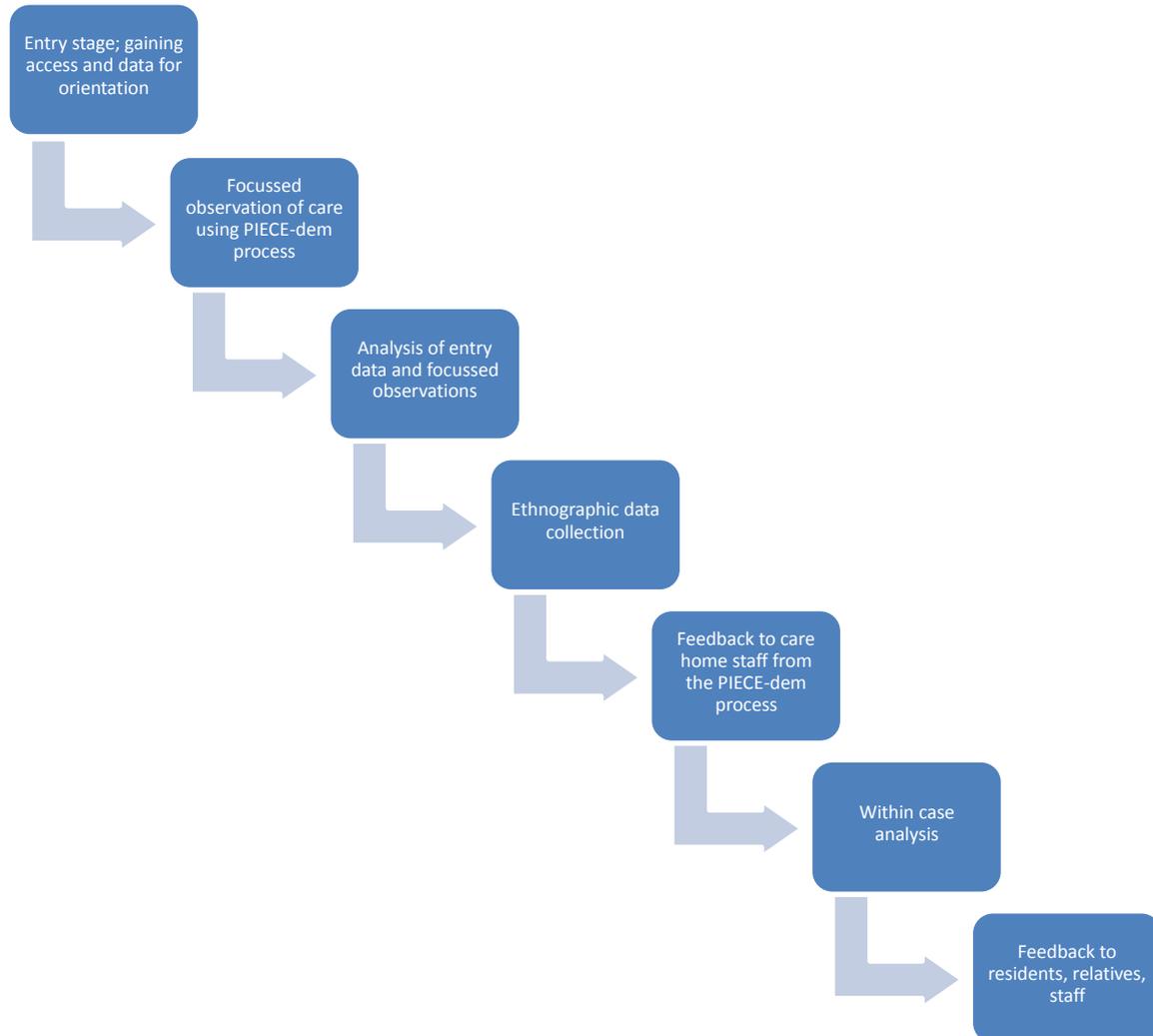
Data collection methods

Each case study included the following data collection;

- Structured observation of care using the PIECE-dem observational framework (described below)
- Ethnographic data collection:
 - Interviews with staff members, relatives and residents
 - Observations of the care home
 - Documents
 - Existing data recorded in care homes on key indicators, e.g. falls, untoward events, safeguarding referrals, length of tenure of staff (these were to be examined as 'artefacts' of culture and practice, rather than taken at face value)

The PIECE-dem observational framework was used within the case studies to illuminate the experience of those people living in each of the care settings who are among the most vulnerable to experiencing a poor quality of life. The findings from this intensive structured observation in each care home were used to help direct the sampling of participants, issues and observations in the ethnographic data collection. In this way organisational cultural and practice issues were examined both from the 'bottom up', working from the detailed minute by minute experience of care, and from the 'top down' as discussions, fact finding and orientation with managers in the entry stage of the case study (see Figure 2 below) began to indicate particular issues impacting on the care experience in each case study. Focussed ethnographic data collection examined the relationships between organisational culture and the experience of care. This entailed observation, formal and informal interviews, examination of key documents, engaged, responsive, context-based, short interviews with people affected by cognitive impairment. The purpose of the ethnographic data collection was to investigate the organisational culture in relation to positive and negative care experiences. Espoused values in organisational documents and as articulated by care home managers in our case studies were compared with the values articulated by care and auxiliary staff. The ways in which care was organised and practiced in care homes was also observed. Comparisons were made of the range of espoused values and the behaviours and interactions observed in organisational processes and work practices in everyday interactions and behaviours.

Figure 2: Flow chart to show indicative case study process



PIECEdem Framework

In each case study the care of between 2 and 4 residents was observed using this new process that was developed specifically for the PANICOA programme (Brooker et al 2011). PIECE-dem is designed to be used with residents who have significant communication problems, many of whom do not have the capacity to provide fully informed consent. During the development work on PIECEdem Brooker et al (2011) used a structured and staged consent procedure involving the resident concerned, significant other and key worker and this procedure was followed in the case studies. In the first instance, the key-worker and/or relative/significant other and researcher explored the residents' ability to consent and approached the resident to explain the research. Consultee advice was sought if the person was unable to consent, but showed no signs of distress at being in the presence of the researcher. Further attempts were made if appropriate to explain the researcher's presence during the period of observation. Every effort was made to ensure that the resident was comfortable with the researcher's presence during observation. If this could not be achieved then the observations were discontinued. During the eleven case studies, PIECEdem was used with 37 residents. Observations with 3 of these residents were discontinued due to circumstances in the home.

The PIECEdem framework is set out in detail in Brooker et al (2011) In summary and for the case studies, one researcher worked with two participants during the observation period, spending time with each participant in alternate 15 minute blocks over two-days, covering a typical waking day. A second researcher worked in the same way at the same time with two further participants. The observations in each case took place over two days in order to observe how different staff impacted upon the experiences of each participant. We observed 1pm- 9pm on day one and 8am till 1pm on day two. Using one minute time frames, the researchers made observations of the participants' experiences of the world around them, including recording levels of engagement, and the interactions that occurred with the participant and their immediate environment. This process was adapted in order to be sensitive to particular situations, such as for example in very small units.

For each minute, the researchers recorded:

- if the person appeared engaged with the world around them or disengaged
- if an interaction occurred
- qualitative notes describing the person's apparent experience of the world around them, what their needs might be, the nature, intention, and experience of interactions and the extent to which apparent needs were met

Additionally the researchers took qualitative notes describing the immediate environment within which the resident lived, including the extent to which the environment supported the physical, psycho-social and spiritual well-being of the resident. Observations were summarised every 2 to 3 hours on each resident, during the researcher's 30 minute break from observation.

Two researchers worked together as described: this work was particularly intense, and the researchers were able to offer each other support during the break. This support proved particularly necessary and valuable in situations where the care was not good. Researchers were instructed that if they saw care that was clearly neglectful or might be harmful (psychologically, physically), where a resident was clearly in danger or where there was clear deprivation, they should feed this back to the manager, or person acting in that capacity at that time, immediately after the period of observation. During the case study work 5 such incidents were reported.

Ethnographic data collection

During the ethnographic data collection process, continued negotiation of access and consent (see section on ethical conduct), for interviews and observations was conducted in an ongoing way as relationships and trust developed between the researcher, residents and staff. The following data were collected:

- Interviews – formal semi-structured interviews (3-15 per case study) were held with a purposively selected sample of staff, residents, relatives and visitors to the home. These participants were selected to further investigate key pertinent issues in each case study site. The selection of respondents took into account, for example, new members of staff and established staff members, new and longer term residents,

residents with relatives and carers regularly visiting and those without, local or non-local staff. A table of the data collected in each case study is in Appendix 3.

- Context specific interviews – in order to explicitly seek the views and experiences of those residents who have some degree of cognitive impairment short, engaged, context-based interviews were conducted (e.g. about bed time routine at bed time).
- Observation – in depth observation was carried out over a period of 2-6 weeks to include observations of activity in the care home, routines, behaviours, interactions of staff and residents in shared spaces. This did not include provision of intimate personal care. Times for observation were purposively sampled to include early, late and night shifts and mid-week and weekend periods. Early data analysis and note taking began to identify assumptions and norms in the home and how these might be related to positive and negative care experiences. The ethnographic data collection was an iterative process with the emerging analysis developed through further observations and the formal interviews. It was also dependant on on-going negotiation and consent with participants.
- Where possible documents were examined as data about stated policies, procedures, ethos and philosophy of care.
- Where possible records of key indicators - safeguarding referrals, falls – were examined as part of the data on organisational culture and practice, investigating the nature of the relationship between the numbers and recording process of indicators and positive and negative experiences of care.

Data organisation and analysis

The data set for each case study (including all the elements of data) was anonymised and stored electronically on a shared NVivo9 data base. Each case study was analysed on an in-case basis, before moving to the cross case analysis. A process of systematic iterative cycling (or trawling) (Eisenhardt and Graebnor, 2007; Eisenhardt, 1989) was used to identify corroborating evidence and establish and test out understandings of the relationship between key indicators, organisational culture and experience of care. Researchers used a common coding frame (see appendix 5), which was generated from initial analysis for the first case studies. The coding frame picked up key themes relating to the research questions, and also incorporated themes emerging from the early analysis. A set of propositions was developed following the first round of four case studies and within-case analysis of these case studies. These propositions were then refined as subsequent case studies were completed and analysed. The panel groups as noted above reviewed the developing propositions for their relevance and usefulness for care practice, care home organisation and resident and carer experience. See appendix 4, page 171, for further detail of the panel group discussion of the propositions and developments of the propositions. Regular inter team liaison across the study network (utilising a combination of virtual meeting, teleconference and face to face meetings) ensured consistency of approach and allowed emerging local analysis and findings to be tested out across the sample. The analytical approach was refined and agreed through this process.

Cross case analysis followed the in-case analyses, and involved a cross-case search for patterns. The propositions generated from the early in-case analyses guided the

comparisons that were made, and the process of comparison included seeking corroborative and contradictory evidence to support, refine or oppose the propositions, as well as to ensure that the analysis captured the full subtlety of the real situations in care homes. The trustworthiness (Guba and Lincoln 1981) and rigour (Morse et al 2000) of the analysis was ensured by the continuous cross checking of analysis between the researchers, as well as procedures within the analytical process, including thorough exploration of contrary findings and the iterative development of the analysis. Morse et al (2000:12-13) argue that rigour in qualitative enquiry is ensured by methodological coherence, appropriate sampling, concurrent data collection and analysis, thinking theoretically and developing theory. All these dimensions were present in our design and in our research process.

During data collection and analysis it was necessary to determine what constituted 'positive care experiences' and 'poor care experiences' for residents (and all gradations in between) and these terms are used in the findings section. Wherever possible the reported or observed experiences of participants themselves were used to make this determination. However, where researcher interpretation was necessary, Kitwood's (1997) model of person-centred care, including descriptions of positive person work, malignant social psychology and personhood were used to inform this judgement (see person centred dementia care section in Background). This model is integral to the interpretive elements of the PIECE-dem observation framework and so was carried through the project. If participants demonstrated divergent views on what constituted good care (such as member of staff and a family member viewing an event in different ways) this was explicitly stated in the data and findings presented here. These instances were often highly indicative of aspects of care home culture at work or in absence.

In presenting the findings in the report, we have focused on the propositions and used the case studies to support, explore and elucidate them into themes. For each theme, we focus on the case studies with the greatest depth and breadth of data on that theme, and bring other case studies to bear where they add additional insights. This follows the principle of theoretical saturation, which guided the analysis, in that we reached the point at which no new data was emerging, and the key insights were therefore established.

Ethical conduct of the study

Ethical review was sought from and granted by the Social Care Research Ethics Committee (SCREC) in respect of the case studies in England and Wales and the Scotland A Research Ethics Committee in respect of the case studies in Scotland (which are flagged to review research subject to the Mental Capacity Act 2005 (MCA), and Adults with Incapacity (Scotland) Act 2000, respectively). As those older people with cognitive impairment may lack capacity to consent to research, the research team had to justify the need to involve these people in the research. Under the terms of the MCA people who lack the capacity to consent cannot be included in research unless the research concerns their condition. The team sought the advice of the chair of the SCREC and established that the research was concerned with specific elements of care related to the condition of dementia: dementia leads to particular care needs and these are frequently not well understood and addressed in care settings (Brimelow and Lyons 2009).

The research team had to develop ethical relationships with members of each of the groups of research participants, staff, residents, relatives and care home managers. In doing so, we were mindful of the potential vulnerabilities and implications of participation in the research for each of these groups, and attention was given to developing sensitive and relevant practices of informing and negotiating consent to participate. For those potential participants who lacked capacity to consent to participate in the research we sought the advice of a nominated consultee who was not involved in the research in any way that would prejudice their advice. The research team used their experience to inform assessments of individuals' capacity to consent to taking part in the research, as well as taking advice from staff and/or relatives who knew them well.

The research team was also mindful of the particular research context of care homes and the types of research activities proposed, and of the ethical issues raised. There are ethical issues to address in involving research participants within care homes. For residents, the care home is first and foremost their home, where they are entitled to freedom from pressure to take part in any activity they do not want to take part in. However, older people and particularly those with communication or cognitive difficulties frequently have little opportunity to voice their views and opinions. The extended periods of case study research and thus contact and familiarity with research team members gave time for researchers to make informed judgements about the capacity of individuals' to consent to taking part in the research. The research team were sensitive to the need to ensure ethical participation both to engage residents in an open and transparent way and to allow participants to disengage where necessary. While it is an ethical imperative that such groups of people should be given the opportunity to be consulted about issues of concern to them, there was also a need to ensure that in approaching and engaging people in the research process they were not exposed to harm.

PIECE-dem framework and consent

In the study informed consent or consultee advice was required specifically for the structured observations. This process is described above (page 18).

Ethnographic research and consent

The ethnographic nature of the study where a large number of residents and staff of organisations were potentially being observed raised particular issues in relation to consent. Consent can be thought of at the level of both the organisation and the individual. In the ethnographic case studies data was gathered both in interviews (formal and informal) and through observation. For each case study the team first negotiated with the registered provider or the registered manager of the care facility. This person held responsibility for managing the facility in relation to the needs of the residents. If this person agreed to the organisation taking part in the research as a case study site, the research team then met residents, visitors/relatives and staff, telling them about the research, answering questions about the research and providing written information about the research. Residents and staff were given information about both observation and interviews. Residents and staff were

each invited to take part in the research. In care homes where the case study was of a part of the care home, such as a specialised unit, the approach was limited to these residents and staff. The research team sought written consent from participants during the ethnographic phase (residents, staff, families, visitors). A poster or flyer with photographs of the local researchers was displayed in an obvious position in the care home notifying everyone that research was being carried out and asking them to approach the researchers with any questions and concerns. A simple folded sheet with key information on it and a photo of the researcher was provided to people who could not give informed consent. The researchers were able to use them as a prompt to reminding the person about the research process over time. The research team ensured that they informed staff members that opting out of taking part in the research would not prejudice their employment. This was carefully discussed with the management of each home. Researchers were also mindful of day to day behaviour of staff and residents that may indicate a tacit withdrawal of consent and thus withdrew from some observations. The ethical involvement of staff and residents did depend on the capacity of the care home to collaborate meaningfully in passing on information, and in each of the case study homes, this was achieved (but see section below on ethical issues in conduct of the study).

Spaces in the organisations can be considered as private spaces (such as bedroom, bathroom, toilet) or shared spaces (such as reception areas, shared sitting rooms, shared dining rooms). Much of the observational data collection took place in shared spaces as intimate personal care was not observed; such observation was considered too invasive. In the conduct of the research it was important to balance the wishes of those people who consented to take part in the research with the wishes of those people who did not consent to do so. At any point the people present in the shared spaces could come from each group. To meet the aims of the research it was important to develop as rich and in depth picture of care in action and the daily experience of residents and staff. The research team took the position that if a resident who had not consented to take part in the research appeared distressed or agitated about the presence of the researcher in a shared space that the resident was in, the researcher would move away from the space. The researchers did not make observation notes on interactions and events where the people most centrally involved had not consented to take part in the research.

Confidentiality of data

Stored information was subject to the usual controls under the Data Protection Act. All identifying information about participating homes, study participants and staff was anonymised in stored data. All homes and study participants have a code identifier known only to the research team. A key to codes was securely stored separately. For the future, all written records will be stored for 5 years in a locked filing cabinet and will only be accessed by the research team. After 5 years they will be destroyed.

In this report, some observations or quotations from the homes have been used to illustrate points, and a brief description of the home and participants included to make sense for the reader. These have been framed so that they provide essential information, but do not include identifying details: for example, we refer to 'a 30 bedded rural care home' or a 'family carer of someone in a care-home' or a 'care-home manager'. No individuals are identified in the report. Where any names of places or people are used these are pseudonyms. We have chosen to use pseudonyms based on the names of herbs for the care homes.

Reflections on conduct of the research and ethical issues

Negotiating participation with case study sites

Negotiations with care homes about participation in the study often took a considerable amount of time. In some cases in early discussions care home managers expressed willingness to participate, then either let the team know they did not want to take part or did not respond to follow-up contact. It seemed in some cases that the thorough approach taken to informing potential participants and negotiating individual consent appeared daunting and complex to care home managers. In some cases it seemed that care home managers delayed deciding whether to take part or not. The implications of this for the research was that a lot of time was taken up with establishing contact with potential case study sites, informing people about the research and negotiating participation, and this was carried out with more care homes than eventually took part in the study.

The way in which care home managers enter such negotiations on behalf of the home is likely to relate to the culture and operation of the organisation, and this has to be considered as relevant to make up of the final sample of care homes. The following example illustrates this:

The team invested a considerable amount of time (1 month) in gaining access to one care home, through initial staff, relatives and senior management meetings. Senior management were keen to participate, but attempts to make contact with staff (via meetings, letters, one to one contact) were unsuccessful and very few staff consent forms were returned. Management reported that action was usually created by authority imposed from the manager. This led to the research team withdrawing due to inability to get staff consent and concern that coercion may be applied from management to effect staff involvement. This raises the possibility that certain types of organisational culture (such as those with strongly hierarchical practices) could have been precluded from involvement in the study. These types of organisational culture may have added an alternative dimension to understanding links between culture and quality of care.

Negotiating individual consent

There were paper-intensive consent procedures for the project and these presented challenges for the research team, even when agreement had been given to combine consent processes for the two phases of observation (PIECEdem and observation). Notably in relation to ethical practice, the paper-focus of the consent processes made the research far less accessible for many individuals in the homes. Consent needs to be understood as an on-going process: In one care home, near the start of PIECEdem observations, two care staff who had signed consent forms made it clear they were not happy with the researcher's presence. Once they had notified the researcher of this, she reassured them she would not document their activities and interactions with residents. However, the observation period was not a particularly comfortable one as the researcher was aware of the need not to observe them, while also trying to carry out PIECEdem. On reflection it might have been better to have rescheduled PIECEdem and ensure they were not on duty. In another case study, researchers felt there was slight coercion in the manager's method of passing on information. To deal with this the researchers were very careful to speak to care staff individually and to ascertain whether or not they really did want to consent to participation. Three care staff did not in fact want to consent and therefore they were not observed or interviewed.

In another care home the research team found that the large amount of paperwork that was required acted as a clear barrier – particularly acting as a strong signal to staff who seemed to feel that they were being audited or their performance being measured even though well founded co-operative relationships had already been developed and on occasion, the atmosphere could become uncomfortable and awkward. The researchers felt that as the researcher was not interacting but concentrating on observation that it drew attention to the researcher as an outsider and due to the particular physical lay out of this home i.e. small lounge and dining room it was very difficult to be discreet. Although the residents who provided the focus of the observation process were living with dementia the researchers noticed that the residents were at times aware of the observation process, and seemed more comfortable with researchers during relaxed periods – although they did not seem anxious as such, but certainly curious and aware.

As has been documented elsewhere care home staff (Hussein 2011) particularly in areas of the UK such as South East England and London are characterised by high levels of recently arrived immigrants to the UK who often have limited language and literacy skills. In this situation presenting staff with a large amount of paperwork to read, digest and then sign in a meaningful process of consent was problematic. In this situation however it was found that if a considerable amount of time was spent with explaining and discussing the research, sometimes with intermediary translators, participants were more than happy to take part in the process if they felt it could improve standards of care.

Reflection on and weighing up of such issues led to decisions in some case studies to conduct PIECEdem observations with fewer than the originally planned 4 individual residents, or to cut short the observation period.

Following the case study process

There were some variations to the case study process set out in Figure 2. In one case study the PIECE-dem observations were conducted much later in the study because of the time taken for the development of relationships and negotiation of participation for this activity. In three other case studies the feedback to staff on the findings from the detailed PIECE-dem observations took place at the same time as the feedback on the case study as a whole. This was for various reasons. In particular, where the PIECE-dem observations had shown particular difficulties in the care practices, it was judged to be more constructive to be able to contextualise this feedback with the analysis of the care home case study as a whole.

Researcher dilemmas about intervening

Dilemmas about intervening occurred during PIECEdem observations and when the researchers were within the care home generally. There were occasions when residents were in need of care, company, support, pain relief etc. and were not receiving it. Ethically, the researcher cannot allow a distressing situation to continue for the resident so had the option of trying to provide for the resident themselves, within reason, or going to look for a staff member to do what is required. However, there was a tension between being unobtrusive or not being a nuisance and irritating already busy care staff with residents' needs that they were clearly unable to attend to. On all occasions, a judgement had to be made as to the best course of action, taking into consideration different factors such as: can I attend to this myself? How urgent is it? What staff can I find/where are they? Can it wait a bit and I will try to reassure the resident that help will come soon? Seeing residents in need and not being attended to caused anxiety to researchers and resulted in constant internal

debate: will I intervene or will I wait a bit and see what happens? If I intervene to help a non-participant resident, I can't observe my participant, so my documentation of their experiences is partial. Inevitably, the researcher intervened, put a stroke through the relevant time frame(s) and justified their intervention on the grounds of safety or compassion.

Focus on small units within homes rather than whole homes

In several care homes decisions were made to focus on small units within the care home as opposed to the whole home. This was because gaining appropriate levels of consent from residents and staff required substantial periods of time in the setting and the study design did not allow sufficient time to repeat this across multiple units (that often had distinct staff teams as well as residents). This means that the organisational culture of the home was examined, as manifest in a unit within the home.

FINDINGS

The findings from the contextual interviews are presented first, as these help to locate the detailed findings from the in-depth case study research in the sample of care homes in relation to the current context of care provision for older people in the UK. This is followed by a short descriptive paragraph of each of the care homes that took part in the research, and then the findings from the analysis are presented in seven themes. In the case study approach taken in this study, the circumstances, organisational cultures and practices implicated in care could be examined in context, and in relation to the experiences of people with very high levels of need for care. A culture that supports positive care appears to be made up of a mix of important elements. The themes reflect key elements of care home organisational culture relevant in the provision of high quality of care.

The current practice context: Overview of Contextual Interviews

Thirty four interviews with key informants in Scotland, England and Wales took place. Key informants were from a range of stakeholders across the care home sector (see Table 1, page 23). Key informant interviews were designed to inform the sampling of case study sites across the UK (to ensure they represented the range of provision available) and to provide an insight into possible indicators and issues related to quality of care within care homes. A thematic analysis was conducted, and the following themes were identified.

Current state of the Care Home Sector

Composition

The sector is in flux and is rapidly changing. There are a variety of characteristics that stakeholders use to describe differences within the sector: Business model (profit/non-profit making); size of owner company; residential or nursing provision and specialist or non-specialist care. However, none of these are clearly correlated by stakeholders with good quality or bad quality, with a much more common perspective that individual factors in homes make the difference rather than overarching features. There does exist a view that correlates profit-making with poorer quality care, but this tends to be dominated by local authority perspectives, and other issues (such as funding and leadership) are seen as far more determinate of quality. These were viewed by some as either correlated with, or compounding, quality issues related to the model of provision. For example, by some informants, the private sector was seen as less likely to take up leadership training and more likely than other sectors to take up rights based training. There was a view that in very large for-profit providers bureaucratic processes could get in the way of managers' initiative and local responsiveness. Provision in Wales was characterised as having more smaller private for-profit providers than England. Some informants felt that the voluntary sector brought 'something special to the care quality in care homes, while others saw this sector as particularly adversely effected by reduced funds in the constrained economic climate. Resources for local authority provision in each of the countries were seen as locally variable, with recent legal challenges to local authorities from providers in Wales over the level of fees

paid. In England there were concerns about the impact on care homes of transition from local authority provision to private providers.

Purpose

Overall there is a sense amongst stakeholders that the purpose of the sector has changed from one providing traditional residential care on a social care model to a sector that caters for more complex needs and conducts high level health care work. This is seen to impact on quality because the sector is now expected to do different things but many systemic features (such as funding) have not adapted accordingly.

Allied to this changing expectation of what care homes provide, provider stakeholders and many representative bodies expressed a sense that there is a lack of understanding about what care homes do, and in particular an underestimation of the complexity of care provision, the needs of client groups and the concomitant skill set required by staff. This lack of understanding was felt in providers' interaction with regulators, local and national government, safeguarding services, commissioners and the public.

Some informants contrasted the sector with residential provision for other groups such as children and young people and people with disabilities. Care homes for older people are consistently less expensive, and also change registration categories more frequently which can lead to the type of provision getting out of step with the skills of the staff and the infrastructure of the home.

Attitudes

Provider stakeholders of all kinds, as well as non-statutory representative bodies spoke of a negative and hostile approach towards the care homes sector. This was variously attributed to financial pressures, ideological drive for 'care at home' or societal ageism. There was a sense from these stakeholders that this had accelerated in recent years with residential care being seen as a last resort or failure rather than a positive choice. These attitudes were identified as impacting negatively on the quality of care in the sector because it reduced the value placed on the work and affected recruitment, retention and career opportunities within the sector. Perspectives from statutory and regulatory stakeholders suggested (although not explicitly) that the prevailing attitude towards the sector is that, despite a rhetoric of 'partnership working', it is a sector to be "done to" rather than able to do for itself. Some stakeholders felt that a cultural change towards openness and transparency from and about care provision would help to challenge unhelpful attitudes. A particular issue in Wales was the lack of Welsh language provision, of particular relevance for people with cognitive impairment who's first language was Welsh. The attitude that people could speak in English if they needed to was unhelpful in developing appropriate provision.

Pressures on the sector

The most obvious divisions between stakeholders occurred when considering the pressures currently experienced by the sector. These divisions were primarily seen between providers (and those representing providers or users of services) and statutory informants.

Funding regime

Funding was the most consistently raised issue, with every key informant referring to its impact, although statutory stakeholders did not correlate it negatively with quality in the

same categorical way that providers did. Cost pressures were understood to operate in several ways. Providers highlighted that underfunding from local authorities had reached a critical point in the sector, leading to a likely consolidation of the market in the favour of those providers whose business model prioritised self-funders. Some informants predicted funding challenges were likely to worsen, and that the market would consolidate into a few very large provider organisations. Current funding levels were linked by providers and non-statutory bodies to poor quality in a variety of ways: lack of investment, poor wages, poor training and development opportunities for staff, poor staffing levels and lack of resources, and financial instability of individual care homes. Some informants described a direct impact on heating, food and activities for residents. The difficulties of providing excellent dementia care (as characterised by truly person centred services) without sufficient funding were highlighted by a number of providers. Where needs arising from symptoms of dementia were particularly complex, necessitating one to one care, such costs cannot be accommodated by local authority budgets.

Statutory sector stakeholders appeared less likely to attribute funding directly to poor quality, although this did not mean they did not express concerns or recognition of the impact of funding on service provision. Instead their perspectives tended to highlight less tangible aspects of quality such as leadership, ethos or quality, but without a direct link made between these aspects and funding. In addition, the profit motive of some care providers was often identified by these stakeholders as having a negative impact on quality.

There was concern from some informants that at precisely the time when there is need for more innovation from the sector to develop more flexible and efficient responses to increasing size and complexity of demand, the pressure of funding restrictions will stifle creativity.

Competing expectations

Provider perspectives emphasised the competing inputs from various parts of the statutory sector (regulation, commissioning/quality assurance and safeguarding) which often had overlapping or unclear intentions and a negative impact on both quality and the autonomy of providers. There was a strong sense from providers that each of these statutory functions positions itself as the arbiter of quality in care homes, but that, in practice, the lack of coordination between these different inputs can be problematic. Providers and non-statutory stakeholders did not reject the necessity of these different inputs but instead emphasised that inconsistency, lack of coherence between different aspects and lack of awareness of best practice from regulators, safeguarding and commissioning often exacerbated rather than reduced problems of quality care. From statutory stakeholder perspectives they did indeed each characterise themselves as having a role in quality care provision, and did not evidence awareness of the impact of such overlapping responsibilities on care homes.

However, it is important to note that this theme was predominantly seen in the interviews from England and Wales. Within England, informants expressed concern about the withdrawal of quality ratings and felt that there was a reduction of the support, advice and inspection role, and this was a loss. There was concern that the regulator would have insufficient resources to address the expanded role across health and social care. Welsh stakeholders suggested more coherence and partnership working in this region, although some argued that CSSIW should engage more with providers. It was still suggested there was a need for greater streamlining of regulation. There was concern that the increasing role

of self-reporting procedures would reduce the voice of residents in regulation. In Scotland, although some similar frustrations existed there was overall more confidence in the regulatory mechanisms. There were concerns expressed that the standardised staffing ratios were not an appropriately sensitive tool, although these were felt to be a loss by some informants from England and Wales. Some UK wide providers lacked understanding of the principles and standards of regulation in Scotland. The coherence of safeguarding due to different legislative arrangements in Scotland also helped reduce conflicts of expectations. Some informants argued for more centralised commissioning in Wales, and for closer relationships between commissioning and provider organisations.

Workforce

Leadership was identified across stakeholders as a crucial factor (if not the crucial factor) in determining good quality care. This was not simply about the manager, but about internal structures of organisations and homes and external support systems available through safeguarding, regulation etc. However, there was also a sense that leadership in care is problematic, requiring specific training and support, and for providers this was linked to funding issues. Where this is regulated, this can also constrict the available manager workforce.

Staff recruitment and retention was also seen as an issue (in terms of both quantity and quality). This was directly linked by many across perspectives to the value placed on care work, the opportunity for career pathways and, from provider perspectives, to wages and funding overall. Increasing professionalization of the workforce was cited as a necessity by some informants, although there was concern about a lack of confidence in care staff generally to engage with this agenda. Training was identified as necessary for both leadership and frontline support staff and again was linked with value of care work and funding. However, there was some dissatisfaction with what was on offer.

With regard to workforce issues many stakeholders, including providers themselves, identified that the type of provider/owner of a home was significant with regards to the extent to which they could support these overheads within their business model. This was not only about whether a business was able to reinvest in services, but also about the ethos that governed an organisation and the size of that organisation.

Prospects

The sector was seen by many as being at a critical juncture. The future direction of the sector was seen to depend on decision-making and responses to the issues summarised below, with concern as to whether there would be sufficient policy leadership in an area calling for politically sensitive decisions and long term planning. Some policy initiatives, such as 'Reshaping Care for Older People' in Scotland, were seen as important in agenda setting. Some anticipated that increased service user involvement will help to positively shape provision.

Funding & consolidation of the sector

The sector is changing due to funding issues and many providers will exit the market. This is not necessarily advantageous to quality care and could lead to a sector that is dominated by large providers, and with profits prioritised over people in decision making. As transition in ownership is destabilising to care homes, with implications for management roles and the

associated leadership functions, it is important for regulators to check that quality is not affected in homes where financial viability is uncertain or where transitions are taking place.

Resident population

The changing demographics of residents with regards to dependency, end of life needs, and cognitive impairment will drastically change the sector (and is already doing so). As both a consequence of changing demographics and the drive towards home care and personalisation there is a trend for later admission, more complex needs and shorter stays. To meet these demands there is likely to be a need for increasing specialisation in care home provision. There is also a need for greater diversity and flexibility of provision and for innovation. Innovation in provision, including for example 'hub' models and 'step up' and 'step down' care, will require innovation in funding. There could be value in care workers working in both care homes and the community as part of 'seamless' services.

Regulation

Within England, there was what could best be described as a crisis of confidence in the current regulator and the return provided for the resources provided to it. In Scotland regulation was viewed more positively as contributing to care quality, with positive financial incentives seen as a useful driver. In England local developments of quality criteria and premium payments by commissioners are emerging. There was a view that commissioners could further influence quality if further trained in specialist dementia care in order to recognise it and understand the resourcing of high quality complex dementia care.

Workforce and leadership

There is need to invest in these aspects in order to improve quality of care provision. In particular, to respond to the need for increasing specialism, diversity and innovation, informants expressed there was a need for increasing professionalization of the workforce. This could contribute positively to career opportunities, and therefore recruitment, particularly among the much needed younger potential workforce. However the extent to which this can be done successfully will depend on changes to the perceptions and value placed on care homes and a resolution of the current funding difficulties.

Participating case studies

The following gives a brief portrait of each of the care homes that took part in this research as case studies

Mantle View

This large home was run by a large not for profit organisation that ran a number of homes in the UK. The home had been purpose built several decades ago but in recent decades has changed from one large home organised around a central lounge to smaller, self-contained 'family' units, each focussed on particular resident needs, including dementia care and medical/nursing. This is a home with a waiting list of both potential residents and potential staff. Families are often thankful to have found a place for their relative in this particular home and will transfer their relative from other local homes as vacancies become available. Staff are paid above the minimum wage. Although there is an ethos of individualised care, on the particular unit where the research was conducted the more mobile residents often spend long periods of time in the lounge without staff contact as many of the residents on the unit were

bed bound and staff spent long periods of time in other residents' rooms in order to meet their needs. The manager is very personally supportive of staff, and the regional manager is also often seen in the home.

Chamomile Place

This is a private home currently owned by a local entrepreneur who also has other business interests in the locality. It is based in an adapted and extended country house, the layout of which can make it difficult for staff to be aware of residents' activities and needs if they are in different parts of the building. There have been several recent changes of ownership, the most recent precipitated by the business going into receivership in the year before the research visit was conducted. Prior to the home going into receivership the inspectorate had identified issues with communicating with residents in their first language. The new owner had initiated a large turnover of staff since he had taken over ownership to replace a predominantly sponsored immigrant Asian workforce with local and Eastern European staff. This had precipitated some feelings of loss and uncertainty among some of the residents. The ownership and management were aware of these issues and were consciously working toward an identified strategy for developing team work in the new staff group and to help the staff build up knowledge of the individual residents and their needs.

Sage Court

This was a small privately run care home located in a converted pair of semi-detached suburban houses. At the time of the research visit the home provided for ten residents all of whom had severe care needs in relation to memory and Alzheimer's conditions but were relatively physically able. Many of the residents in this home had been referred to residential care by the local social services department when either individually, or with their families, they were no longer able to cope in the home environment. There were a number of ethnicities and religious affiliations represented within the resident group. Within the workforce there were seventeen different nationalities represented and only one member of staff was UK born. Some staff were working on restricted UK student visas, which had implications for the number of hours they could work. Many of the staff and a number of the residents were not first language English speakers and a number of staff and residents had trouble speaking English and used other methods of communication such as touching and hand gestures. Considering the multi-ethnic makeup of the workforce and the local labour market the staffs were relatively settled with most of the care workers having worked at the home for a number of years. The home had a very strong family ethos with staff, owner and relatives "popping" in and out on a regular basis.

Lovage View

This is a recently refurbished former hotel with 51 bedrooms, most of which are ensuite. It is set at the edge of a small town. The home is part of a large for profit chain and provides nursing care to people with dementia and people without cognitive impairment. There is always one nurse on duty. At the time of the case study, the home had recently reopened following refurbishment and extension of new ensuite bedrooms and was operating at just under half its capacity

Marjoram Place

This is a converted Victorian building at the edge of a town in a remote region. It is owned by a charitable religious organisation and is run on a not-for-profit basis. It has recently changed to providing care solely for people with dementia and has increased its staffing levels and

focus of training to accommodate this change. The home has strong links with the community, with residents going out to community lunch clubs and various members of the community entering the home for activities and entertainment.

Chives Court

This is a Local Authority run care home and was built in the 1960s as a residential home. It has three floors, each with kitchen, sitting rooms and dining room and provides care for approximately 60 very frail residents with and without cognitive impairment. None of the bedrooms are ensuite. It is situated in a residential area of a major city in the UK. There have been recent changes of management and staffing difficulties and the home relies heavily on agency staff, many of who do not have English as their first language.

Tansy View

This is a new, purpose built home in a small town. The home is owned by a charitable religious organisation and runs on a non-for-profit basis. The home has experienced a change in management, but has had the same manager for the past four years, providing stability and direction. There is a core group of staff who have worked there for over two years, along with long term arrangements with individual agency staff. There is a culture of caring for everyone, including residents, staff, relatives and people from the local community. The home has recently introduced a new staff structure and has widened the types of care it provides to people with a wider range of needs. This includes providing end of life care for people living in the wider community.

Bergamot Place

This specialist, purpose built dementia care unit is in a quiet suburb. The home has experienced a change of ownership in the last five years, but a core group of staff have worked there since it was developed by an individual provider. There is a strong culture of providing the highest standards of care, and new comers to the staff team can feel the pressure to achieve this. Care staff are very mindful of the tensions between facilitating choice and attending to residents best interests. Relatives and family carers have high expectations and the management and care staff work hard to meet these. All staff, including housekeeping and administrative staff, see their work as meeting each resident's needs.

Thyme View

This large home, built over 50 years ago, was located on the outskirts of a major city. It had a newly built extension for people with dementia, as well as older 'hospital style' units for residents with nursing needs and those needing only residential support. Staff were allocated to specific units, but were known throughout the home. Owned by a medium sized, not-for-profit organisation affiliated to a religious faith, it was held in high esteem by residents, relatives and staff alike and was strongly linked into the wider religious community. All residents were of the religious faith, although this was not a requirement of admittance. Approximately 50% of the staff were of the faith. The home had no problems with recruitment of staff, and received many 'off-the-street' applications due to its reputation. Residents were funded both statutorily and privately. Management and the wider organisation accepted that the home would run at a financial loss, with shortfall being met through appeals to the wider religious faith and fundraising activities. At the time of the research it was compliant with regulatory standards. There was a strong ethos of person-centred care throughout the home that was frequently (almost constantly) seen in action.

Hyssop Place

This large residential home, in a semi-rural area, was built a decade ago on the site of a previous, smaller home. It provided residential care across three floors, including a small unit that was described as 'dementia specialist'. There were distinct staff teams for each floor, although non-regular staff were often seen in the dementia unit. Management reported no problems with staff recruitment, retention or sickness, although staff and visitor reports, as well as observations, differed from this perspective. Ownership had transferred to a large not-for-profit organisation within the last two years. Previously it had been owned by a similar type organisation and before that, the local authority. One quarter of the residents were funded by the local authority with the rest being privately allocated (at a much higher rate). At the time of the research the home was non-compliant on one regulatory standard. The home had received dementia service accreditation from the local authority and the manager was proud of this status. However, whilst a strong rhetoric of person-centred care existed, actual care experiences were observed to be hampered by several issues. These were recognised by staff and relatives, although not by management.

Angelica Court

This large home, in a semi-rural area, was built a decade ago. It provided care across distinct units for residents with nursing needs, those with residential only needs, and those with residential needs related to dementia. One quarter of the residents were block purchased by the local authority with the rest being privately allocated (at a much higher rate). Staff teams were distinct across the different units. There were no problems with staff recruitment currently, although wages were lower than other homes nearby, and the home had lost a number of experienced staff recently. The home was owned by a large not-for-profit organisation and had been for the last decade, transferring from local authority ownership. At the time of the research the home was compliant with regulatory standards. There was a rhetoric of 'person-centred care' in this home. However, actual resident experiences, particularly for those with more complex needs related to their dementia, appeared inconsistent at best.

Key themes relevant to care culture

The following section addresses in detail the findings of the study. As outlined in the methods section, each case study was analysed individually and then compared with others as part of an iterative process. This led to the emergence of key propositions that were refined as further case studies were completed and analysed. These refined propositions resulted in the seven themes presented below. In exploring each final theme, and in accordance with the cross case analysis design, focus was placed on comparing case studies that were particularly illuminating of the theme in question, examining it both in a context of positive care and culture and in challenged care culture. The findings from this exploration were then refined with reference to the remainder of the case studies, to ensure concepts were deepened beyond application in specific cases. This means that data drawn on under each theme will focus on illustrating examples from selected case studies. This does not mean they were the only homes exhibiting such characteristics (unless this is explicitly stated). The themes are:

1. Shared purpose in providing best person centred care
2. A sense of community between all involved in the care home
3. Managers ensure external pressures do not have a negative impact on care delivery
4. Staff are empowered to take responsibility for resident well-being by active management
5. Openness to change for the benefits of residents
6. Using the care home environment to the benefit of residents
7. Person centre activity and engagement is integral to care work

Theme One: Shared purpose in providing the best person-centred care

Findings show that having a shared purpose in a care home can have a bearing on the quality of care. Shared vision and understandings of the purpose of the home and the aims of care among management and staff that put the needs of residents as paramount were associated with positive care experiences.

The most important part of my job is making sure that everybody in the home gets proper person centred care, and that they feel that they're wanted and valued and that they're well looked after, and that this is their home, and that the staff do their best to facilitate that. There's no "no's" or "don't do's" [for residents]. You do within reason what you can achieve and do for them. And that's what I try and filter down to the staff that are on my team. (Tansy View, interview with team leader)

The case studies showed that shared understandings of the purpose of a care home can influence the quality of care. Where staff members and management have similar understandings of the purpose of their work, this was found to have a bearing on how consistently good care was experienced by residents. This theme was examined through a comparative analysis of the espoused values of the home (articulated in organisational documents and by care home managers), those values articulated by care and auxiliary staff, and the ways in which care was organised and practiced in the home.

At a basic level each care home was found to have an espoused organisational value pertaining to the *individualised treatment and dignified care* of their residents. Lovage View was the exception, in that a single value was espoused to care for residents as *if they were a member of their own family*. All the care homes varied however, in the extent to which espoused values were similar to the underlying assumptions in the care homes, as shown in the day-to-day practices, behaviours and interactions of people in the home. Notwithstanding the negative impacts on care of organisational factors such as chronic understaffing, the

case studies suggest that where organisational values and purpose were consistently shared among management and staff, care experiences tended to be positive.

Espoused organisational values

All of the care homes, except Lovage View, had written documentation explicitly espousing values relating to person centred care. For example, each of the other care homes commonly reported philosophies, visions and ethos statements involving the treatment of residents as individuals with rights to 'privacy, dignity, independence, security, choice and fulfilment' (Hyssop Place, Tansy View, Marjoram Place, Mantle View, Chamomile Place, Angelica Court) and in some cases to facilitate 'relationships, empowerment and rights to self-determination' (e.g. Thyme View, Sage Court, Bergamot Place). Notably, some homes' written documentation was more detailed and specific about what they valued and how this was to be carried out in practice.

The shared sense of purpose in care homes where positive care was more consistently observed tended to have both espoused values for person-centred care *and* assumptions underpinning the culture that were broadly person-centred.

Good care means if somebody needs attention, just attend straight away rather than leave them. And just to look after them as a person, like an individual, you know, what she likes to be, does she want to be dressed at this time or does she want to go to bed at this time, it's up to her, if she wants to go, whatever the time. (Bergamot Place, interview with nurse)

The care needs is the most important part of my job. Definitely the care needs, and the social needs as well. You know, they've got to have the care needs met, but they've also, relatively as important, they've got to have social needs met. It's no good somebody being in absolutely pristine condition, you know, their skin's fantastic, it's all intact, but nobody speaks to you. And likewise, it's no good having all these fantastic activities but you're sat with a massive pressure sore because your care needs...you know. So it's getting the whole package, getting the whole package of the needs. (Bergamot Place, interview with care assistant)

These views of person centred care and the view quoted in the theme heading were typical of the values individual staff working in Bergamot Place and Tansy View articulated in interviews with researchers. Staff values were also apparent in the way certain behaviours and instances of care were performed. Below are examples of how person-centred values and assumptions underpin the rituals and practices in these care homes. In the first example a new resident is moving into one of the homes and in the second, the researcher is entering the home for the first time.

A new resident arrives by ambulance from the hospital. The resident is able to walk unaided and the team leader on duty walks with her through the reception and cafe area and into the room she has been allocated. The new resident stays in her room for the rest of the day. The team leader facilitates initial contact between the new residents and other residents. A member of staff is setting up the new resident's TV, and they ask the team leader to ask the resident what channels she likes to watch. The message is relayed and the member of staff says, 'I will set this all up for her'. It is interesting that the member of staff chose not to speak to the new resident in person. I had the

impression that this was an arranged way of doing things in order to limit the extent to which the resident may become over whelmed by her new surroundings and the amount of new information and new people she was meeting. There appears to be lots of input behind the scenes as well as in person from staff to help the new person orientate to the home in a gentle way. They have spent time finding out about who she is and what she likes and doesn't like. The resident is invited to join the other residents in the dining room for lunch the next day. Lots of staff stop and talk to the new resident during her first visit to the lounge. (Tansy View, Ethnographic Observation)

After the Manager had informed staff and residents that a visitor was about to come into their home and gaining their permission for the visitor to entre, the Manager took me into the enclosed part of the home where residents live. She quietly introduced me to each resident. This was done in a very 'normal' tone. The manager typically squatted beside seated residents, on a level with them, introduced me and picked up on concerns as we went round. For example, caught a cup as a resident knocked it, spoke to her about whether she wanted the rest of the cup of tea; fetched a tissue for a man who asked for one, helped him to get re-positioned in the chair, felt that his trousers were wet where he had spilt his drink on them and quietly fetched a carer to help him to get changed. She engaged in conversations with residents, typically following their lead. With some residents the meanings of the words, or even if there were words, were not clear to me, but the interaction seemed to follow a turn taking rhythm, and the residents seemed engaged and to find the interaction positive. I found myself wanting to emulate this respectful mode of interaction that seemed to carry a broad meaning of social exchange. (Bergamot Place, Ethnographic Observation)

Both examples illuminate the ways in which visitors from outside the home and newly admitted residents are introduced to what is deemed to be important in these homes. In these examples, it is the respect and privacy of the residents and their needs that are illuminated. There is also the empathic way in which the resident may be experiencing the particular moment that appears to be at the centre of how care is carried out. Such empathy is also evident in the responses to untoward incidents:

Researcher: you said earlier that the home were very quick to deal with things. Relative: Oh absolutely. It was everything from ringing for the ambulance immediately, ringing me immediately, setting the wheels for the enquiries that there have to be in motion immediately, the staff stayed behind to fill in the questionnaire things that they have to do. One of the support workers, she came round to the hospital with us, and would have stayed as long as I wanted her to. But the staff there were fine so, you know, it was fine for her to go. They could not have been more supportive, they couldn't, everything was done absolutely correctly and caringly. (Bergamot Place, interview with relative)

The role of empathy in implementing a person-centred way of working was also deemed to be an important feature of the care experiences.

An empathic connection was made with the resident. Staff approached entering her room respectfully and gently. They listened to her express her needs, and made suggestions to what could be done. They checked this action with her and if she said yes, they carried it out. (Tansy View, PIECE-Dem summary)

Participant one is free to move between rooms and places in the home. Every staff member who she walked by or she approached directly, interacted positively and enthusiastically with her, including other residents. (Tansy View PIECE-Dem Summary).

The participant interacted with another resident and a member of care staff sitting beside her. The member of staff engaged them both in conversation and two other residents sitting nearby. The participant appeared to enjoy the interactions. The staff member drew on knowledge about the each of the resident's pasts which opened the conversation up and a long and enjoyable dialogue between the participants, other residents and member of staff took place (Tansy View PIECE-Dem Summary)

Staff were also found to have developed understandings of what may be needed to practice person-centred care. For example, the extract below shows how one care assistant relates caring to compassion and making connection.

Showing compassion to the residents is more important than anything. I know the care is paramount but you've got to be compassionate to get close enough to them that they'll let you care for them. Because a lot of them, it must be weird having someone else look after you, and it would be harder for them if they didn't know you, or could at least talk to you, that's what I think. So you've got to have a compassionate side and be able to connect with someone before you can do any personal care, because it's not fair otherwise. I wouldn't like a stranger looking after me that I couldn't talk to. (Tansy View, interview with care assistant)

The connection described above by the care worker, was observed in the way she behaved when carrying out a routine part of her job, meeting the nutritional needs of a resident.

Two care workers had tried encouraging Martha to eat. Martha, who had lost weight recently, picked at the crisps on the side of her plate of cheese sandwiches. One care worker said in a kind voice 'you can't live on crisps alone' and offered her other options of food. The care worker brought some mashed potato mixed with butter for Martha. Martha didn't eat any of it. Another carer came into the dining room, saw the mashed potatoes and cheese sandwich on Martha's plate. She bent in close to Martha, lightly touching her shoulders and speaking closely into her left ear. Her voice was warm and gentle. I didn't hear all she said but caught bits 'one sandwich for me please'. The carer used touch, proximity, voice. The other care workers had spoken to Martha from across the table, at eye level. This care worker had used a lot more touch and had spoken directly into Martha's ear. Martha moved her arm and her hand appeared from under the table, she picked up one of the triangles of sandwich and she took a bite. The carer touched her shoulders and said closely to her ear 'thank you'. When this carer came near the table 10 minutes later she glanced at Martha's plate and saw she had eaten the rest of the triangle and looked pleased. (Tansy View, Ethnographic Observation)

Making connections was also indicated as important component of care in Bergamot Place.

I can go away at the end of my shift and feel as if I've really, really achieved something because we've managed to get through to...it might be something really, really tiny but that makes such a big difference. It's just being able to connect and get through. You know, like for somebody that doesn't have dementia, you know, they've got their full mental capacity, they understand what you're doing, you know, when you say it. But obviously a lot of clients with dementia don't understand, depending how bad their dementia is, and it's being able to get through, it's being able to connect. And it's like there's that recognition there. You know, when you walk into a room, obviously they don't know my name, they don't know who I am, but there's definitely that recognition there, you can see it in their eyes, you can definitely see the recognition. And that's just, to me that feels so much nicer than a nursing home patient saying "good morning" if I get that connection. (Bergamot Place, interview with senior carer)

There are numerous episodes of positive care experiences provided by staff observed at Bergamot Place. Below is one example from observations made of the care provided to and experienced by a resident at Bergamot Place.

The personal choice for residents is important in this home. The participant was engaged in her own activities of daily living and was supported with warmth and a positive approach from staff. When the participant had her personal care needs met, this was done with privacy and dignity, the door to the bedroom was closed while she was being assisted. Her social needs were met by warm, engaged and authentic social connection. For example when the care assistant went in to help her get up she made comments about the weather and other things and when the senior carer joined her for breakfast this kind of connection was made again about getting up, the day, breakfast. The participant responded positively and engaged. People are treated as an individual. (Bergamot Place, PIECE-DEM summary).

The person-centred assumptions underpinning the behaviour and work practices when caring for residents were also found to be guiding how staff behaved with each other as the example below illustrates.

You know, there's always somebody that you can go to even if you want to go and have a moan, or you know, there's always somebody there, you know. Because everybody's human, sometimes you've got to get things off your chest. Or if something bad has happened at work, you've got to have that time-out period where you can discuss it as a team, get it off...you know, you don't want to be taking stuff home and chewing over things, so it's that bit of time for reflection really that's really important. And there's always somebody here you can do it with. (Bergamot Place, interview with care assistant)

In Bergamot Place, the shared purpose and value for person-centred care had a long history and was embedded in the everyday practices and thinking in the home. In Tansy View there had been a relatively recent shift in emphasis towards person-centred care. Senior members of the care home explain this change as necessary in countering an overly task focused and regulatory driven approach to care.

Staff were becoming too hooked up on tasks “got to get all this done by 12 o’clock, got to get all the beds done, got to get this done”. And we sat them down and said “no, it’s 24 hour care, what’s not done by the time you go off shift somebody else can do when they come on”, you know, “think of the person, not that you’ve got to wash them, you’ve got to change the bed, think of what that person wants more than what you want to do”. (Tansy View, interview with Manager)

Yes red tape’s there and we know we’ve all got to adhere to that, but there’s got to be a little bit of give and take as well. Because human beings don’t come with a book, they’re individual, totally individual and you have not to be task orientated, to be person orientated. What you see in front of you is what you deal with, not what it says in the book, you know. (Tansy View, interview with Care Manager)

I know tasks have to be done, but in this home we try to put the person first, task second. Although the tasks have got to be done too because they’re part and parcel of the person-centred part as well, so it’s a difficult balance, it’s a difficult balance. (Tansy View, interview with Care Manager)

Thus person centeredness had a particular function in the view of the managers at Tansy View. This was to counter task focussed care and also as a means to create reflection on how tasks can be completed in a person-centred way. The above examples illustrate how managers were creating more flexibility in the way care is understood in the home.

Values from wider organisation and the enhancement of positive cultures

In some of the care homes there are also values imbued by the wider religious organisation. In Tansy view there is a value to ‘care for everyone’. The manager and senior staff report the values and purpose of the wider organisation as something they want to incorporate within the care home.

Within this home, I mean I’ve spoken to a number of agency workers that we’ve had to find out what other homes are like, and they say that this can’t be matched or beaten. They say this is, so I ask them why. And it is down to the values that we have installed and try to install into the staff about how we want people to be looked after in their later life. How staff when they’re here, how we would like them to treat people when they are near end of life. And all those sort of things come from a base that the [names organisation] cares for those around them. And that’s what I would like to think we do. (Tansy View, interview with senior carer)

The purpose of the wider organisation manifests in the way in which residents, as well as relatives and members of the wider local community, are also considered to be the focus on what they do.

We do funerals for the families, Richard does the funerals. Quite often families that have had people die here still come back, they come back quite often, and Richard has quite often gone to their houses and seen them through bereavement, depression and things like this. The [names wider organisation] have their own pastoral care unit, so if anybody is deeply affected by death, or even something that’s happened in their own family, we can get them help from the pastoral unit. (Tansy View, interview with Manager)

We had a staff member that used to come to us as a volunteer, who self-harmed. She fitted in well and she liked the older people and doing activities, so her probation officer asked could she come here as a volunteer. And we've had her coming for quite a long time trying to help her out of this self-harming thing. And it took her mind off things and made her feel that she was useful at something. (Tansy View, interview with Manager)

The pastoral ethos in the home was noted and appreciated by relatives of residents who live at the home.

It's fabulous to visit here. Well now most of the ladies and gentlemen [residents] know us as well, but the staff are always very welcoming. Even Judy, the manageress, she doesn't need to, you know, she doesn't need to but she does make a point of coming over and talking to you and asking how you are. And they're interested in you as well as a relative, and they'll tell you anything that's amiss, they will talk to you and let you know. And there's always that lovely calm atmosphere and it doesn't seem like an old people's home somehow, it hasn't got any smell about it or, it's just that little bit different and so spotlessly clean. So very well run. (Tansy View, interview with relative)

However, even in care homes where espoused values for caring for everyone and for a person-centred approach to care underpin the culture in the home, pockets of less than optimal care can also simultaneously exist. For example, the way needs for activity and occupation were envisaged, organised and delivered were not attuned with the person-centred assumptions elsewhere in the home.

The staff are very caring, very pleasant, they do their utmost to meet the needs of the patients as they see them, but at the bottom line it's very like other care homes that I've seen in that the residents are woken in the morning, are fed, are put in chairs, are left to listen to music or watch television, are fed, are put to bed again. And so long as they don't make waves everything follows that sort of plan. There is what appears to be an Entertainments Officer, but so far as I've seen, all that actually happens is that he plays nostalgic music and puts on a nostalgic film and does physical exercises which involve all the folks squeezing a foam rubber ball – and that's it. Now when Betty comes home she can't cook dinner but she helps me to do it, and loves helping me to do it. And when the meal's over the first thing she wants to do is get to the sink and wash the pots. And she used to love crocheting and has made all sorts of things in crochet work, and she loved reading but can't manage that any more. But none of these things are encouraged, you know, there's no emphasis on what is possible and what the residents can do. (Tansy View, interview with relative)

We also had less frequent example of residents who felt their needs were not being met because staff were spending time with residents with more complex needs such as dementia.

I scrimp and save to pay, but not get my money's worth and I am worrying about paying. There is too much focus on caring for people with dementia in this home. It takes a lot of staff time to care for them. There is less time for

staff to listen to the worries of residents who are more physically and more mentally independent. We want to name the little worries that bother us and staff don't have the time to listen to us now. The home is taking too many people with dementia but where else have they got to go? (Tansy View, Ethnographic Observation, conversation with resident)

This example highlights the varying expectations residents may have for what constitutes care particularly in homes where there are residents with relatively few needs alongside those with complex needs.

Values from the wider organisation detract from positive cultures

The business culture of care homes can bring a particular value that may complicate the development of positive cultures. Staff at Tansy View, a care home run on a not-for-profit basis, comment that this basis is helpful in maintaining standards of person-centred care.

And we're not money orientated in this building, it's not profit, we're not here for profit, we're here for the people that are here and we're here for that reason, and we're not here to make a profit. Obviously we have a budget that we have to stick to but we're not here for profit, whereas a lot of other places that you go to are there for profit, and I personally think that's a massive difference. I've worked in several different homes and that is a massive, massive difference. If you've got someone at the helm who is counting the pennies on how, you know, when their next holiday or what next car they want, or so on and so forth, you know, we don't have that. So we're lucky, I'm glad we don't have that. Obviously we have to stick to a budget and we have to make sure that we do things in the correct way, we can't throw things at people or anything, but having someone good at the top helps, you know. (Tansy View, interview with care manager)

In contrast, Bergamot Place is run on a for-profit basis. The home was sold to a company in relatively recent years and then sold again. Individual staff members were unanimous that the company's focus on profit-making had led to unwanted changes and tensions in the culture of the home.

I don't always feel as if they [the company] are wanting the same as what we're wanting to give. They are and they're not, if that makes sense. It's just we feel sometimes as if you're having to fight for things. (Bergamot Place, interview with senior carer)

Well an example [that the company's values differ to the staff] are the new table and chairs, in the dining room. They're not suitable for the clients. You know, we had a beautiful set in, like a 1940s thing, but it was lovely, they all commented on the dining room. They got these tables, they were like "nothing wrong with ours, why have they got rid of them", you know, "these look like truckers cafes, they're awful". And then we sat on the chairs and actually the seating just doesn't feel right. And I'm like "how can the clients manage with this", and you know we've got some tiny little ladies. But it's as if like "well you've got them and that's it". (Bergamot Place, interview with senior carer)

Our focus is the clients, and that's it, our main focus is the clients. You know, we sort of think what they [the company] choose to do it's irrelevant to us as

long as it's not affecting our clients. And if it is anything for the client, as long as it's for the benefit for the clients then that's fine. But if it's anything that we feel is affecting in any way, then we will fight it and voice our opinions. (Bergamot Place, interview with senior carer)

Recent compression of staff pay and conditions included the removal of the company sick pay scheme and the introduction of unpaid breaks.

I think the main impact is staff morale, for the way that you get treated by the company. But thankfully, I mean they're all touching wood here, in this setting it doesn't affect our care towards our ladies and gents. Because the minute it starts doing that you might as well walk out of your job because it isn't their fault that "management" shall we say, think it's alright to treat their staff in this way and not respect or recognise what you're doing. (Bergamot Place, interview with care assistant)

We all joke "oh God I could walk out tomorrow", the thing is, none of us do because there's 25 people that we care about, it's nothing else, I don't care about the company, it's the people we're looking after. It is, we're their family, and we're all like a little extended family I think, and you just wouldn't walk away just because somebody wasn't nice to you. So it's not the company that's keeping us, it's the ladies and gents. (Bergamot Place, interview with care assistant)

However, whilst the possible disjunction between wider organisational values and those values held and practiced within the care home is highlighted here, it is important to note that across the case studies within this research both good and poor care experiences for residents were seen irrespective of business model. We saw examples of overwhelmingly positive care experiences in for-profit homes and examples of negative or inconsistent care experiences in not-for-profit homes, and vice-versa.

Disparate purposes and unshared values

The case studies also highlighted that where the purpose and values in the home are unshared this has an impact on care practices and experiences. For example, there is an absence of a clear and detailed organisational vision of the purpose of Lovage View.

The values are written down somewhere. The key value is, as Tony would say, "To be the best." That's his motto. "To be the best in delivering the best care that we can give". (Lovage View, interview with manager)

My understanding of good care for me is common sense. As far as I am concerned general care is are they comfortable, are they clean, are they being talked to and spoken to as you would want to be, are they doing the things that they are able to do. Just generally how you would want to be looked after yourself or you'd want your parents to be looked after. (Lovage View, interview with care assistant).

However, the case study shows that an onus is placed on individual staff to interpret the organisation's value to provide the best care within their work and day to day practices.

But, 'care', there's all different aspects within the care environment. There's respect, dignity for the person themselves, and that has to come from the

staff, which does come from above, absolutely. (Lovage View, interview with manager)

The company is good. Everything is there. The recipe is there, it's down to people to follow the recipe and it's down to the individual. It's just down to an individual's personality whether they're going to make it work or not (Lovage View, interview with care assistant).

You can have the requisites there, but it's about whether they're followed by the individual. Like this morning, as a carer it can be all written there, but whether it gets followed or not. I worked in another care home and it was the same company but totally different there. (Lovage View, interview with care assistant).

The manager appears to suggest the driver for 'best care' comes from the top as well as from individual staff, through the training the organisation provides.

It's getting the right staff. Training is very important, and we have training managers on board now. They didn't at one time, but they do have now. And in-house training, which a lot is mandatory, fire, infection control, health and safety. Actually, we're virtually up at a 100 per cent for the staff, but then there's, depending on the client group that you've got in, Parkinson's, diabetes, anything like dementia, obviously, training, which the staff have done that. So, they may not be mandatory from the legal side, but very, very important. The staff have to take that on board, as well. It's their responsibility to attend the training because you do see, "I haven't time." You're working as a carer in a care environment, it's your responsibility to make sure...Don't turn around and say, "Oh, we've never had any training on that." The training is there. (Lovage View, interview with manager)

However, individual staff were adamant that there are problems with the way training is organised by the company. They told us that anything other than mandatory training has to be undertaken in the staff's own time and that the staff has to pay for that training.

You have to look at, I suppose the other issue there, budget, staffing levels, and then they sort it from that, cos when I first started before changing to a carer, it was once you've done it three months you can apply to do your SVQ2, blah blah blah, the funding is there for training and then when it can to it and I went well what about that, 'well you can pay for it yourself and you can do that', now, I'm sorry, but on a minimum wage of six pounds eighty I can't afford to take any, any courses what so ever, I am only just getting by, and then it was 'oh well, you know'. (Lovage View, interview with care assistant).

I think, we have mandatory training, and even if you take an interest in something like dementia, which I think, for the type of job that we do, it should, that should be a mandatory training. We do, like a very very basic couple of hours on dementia. Anything else, you would have to go and do yourself and pay for it yourself, which I have done, I've done the course from Aberdeen university and it was a home learning pack and you had your four units to do and things like that, but if you're, it doesn't cost a lot, but it's a hundred and fifty pounds, and some carers don't have that for these things, you know, courses and stuff like that. (Lovage View, interview with nurse).

But when you're told at the beginning that there is a woman that does training and there is something that is there and then as soon as you go to get them they go 'you can do it at home online, some of them are free, you can do them at home online'. I was working 48 hours a week, I've not got time to go and sit and do that when I go home. (Lovage View, interview with care assistant).

The care experiences in Lovage View were mixed, with some examples of positive experiences. However, there were numerous episodes when the needs of residents' were not met or were delayed.

During the morning session on the second day there were long periods when there were no care staff present in the TV lounge and it was obvious that one or two residents wanted attention. One resident was calling 'please hurry up' in a pleading voice as she required the toilet. (Lovage Place, Ethnographic Observation)

I go into the quite sitting room and see that the three residents are still sitting here but the relative has left. One resident is sleeping, one is staring into space and the other is pulling at his catheter. I go and say hello. He is now pulling at the sleeves of his jumper and I can feel they are soaking wet, as are his trousers judging by the dark wet patch on them. There is a strong smell of urine. His face is dirty from leftover food and he is wriggling and pulling at his jumper. (Lovage Place, Ethnographic Observation)

There is a resident needing the toilet (bowels). I nipped out before starting the Piece-dem observation period and told a member of staff. He said they were busy and she would have to do it in her trousers. Just as the observation period finished [12 minutes later] he arrived and took her away in her wheelchair much to her relief. (Lovage Place, PIECE-dem Observation).

Calls for help from a resident have gone ignored and not one member of staff has been in the room during this session. (Lovage Place, PIECE-Dem Observation)

The care assistant checked participant 3's catheter while not appearing to engage with him as she did so. (Lovage Place, PIECE-Dem Observation)

At cup of tea time she was offered a choice of tea or coffee and a choice of cake. However on another occasion the cup of tea routine was perfunctory with the biscuit being placed on the table rather than on a plate. Tea time appeared perfunctory with the aim of providing nutrition and hydration rather than also ensuring a positive social experience – there was only brief task focused attempts by staff to communicate with the participant. (Lovage Place, PIECE-Dem Observation)

In contrast to Tansy View and Bergamot Place, in Lovage Place there appears to be circumstances and conditions that are inhibiting the development of a culture of person centeredness. Whereas Tansy View and Bergamot Place had both clarity of purpose and a relatively adequately sized and stable workforce, Lovage Place had an enduring problem of low staffing levels. In addition, the organisational vision is vague and the lack of specificity appears to be creating a situation where responsibility for interpreting the purpose of the home is the responsibility of individual members of staff. In addition, the lack of adequate staffing levels appears to be impacting negatively on the quality of care and prevents the

establishment a shared understanding of standards for practices. The problem of staff shortages in Lovage Place were identified as a problem for other care homes in the region owned by the same company:

I cannot tell if it's just this home where it's like this, but if we are short staffed, we have to phone another of the nursing homes and see if they can help us. See if they have got some extra staff to help us, but sometimes they say they can't help. They said that they are understaffed also. One of my carers also works in another home and she told me they receive so many phone calls, she receives so many phone calls from other nursing homes in this company, and they call here too to ask us, so, what's going on? There's some alarming, there's an alarming issue. (Lovage View, interview with care assistant)

Normally what's recommended is often diluted by the time it gets down the chain. A fantastic recommendation's made, but what I've seen happen, it's become a shadow of what it should be. It is maybe financial restrictions, staff restrictions and environment restrictions. What the manager sees as a priority... (Lovage View, interview with nurse)

I'm not saying that, I'm not saying that even though we are short staffed we will not give anymore, no, no, no, it's not, it's not my practice for the past eleven years. Maybe, if we are short staffed maybe I can go home by 9 o'clock, or half past 9 just so that everybody has had [what they need], and I give everything the time that it needs, I will go home and will not feel guilty when I go to bed. (Lovage Place, interview with care assistant)

The staff at Lovage Place implied the company was ignoring the problem of staff shortages. Rather than addressing staffing numbers to enable a new system for care planning to be implemented, the company were reported to have pressurised individual staff to complete the care planning in their own time.

The head office are now getting on our paperwork, our paperwork is behind, they brought out these new folders, very detailed care plans for each individual resident, a good idea but a lot of work, hours and hours of work. We've just not got the time to do it. Head office are saying it is not a valid excuse anymore and people are now having to come in on their day off.... they are saying, they are threatening staff that they'll report them to the NMC if they don't come in and do the paperwork. (Lovage Place, interview with nurse).

Conclusions

These findings suggest that having a shared understanding of the purpose of a care home is an essential component for creating positive care experiences for residents. This shared purpose needs to exist across all levels of staff in an organisation and be evident in both articulated values and values demonstrated in practice. Findings also show that having a shared purpose in and of itself is unlikely to create the cultures necessary to achieve good care. Care homes are simultaneously guided by other sets of values that may be external to the home itself, such as a business-orientated value to create profit or a religion-based value. Individual staff in these situations do not necessarily place an importance upon these values, and in practice they can conflict with outcomes of positive care for residents. Equally, it appears essential for care homes to have adequate and stable workforce for a shared understanding of values to develop and become embedded.

Even though care homes operate under the impact and guidance of a range of values, what appears to be important for positive care experiences are managers and staff members who share an overriding focus, understanding of and commitment to person-centred care. This can then result in behaviours such as those that create compassion and connectedness with residents, as well as behaviours such as resisting and protecting residents from the impacts of decision-making by the owning company. In exploring the circumstances within which shared values are associated with positive care experiences, other aspects of care home culture are implicated, such as the sense of community within the care home and impact of external factors on the life of the home. These aspects of organisational culture are the next themes to be discussed and are both impacted by the shared understanding of purpose in the home and have an impact upon its functioning in the care home.

Theme Two: A sense of community between all involved in the care home

The sense of connectedness within a care home impacts on care quality. An active facilitation of this connectedness is required to create a sense of community and positively impact care experiences.

I've bought my puppy in, you know...they're normal people, they're living with dementia, but you know it's still a person and they respond so positively to things...yeah, come in, bring your kids and grandkids in...it's like a big family (Bergamot Place, interview with staff)

The findings showed an association between the extent to which care homes demonstrated a sense of connectedness within them and the quality of care experienced by residents. Connectedness within the home concerned the sense of community demonstrated by all involved in home life. It is notable that this concept was difficult to unpick as it often referred to a “feeling” or “atmosphere” expressed by residents, relatives and staff. When a care home exhibited a strong sense of this connectedness then care experiences were predominantly positive. However, when this sense of connectedness was absent or partial, care experiences of residents appeared to be less positive or inconsistent in quality. Within those care homes where connectedness was strong, active facilitation of such connectedness was evidenced, suggesting that creating and maintaining connectedness (and thus its positive impact on care experiences of residents) is something that is facilitated, at least in part, by action within the home. This theme was examined through a comparative analysis of the ways in which connectedness manifested itself within the care home (through documentation, verbal accounts or behaviours), and the experiences and observations of care in the home.

Our case studies illustrated that connectedness within the home involved the following dimensions in which behaviours and experiences of staff, visitors and residents interacted to create and reinforce the home community.

With regards to staff, care home connectedness appeared to be created (and experienced) by staff groups that exhibited a care and respect for each other, and a shared understanding of residents as the primary focus of the home, and this suggests a link to the previous theme of shared values. The specifics of this staff interaction varied, but all resulted in a staff team that was focussed on residents rather than predominantly concerned with staff relationships,

and that recognised their workplace as primarily the residents' home. In Thyme View, for example, the lack of gossip amongst the staff team continually surprised the researcher;

Staff member that I am due to be interviewing is not around. I ask several different staff about her and they each tell me that she is 'not in'. Something has clearly happened, but no one is going to gossip about it to me. This does not feel like I am being excluded here, instead that...it is not their place to discuss with me. Evidence of a staff person-centred approach here. We must be respectful and loyal to staff just as we are respectful and loyal to residents. (Thyme View, Researcher's Field Notes)

This aspect of staff behaviour was experienced by visitors and residents as well. When discussing the difficulties staff may experience with some residents, a couple explained:

They don't tell you, you know...the staff tend to stick up for the patients. (Thyme View, interview with two residents)

I don't see any difference at all, I don't see any (staff) being treated differently or them treating residents differently. (Thyme View, interview with relative)

At Bergamot Place, whilst some divisions within the staff team were evident, they still recognised the need to support each other in order to achieve positive care for residents:

I'll say "come here" and I'll have a little chat and I'll go "if you do such and such...oh and they'll love this, and oh they'll like that" or "they don't like this", you just try and help don't you?...We all try and help whoever comes in. (Bergamot Place, interview with staff member)

I was struck by the very practical ways in which staff support each other. Covering shifts and being adaptable so to ease each other's work/life demands. (Bergamot Place, Ethnographic Observations)

For relatives and visitors, connectedness and community was experienced as belonging in the home and feeling welcomed;

When (niece) was visiting, saw her chatting and welcomed by staff. Smiles and 'how are you?' she knows where she is going, there's somewhere for her stuff. She belongs here...She is not just NOK, she is a friend to us...A wife and daughter (visit) hellos and how are you...it is okay to chat in the corridor, you are not in the way. (Thyme View, Researcher's Field Notes)

This also meant varied opportunities to be involved;

When I go there, it's a bit of company for me as well...so they will chat to me about various things, just general conversation (Bergamot Place, interview with relative)

like one wife likes to come in and still help the husband to get ready on a night...it's important we keep them as involved as they want to be (Bergamot place, interview with staff member)

And receiving support for themselves in the home as well as for the family member;

The tears were coming down. One of the carers, I don't know where he came from but he put his hand on my shoulder, squeezed it and said, 'I know, are you alright?' and by golly that made such a difference, knowing they cared not just for Mum, but for the family as well. (Thyme View, interview with relative)

You know, sometimes we can spend as much time with the relative as we do with the client, you know. They do need a lot of reassurance...they need that time to know that their loved ones are being looked after. (Bergamot Place, interview with staff member)

Residents reaped the rewards of connectedness within the home through a norm of positive care experiences. Their home's community did not simply result in good physical care but in a life within the home in which they were known by all those around them;

They do try and learn about the client as a person...they know that (resident) likes classical music, they know he likes cricket. They're all involved...I feel I could go to anybody. (Bergamot Place, interview with relative)

When staff chat, residents are not excluded, it is often about them and with them... (resident) is not seen as a (downstairs unit) resident, he belongs to the home and we all know and take responsibility for him. (Thyme View, Ethnographic Observation)

In which they knew others in (and outside) the home;

Visitor is a relative of someone else in the home. Has popped into say hello. They have a brief catch up about family, (Thyme View, Observation during interview with resident)

They also experienced a life that contained normal, everyday experiences regardless of disabilities or need;

I don't think it will be quiet down there now, because a resident's family have come...they all had lunch in her room, they've set up a nice table with a nice cloth on, they've had a family lunch in her room (Thyme View, interview with manager)

At the end of visit staff and residents are having ice cream. Staff member supporting highly dependent resident to eat ice cream out of a cone. All the staff have ice creams as well (Thyme View, Researcher's Field Notes)

The experiences and behaviours of staff, residents and visitors with the care home were both created by and contributed to the community of the care home; Two features appeared to be common elements that ran across accounts in connected care homes. Firstly, there was a perception of frequent friendship-like relationships and close, micro-level connections in care giving and social interaction;

(resident) looks at me. Smiles, frowns. Repeats a syllable. Gets up and leaves sitting area. I hear, "Ah loving loving" as carer cuddles her, (Bergamot Place, PIECE-dem Observations).

Carer comes in and sits next to Resident. "Good Evening (full name)". They discuss the colour of her top and that it has a stain on it. "Shall we put it in the wash?" "Do you want to come with me and we'll put something clean on?" resident replies, "It depends. I mean you're more particular than me" Carer continues "(full name), would you like to put something more comfortable on and then when we're done we can have a drink" (more back and forth about getting changed and whether this is a good idea). "It depends. Will there be crumbs on it?" "No, it will be fresh and clean". Eventually resident goes with Carer. (Thyme View, Ethnographic Observations).

Carer says "It's chewy today isn't it?" resident nods. Carer gives him time to chew and swallow. "You're doing well this morning. Nice and bright"...he has his eyes closed. "(name), can you open your eyes for me?" Carer bends down to look at his facial expression. Resident is less alert now. Carer says "Can you open wide?" whilst holding a spoon to resident's mouth. Resident does not open. Carer switches to a drink instead, resident takes a sip. Carer says "(name), you're falling asleep!" This said in a gentle and amused tone. Resident opens his eyes, smiles and laughs. Carer says "we're almost finished, sweetheart. (Thyme View PIECE-Dem Observations)

Carer goes in – "morning [names resident]" "that's a lovely smile". Asks if she would like to get up. Resident agrees. (Bergamot Place, PIECE-Dem observations)

Carer approaches resident, "Do you want a biscuit. I've got posh ones, don't tell anyone" Resident seems very excited by this "Oh! Lovely" giggles to carer. Singing starts again and several residents start to join in. Resident calls carer over with a big smile on her face. Carer says 'give us a kiss! (Thyme View, Ethnographic Observations)

Secondly, relationships were reciprocal, in which others' needs were considered and all were thought of as community members with contributions to make. Notably, this reciprocity was evidenced from residents, visitors and relatives, as well as those employed in the home.

...when one of the other residents was really quite ill, I wouldn't have dreamed of, you wouldn't interrupt the situation...I don't mind what I do, I can be alerted to watching what other people are doing (Bergamot Place, interview with relative)

(head of care) said 'how would you feel if we moved your Mum (to another unit)...I said, my experience, when I was desperate, end of my tether, you came up trumps, there must be other people out there...and who am I to say oh no, I don't want to move her (Thyme View, interview with relative)

I've just organised to try and take 6 out each day...even the girls (staff), they have to give up their spare time, say they've got a day

off and I'll say 'anyone want to go to the theatre (Bergamot Place, interview with staff)

In a community I can hardly do that can I, speak personally about what I would like. I've got to see the other side of the picture a little bit, you know (Thyme View, interview with resident)

I think the staff who aren't here primarily as carers...we all play our part...entertain them you know, you can have lots of fun (Bergamot Place, interview with staff)

Within our study, when care homes did not exhibit these features of connectedness, the sense of community was limited or absent, and care experiences were observed and reported to be, on the whole, poorer. Whilst positive care experiences did occur, they were often experienced inconsistently and were reliant on the ability and will of individual members of staff. The ways in which care homes lacking connectedness presented themselves within our case studies was far more varied than those with a strong sense of internal community. Essentially, care homes lacking connectedness failed to consistently demonstrate one, or more often several, of the features outlined above. Some examples of unconnected aspects are given below:

Firstly, some staff in homes that were less connected often approached the home as a workplace rather than a home, in which the primary purpose of the home was to conduct their own relationships, rather than facilitate residents' lives. Staff interactions and norms of practice at Angelica Court illustrated this feature well;

...the impression I get here...is it feels clinical and functional here rather than a place for living and being. Any 'living & being' function is down to the staff on duty and their innate feel for the work... It is a workplace. We do not come early or stay late. We take all our breaks. (Angelica Court, Ethnographic Observations)

Chat with member of staff re: seating, (used to be) a small seating (area) in centre of hall where care station now is. But it got very busy and the computer was installed. 'caused an obstruction'. Residents really liked it as they could see what was going on. Since moved down to end it is hardly used. (Angelica Court, Ethnographic Observations)

Two staff members chatting in kitchen...not focussed on residents at all, chat about rates of pay... Resident Emma says something and staff 1 corrects her 'we're on about staff, not residents'. Chat about other staff who have worked there. (Angelica Court, Ethnographic Observations)

Secondly, visitors to care homes lacking connectedness seemed to experience them as places they attended, as opposed to places in which they belonged. This could manifest in different ways; as brief or functional visits to their family members or as occasions in which they interacted primarily to check or facilitate an aspect of their relatives' care. This was not that they felt they could not or should not visit, but that their role in the home was about

something in addition to a relationship with their friend or relative. At Hyssop Place for example, whilst visitors were seen frequently, and had connections with each other, they primarily saw their role as checking on their relative's care;

Yeah, because I've had to bring that up again. I brought it up. I said to you, with (manager) nothing got done. Also, the staff have had to be told to put it on, because quite often they don't bother to put it on, which makes more work for them. Because he's so aggressive it's difficult to change him, so he gets left. And sometimes I walk in and I can't bear to see him because, you know, would you like your father sat there with mess all down him. And he's got nice clothes, because we buy nice things for him... (Other relative interjects) I mean if you didn't keep on top of it I dare say things would slip. (Hyssop Place, interview with relatives)

Mum's wheelchair is not cleaned, it gets really grubby, bits of toast go down and I groused about that hugely. And the way I get round that now is, I go in and it's dirty, I strip it down in the kitchen, and normally somebody comes in and takes over "that's not your job, we do that". So I've worked that one out, I'll just start doing it, (Hyssop Place, interview with relative).

However, it is very important to note that, in homes lacking connectedness, it was often hard for researchers to engage with visitors in a meaningful fashion and so their perspectives on this aspect were under-represented. However, the very fact that visitors were not an obvious part of the care home, or did not wish/feel able to connect to the (research) activity in the home, may be some evidence of this factor at play. In addition, several care homes reported challenges in engaging with family and friends.

Finally, residents in care homes lacking connectedness, whilst experiencing some positive care, appeared to encounter daily situations in which they were either not known or not engaged with beyond their physical care needs by at least some of their care staff. Sometimes these occasions coincided with homes that used high levels of agency staff and so disconnection was less surprising, but in other homes these experiences occurred with regular staff and stable staff teams.

Her medication was given to her by the nurse with patience but no meaningful communication. (Lovage View, PIECE-dem Observations)

The (carer) spoke with Resident on several occasions but always 'in passing', never with any intensity or empathy. (Marjoram Place, PIECE-dem Observations).

"Fire alarm also went off during evening whilst standing with resident. Resident reacted strongly to the alarm and looked distressed (very loud and doors closing). Carer came out of kitchen across to the lounge and as she passed (us)... she said '(resident) won't be able to hear, don't worry about her'. It was very obvious that resident could hear, was distressed, and regardless of hearing

could see all the doors having shut. (Angelica Court, Researcher's Field Notes)

In exploring the differences between care experiences within connected care homes and those that did not show such connection, it appeared that connectedness and community were features of home life that were actively facilitated by those care homes who achieved it.

Clear, deliberate and multiple attempts to communicate with all in the home about the life of the home were a significant feature of connected homes, and this appeared to facilitate and perpetuate the community by emphasising membership, demonstrating opportunities to participate and providing support. These attempts went far beyond 'relatives' meetings'.

At Thyme View, a regular newsletter and email communication were used by activities staff, management and care staff to keep relatives, volunteers and other visitors informed about home events, opportunities for involvement, and individual residents' stories, poems and photos, (Thyme View, artefacts and interviews).

Verbal communication with visitors in relation to their individual family member or friend was a frequent occurrence, and seemed motivated by maintaining the relationship rather than simply updating on care needs:

Yeah, they'll give me little snippets on what he's done and what he hasn't done. (Bergamot Place, interview with relative)

I think you need to know about the support relatives are given when their loved ones are here, (manager) is always on the end of a telephone. (Thyme View, interview with relative)

In addition, connected care homes appeared to use rituals and events to help reinforce membership and participation, as well as contributing to the 'normal life' of residents. For example, at Thyme View the researchers witnessed 'the birthday celebration' frequently throughout the research, and were themselves invited to participate, despite being strangers in the home;

"A birthday celebration was occurring, lots of pleasure expressed and staff expressing the desire to be involved... (the resident) regularly received greetings from staff, offered sherry...and seemed to be made to feel special throughout the afternoon...a birthday cake was produced with candles," (Thyme View, PIECE-Dem Observations)

"...Easter, so I arranged loads of competitions and got someone to bring a rabbit in and we made eggs and decorations..." (Bergamot Place, interview with staff).

It was also notable that Thyme View in particular used the environment in the home to reinforce and facilitate the community; a photograph album of photos of residents and staff enjoying each other's company; Christmas decorations with resident's faces/names; the front entrance showed a rolling display of photographs of residents, staff and visitors

enjoying life; and a display in one unit used quotes from residents and staff to explain a key concept in the home's faith, ([Thyme View, artefacts, field notes and interviews](#)).

Furthermore, connected care homes appeared to actively pursue the objective of integrating the home into the wider world, with attempts to bring 'outsiders' into the home, recruit volunteers, fundraise for home and external causes; as well as seeking opportunities for residents to participate in events outside of the home (regardless of their care needs). This not only created 'normal life' experiences for residents but also facilitated relationships with and between members of the community.

Oh, (manager) she'll put an advert out, and we get people with different skills...sit in the garden, sit and chat...painting, decorating, woodworking, all these are skills that people can bring in the care setting. ([Bergamot Place, interview with staff](#))

(befrienders) visit residents every week...they keep the resident for life, so they get to know them and feel they're part of the family...it's adds another dimension to the home. ([Thyme View, interview with manager](#))

All of these features were the product of active and consistent efforts on behalf of homes to create and sustain the care home community, and they could be seen to positively impact the care experiences of residents, particularly in terms of encouraging close, friendship-like connections in care-giving. However, it is notable that our case studies did show that some (although not all) successfully connected homes benefitted from external factors which facilitated this feature. For example, a highly connected home, Thyme View, was part of a close knit religious community which provided an external community into which the home fitted, and which was actively used to provide volunteers. ([Thyme view, field notes & interviews](#)). Nonetheless, use of this external community still required a great deal of activity on behalf of the manager and staff to sustain this involvement.

In addition, Marjoram Place also benefitted from this aspect which facilitated their connectedness both within the home and with the outside world;

"Well, the role of the wider community in the home is very important because we draw a lot – I hate to say it – of our funding from the wider community. They have been incredibly supportive when it came to buying a new minibus. We've got a circle of friends... basically, they organise fund raising for the benefit of the residents. We're not involved in it, it's external to us and [Manager]'s asked to go in and maybe give them a report and update them. It's held in the home, but it's not us. They take over the dining room of an afternoon and they have their meeting and we're asked to go in and make various reports of what we're doing and what's been happening and any updates and things. So, they're incredibly useful for us in the wider community. Also, a lot of our entertainers are the wider community in [the town]. We have kids coming in from the secondary school to entertain. We actually had them in doing a history and drama project and they were in talking to the residents so that they could then write and perform a play, which was historically based on [the town] during the war years.

It was really good. Yes, wider community is very important to us and we have been in the community in [the town] for 60 years – we have served [the town] for 60 years” (Deputy manager Marjoram Place)

Conclusion

Our case studies showed that in care homes where there was a strong sense of connection across all involved in home life, care experiences appeared to be on the whole, positive for all concerned, and the care home was described and experienced as a community. For care homes that did not demonstrate connectedness, a sense of community was not present and care was observed and reported to be more inconsistent in quality. This did not mean that positive experiences were wholly absent, but that they seemed to depend on the actions individual staff as opposed to being the norm within the care home. The features of a less connected care home varied hugely and were often experienced and demonstrated in different ways by different people involved in home life.

Connectedness and sense of community seemed to be features that were actively facilitated by the home, rather than something which simply happened irrespective of action. In some cases, connectedness could be enhanced and enabled by an external community to which the home belonged, such as a religious faith, although this was not the case for all connected homes. Connectedness appeared to be both facilitated by and reinforcing of shared values in the home, as discussed in the previous theme. In addition, the active facilitation evident in creating and maintaining a care home community implicate the next themes to be discussed: the mediation of external factors by management and the role of management and leadership in creating and enabling effective staff action.

Theme 3: Managers ensure external pressures do not have a negative impact on care delivery

The forces and factors from outside of a care home such as those from the regulator, from owner organisations and from families can impact on the care experience in a negative way even when they are meant with good intention. Managers can mediate these pressures so that they do not have a negative impact either by taking on the responsibility for them or by interpreting them into meaningful types of activity.

“CQC does not drive this home (regulatory action) is something they do because of the home rather than their reason for running the home.”
(Thyme View, Researcher’s Field Notes)

Findings suggest that factors external to the care home can have considerable impact on the care experiences of residents. These external factors can come from a variety of sources,

such as regulation (through the relevant care inspectorate), the owning organisation, family members and visitors to the home, and financial pressures. Our case studies have all experienced and dealt with these factors in different ways. However, when care home managers demonstrated efforts to mediate the impact of these factors for their staff and on the daily life of the home then care experiences appeared to be more positive. In care homes where mediation did not occur (whether through lack of recognition of the need for mediation or difficulties in practically doing so), care experiences appeared to be less consistently positive. This theme was examined through a comparative analysis of the experiences of care in the home and evidence (or absence of evidence) of external factors impacting on that care as demonstrated through behaviours or articulated in interviews.

Mediation of external factors related to the ways in which managers sought to either cushion the impact of those factors on staff, or to translate the impact of such factors onto staff practice in a way that was understood by staff in relation to the care of residents and values of care in the home. Successful mediation in our case studies was often denoted by a *lack* of reference to external factors in staff actions, experiences and thoughts about their work and an experience of care by residents, staff and visitors that related to their needs (and practices of staff) as opposed to external factors. It was not that these external factors did not exist for these homes, managers often articulated their presence, but that they were managed in a way that meant staff behaviour and resident experience did not reference them.

Regulatory Organisations

Regulatory requirements (via differing regulatory localities; CQC, SCSWIS, or CSSIW, see Background) are an obvious external pressure to which all of our homes were subject. However, the extent to which care practice and experiences were driven by such requirements as opposed to driven by the care needs of residents, illustrates the mediation at play within some care homes and the positive impact it had on care experiences.

For example, in Thyme View, the researcher was continually struck by the extent to which the regulation and regulatory aspects were absent from the rationale, discourse and practice of daily life in the home. As the researcher noted in reflection;

“CQC does not drive this home, (regulatory action) is something they do because of the home rather than their reason for running the home.”

(Thyme View, Researcher’s Field Notes)

It was not that care was non-compliant with regulation in this home, (it was fully compliant and had been consistently so for some time), but that regulatory requirements were viewed only as a by-product of good care. The manager, deputy and trustee of the home were all aware of regulatory requirements and ensured the home complied, but the impact of these was either absorbed within management tasks (such as collating/reporting of data), or articulated to staff in a way that facilitated their care on the ground.

For example, the recording of daily information for each resident was observed infrequently in the home. It was never seen to dominate care-giving itself and was viewed only as an

ancillary task. Care workers simply recorded short notes on a shared clipboard in each unit throughout the day and then team leaders were tasked with transferring this to the computer at the end of the shift. The computer notes were used as the basis for handover by all in the home, (Thyme View, Ethnographic Observations).

The manager's approach to supporting staff at Thyme View also showed this mediating approach. In discussing the ways in which she supported and supervised staff, she noted:

I don't think (CQC) take into account the fact that here, particularly, we do a lot of informal chat where people come in and sit and talk about issues. Because I have an open door policy you see, and that saves a lot of hassle because everybody knows they can come and say and talk to me. But remembering to write that down as supervision is something I don't do, I forget, and then I'm thinking "oh dear, I haven't done proper supervisions"...supervision is something, I think it's still something we are struggling to make sure it's six times a year, but it does go on and it is important. It's important for the staff as well to know that they've got a platform that they can talk from as well and say their concerns. (Thyme View, interview with Manager)

This manager's approachability and support for staff was implicated heavily in the overwhelmingly positive care experiences for residents observed and reported at Thyme View, and so it is notable that she explicitly chose an approach that best met the needs of her staff (and therefore residents) as opposed to a system that would most easily meet regulatory requirements. Instead she acknowledged that she would have to find a way to make their system demonstrate what was required for regulation, rather than base their system on what was required for regulation. This is mediation in action.

Mediation could also involve a thoughtful consideration by management on some aspects of regulation, deciding on a course of action or way to help staff through what could be contradictory requirements. The manager at Marjoram Place explained:

Sometimes if you're following what some of the things that the Care Commission come up with it's a bit like the conversation that we were having earlier about the lady with the low BMI, the framework states one thing but if you were following through on the framework it could be detrimental to the resident's wellbeing because....if you're following the guidelines in that situation you have to put up the weight. In order to put the weight up then you would have to be more...[Interviewer: Antagonistic? you would – yes]....That would not have helped her. That would have turned the tables and she would have become more unwell and would have eaten less. But, the guidelines state – so the guidelines don't always work with you. They're not flexible enough. (Marjoram Place, Interview with manager)

In some care homes, this mediation was lacking and it appeared to contribute to poorer care experiences for residents. This was most commonly evidenced in relation to paperwork. For example, Hyssop Place had received a number of requirements in relation to a safeguarding

incident and two inspections. Several aspects of these referenced the need for better record keeping;

“We found that there was no written evidence that staff were monitoring the skin condition.

We saw that information had not been calculated and recorded in the care plan or fluid chart.

We found that there were other areas of recording in care records that needed to be improved”. (Hyssop Place, Artefacts)

The manager at Hyssop place explained the impact of this type of external pressure, apparently seeing no alternative to transferring the pressure directly on to the care staff role:

Making sure the T's are crossed and the I's dotted...constantly nagging about 'have you completed this form, please makes sure this is done, is this new care plan in place, have you reviewed this.' That's what the job is mainly about now. The amount of time staff have to sit down and spend on care plans. (Hyssop Place, Interview with Manager).

However, what this direct transfer (as opposed to mediation) resulted in, was a situation in which paperwork was the most highly monitored task of care, was never forgotten or replaced with other priorities and was seen as an action of care rather than a product of other actions. On some occasions it even appeared to be utterly disconnected from the care that was actually provided;

I x member of staff is finishing off care plans and food charts (before they've finished eating) (Hyssop Place, Ethnographic Observation)

Member of staff asks about recording of dinner data for residents who haven't eaten yet. Other member of staff gives answer 'just record spoonful'. Again, care plans are a task here rather than a product, to the extent that we record something when it hasn't been done. (Hyssop Place, Ethnographic Observation)

Moreover, this raised the possibility that it had, at best, no impact on residents' experiences, and, at worse, a negative impact, not least because of the staff time it occupied and the issues it prioritised.

Other [non-regular] member of staff asks resident if she went to the entertainment. Resident says No, [but the resident nods her head to indicate yes]. Member of staff records 'no' in the care plan...care plans are so important here that non-regular staff complete them when they have inaccurate information. Care plans are more important than what is in them. It is them being completed that is the care task. (Hyssop Place, Observation)

These were amazing exchanges for (resident) and staff. None of their care plans or (paper) outputs have shown this. There are daily outputs about (resident's) "behaviour" meaning his aggressive behaviour. (Hyssop Place, Ethnographic Observation).

Overall, this direct transfer of external factors onto staff had resulted in a situation in which there did not seem to be any discourse related to a need to improve actual care, only the need to improve the recording of that care. These pressures and experiences were felt in several other homes as well as Hyssop Place. For example, Mantle View had the following recommendation on their most recent inspectorate report:

Daily statements required more detail and entries should be made in the residential documentation during each shift of the care delivered. (Mantle View, Artefacts)

A member of staff at this home when interviewed said;

"I don't think I've ever worked in an environment with as much paperwork but it just seems to be one of those things that you get used to," (Mantle View, Interview with staff)

All of our care homes were impacted by similar regulatory regimes, particularly with regard to record keeping requirements, and many of them articulated the pressure the requirements placed on them, whether they were fully compliant or not. For example, the latest CQC report for Bergamot Place noted that 'care plans and risk assessments were regularly reviewed and did take into account some of people's changing needs and were person centred',

The following extract from a relative illustrates possible tensions between recording and acting in the context of risks that are constantly changing.

'I said "well they rang me last night to say that there'd been an incident and one of the residents had hit him over the head with an ornament and so they'd taken him to casualty". And he said "Lilly, I've literally just walked in and I don't know what's gone on, can I ring you back". So he rang me back some time later and he said that they'd taken him to hospital and they'd examined him and said that there was nothing to worry about and he seems OK. And I said "well what actually happened" and he said "well we don't really know, they haven't put it in the incident book yet"..... I never really got to the bottom of that.... I thought it was strange that I got two conflicting reports about what had happened – not that I could have done anything about it, these things do happen, I can't say that I held anyone responsible because, you know, you see occasionally things happen that no-one has got any control over because they happen in a flash. (Bergamot Place, interview with relative)

As the manager said:

I feel sometimes that the staff are having to spend too much time trying to get the records and the paperwork up to scratch, when it would be really

nice if they could spend a bit more time interacting with residents.
(Bergamot Place, Interview with Manager)

However, what is significant is that this was not seen to impact negatively on care experiences within all homes. Therefore it would suggest that, at least in part, it is action and decision-making within the home that mediates these pressures in such a way that protects care experiences (through staff action) from being affected negatively by them.

Owner and Owning Organisation

Another external factor that had impact within our case studies was the requirements of owning organisations. Again, these factors could be seen to impact on the care experiences of residents within the homes, but the nature of this impact was dependent on mediation that did or did not take place. Owner pressures could take a variety of forms including; paperwork, quality and other audits, or oversight management tasks

At Thyme View, the home was responsible to a management committee within an overarching organisation. This committee had responsibility for oversight of the home, particularly in terms of social and activity elements. In addition, this committee was chaired by a trustee with audit responsibilities. The manager noted that this could cause difficulties at times; she had met some resistance to changes that she wished to make, and occasions when the committee made decisions that affected the home with which she was not involved and disagreed. (Thyme View, interview with manager)

However, she saw managing this relationship to the benefit of the home as an integral part of her job, and had a number of strategies for doing so.

"...they are much more willing now to listen. And it's education isn't it? And we train them as well. So they have dementia training because we think it's important. We also given them manual handling training because if they're taking them out... So I think education is part of it, so we keep telling them the same things and repeating it," (Thyme View, interview with manager)

In addition, she recognised the positive impact such a committee could have on the home and sought to maximise their involvement in the home to benefit residents and staff. This required daily consideration of how to manage and encourage their role:

"A lot of benefits, because they are so willing to do things, and it adds another dimension to the home. Because if they come in and do an afternoon tea afternoon and they bring lovely cakes...they'll do a reminiscent session or a poetry session, and that's important. And they love to take people out... and they organise it all. ...you feel you've got to sort of do a lot of the work behind the scenes to make sure that they're not staggering round with tables and things. But the benefits that brings, and the fact that they come and sit with residents and talk to residents and get to know the residents, it's worth the hassle...we just have to

work...be very diplomatic all the time.” (Thyme View, interview with manager)

In these actions the manager had transformed a potentially negative external pressure into a factor that had an enormously positive impact on the care experiences of residents (and staff). She did this by anticipating difficulties, recognising and developing positive contributions, and fostering relationships with individuals; the end result of which was a management committee that was part of the care home community and adopted the shared values of care. It was notable that the relationship between manager, trustee and individual committee members was observed to be professional, supportive and respectful at all times and from all parties. This highlights that mediation may well require a two-way effort (both to and from the external factor). However it also illustrates the roles managers have to play in mediation.

An absence of mediation, leading to less positive or inconsistent care experiences was evidenced in relation to these factors in several of our care homes, and again the issue of paperwork was prominent. Several of our homes (Lovage View, Chives Court and Hyssop Place) had changed care plan systems because of organisational requirements, These changes did not seem to have been instituted in a way that positively impacted (or enabled staff to positively impact) care experiences, and in several cases appeared to have a negative impact.

For example, at Hyssop Place, the length and complexity of new Organisational records did not seem designed to enhance staff understanding of the purpose of care or care plans; with risk and pressure ulcer assessment using technical language that the researchers found hard to decipher. In addition, the changeover was burdensome, leading to staff actions that sought to minimise the work involved, as opposed to maximising impact on resident experience

I could have transferred them all across – the things that used to be on care plans (including an emphasis on meaningful occupation) to the (owning organisation’s) new ones – there were 15 mandatory ones and could have 9 extras, including activities but more work for me, I incorporated it into the others. (Hyssop place, conversation with team leader)

At Lovage View care staff did not have time within working hours to complete a transfer to a new care plan system and pressures were brought to bear on staff by the owning organisation that resulted in them returning to the care home in their own time to complete paperwork:

They [head office] brought out these new folders, very detailed care plans for each individual resident, a good idea but a lot of work...to get them done and we’ve just not got the time to do it, and head office are saying it’s not a valid excuse anymore and people are now having to come in on their days off.... so head office they’re threatening staff, the nurses that they’ll report them to the NMC if they don’t come in [and do them]. X is on

night shift and she's [also] been in here from 9 til 2 to do her paperwork.
(Lovage View , interview with staff)

Even structures in place to explicitly enhance the resident experience, could be seen to potentially have a less than positive impact on residents, depending on how they were put in place on the ground. In homes with systems of quality management staff expressed anxieties about the way in which concerns were dealt with during audits, sometimes leading to dissatisfaction in the process. The care home in question has met all of the criteria necessary to achieve the quality standard. However a review visit caused a great deal of resentment in one member of staff, who felt that the process had not allowed them to explain what the auditor saw, and demonstrate their experience and judgement in caring for residents. This suggested that suggesting that mediation (in terms of cushioning the impact such events may have on staff) had not taken place.

In relation to another audited issue as part of this approach to care, Bergamot Place demonstrated mediation in action, highlighting that even when a system of quality management is designed to benefit residents, active mediation (and flexibility within the system to allow mediation) remains essential. The organisation's senior management had questioned why dementia-specialist signage was not used in the home, however the home responded in the following way:

"We found that we either have people who will be in wheelchairs so they will be taken to the rooms, or other residents who can find their way. So we asked residents and they didn't like it. So we told her residents didn't want it and she said 'Fine.'" (Bergamot Place, Staff member)

Again, in examining the impact of external pressures from owner organisations, our case studies showed that without effective mediation (and a corresponding recognition from an owner/organisation that mediation was appropriate) these external pressures could be seen to have a less than positive impact on staff work and resident experiences, even when systems may have been designed to enhance resident experiences.

Relatives and friends

Another external factor that impacts on care experiences of residents is the influence of relatives and friends on the life of the home and care of individual residents. Whilst all of our care homes provided evidence that the involvement of family and other carers was a crucial aspect of positive care experiences for residents, they also demonstrated that mediation of their influence again appeared to be key in determining whether this influence enhanced positive care experiences or was more problematic. Mediation in this respect was not about limiting or restricting the family/visitor relationship, but concerned the extent to which the home were able to be responsible for the care of residents, and the role family members were enabled/encouraged to play within the home and life of their resident.

Thyme View again demonstrated this mediation in action and the positive impact it had. Two relatives recounted their (separate) experience of the homes' decision to move their mothers from the dementia specialist unit to the nursing unit of the home. Both expressed that they

initially had reservations and some resistance to the move, because they were comfortable with the unit they knew and the care their mothers received. However, the manager and head of care knew that the move was in the best interests of the residents, and were able to demonstrate confidence in their own decision-making and responsibility for the residents within their care;

I was a bit concerned about it at first because I thought “mum only knows [unit]”, but she’s certainly, I think everyone is trying so hard up in [new unit]..... (how did the move happen?) I suddenly realised mum wasn’t going down(stairs). I mentioned it to (manager) and she said “well really she needs to come up here now”. And I was a bit upset about it because, as I say I thought ‘mum belongs down (stairs) and I know the staff all down there really well’ but I’ve got to admit since coming up here she has improved, and I think it’s because it’s quieter, (Thyme View, interview with relative 1)

Who am I to say “oh no I don’t want to move them”. So I sort of bowed to her greater knowledge really...that transfer to nursing was quite difficult for me, because you sort of leave your mother, she’s not capable of ringing a bell or whatever, and you sort of think ‘well is the level of attention going to be the same in nursing as it was down there, because it’s a different sort of care package up this end .(Thyme View, interview with relative 3)

Moreover, both relatives spoke positively of their current care experiences, with only a short period of time since the moves took place. Crucially, action had taken place in the home to help show the relatives the positive impact of the move and maintenance of level of care:

“The other week mum was joining in things, and they were so excited that they videoed her, and they have actually sent the video through to my computer,” (Thyme View, interview with relative 1)

“We bought the staff stuff, a little thank you present at Christmas time, downstairs and nursing, and we had a lovely thank you card from them, all signed by the different members of staff. And on the back it said “card made by (mother’s name) with the help of (staff member’s name),” (Thyme View, interview with relative 3)

What is demonstrated here is that positive involvement of family members was not about ceding responsibility for care to family members, but about facilitating involvement in a way that enhanced the care experiences of both relatives and residents.

At Sage Court, mediation was achieved through the involvement of an external advocate. In this instance, family had been quite critical of where their relative was sitting in the lounge;

So we had a very useful meeting in which this (resident), who I’d never heard speak, and her relatives and I and the manager sat around and she

suddenly started speaking and I'd never heard her speak before.....she indicated what she would like to do and that was all set up.... there was flexibility to move people around so she could sit and have a different view and look at the television. (Sage Court, Interview with advocacy volunteer)

Conversely, within our case studies there was evidence that lack of mediation in respect of family involvement could result in less than positive experiences for residents. For example, at Hyssop Place, relatives were heavily involved in the care of their family members. However, rather than this involvement being managed or facilitated by the home, it was a situation in which staff were viewed as there to do what families instructed:

Family members seem to be the deciding voice – several situations/care plan actions seem to have been 'signed off by' or instructed by family members: 'He has to get up', 'the family want'. Appears to be norm of meeting families' wishes before residents'? (Hyssop Place, Researcher's Field Notes)

Whilst family involvement in residents' lives is vitally important to well-being, when it is a driver of care as opposed to a component, this was observed to lead to difficult situations in which staff had to manage contradictory inputs to care and complex relationships on the ground, and this led to less than positive care experiences for those residents. For example, one resident at Hyssop Place showed clear indications of a desire for independence and staff recognised this (and its value for the resident's well-being). However, visitors did not wish the resident to carry out tasks independently. Staff dealt with this by behaving differently in the presence of visitors than at other times, and often recounted receiving a 'backlash' from the resident when visitors left.

I'll give (resident) a drink in that and then she can feed herself. Her daughter had a go at me once, saying she wouldn't drink out of it, but I did tomato soup in it and she did and I was like 'get in'. (Hyssop Place, interview with staff)

Moreover, staff were seen to adopt families' perceptions and translate that into their care giving, in the absence of more appropriate guidance and support from management for either themselves or family members.

(resident) is in the lounge and seems quite vocal and distressed... member of staff sympathise with relative re: (resident's) behaviour...Relatives and staff talk about (resident's) behaviour, it is problematised rather than seen as distress. Talk with (resident's) relative, she feels he is angry with her and is stuck in this state. (Hyssop Place, Ethnographic Observation)

Lack of mediation could also be seen to have a disruptive effect on the life of the home. At Chamomile Place, activities are regularly held in a particular room but as the activities co-ordinator stated:

The little room I use [for activities], the quiet lounge, visitors [also] go in there and there have been one or two complaints that they've got no privacy and I can't use that room anymore. It was told to me this week and I thought, well that's silly; this is their home, you know. If these visitors want privacy, go to their [relative's] bedroom or to the conservatory, or come in here when it's quiet. Don't take that [activity] away from them [the residents]. (Chamomile Place, Interview with activities co-ordinator)

Our case studies demonstrate that in order to positively impact on care experiences of residents, homes needed to mediate the influence of relatives and friends. This is not to suggest an exclusion or ignorance of these inputs, but that mediation concerns the way in which relatives are involved. Where mediation did not occur, it created situations in which the responsibility for residents was ceded to family/visitors in replacement of effective involvement and input from them in other ways, and this did not always result in positive experiences for residents, or indeed relatives/friends themselves.

It is noteworthy that those homes which appeared to show the most effective mediation in respect of family and visitors, were also those homes which demonstrated high levels of connectedness and community within them, as addressed in the previous theme. This could suggest that mediation facilitates the conditions for care home community, which in turn eases the on-going process of mediation between care home and family/visitors by creating a level of trust in and clear expectations of each other's' roles.

Financial Pressures

Financial constraints are a pressure experienced by all of our case study homes. Examples of these pressures include static local authority contributions, cost implications of health and safety conditions, and varying budgeting procedures used by local authorities for external services:

Yes and the other thing is, the whole thing has gone up, energy price, the running of the care home, everything, the food, minimum wage has increased I have to get a bit more to them, so everything has increased but the social services have not increased their rate. Sage View, interview with staff

but we do have problems, the money that the local authority want to pay for people to come in is nowhere near the breakeven figure, it's nearly £200 less than what it costs to keep somebody. Tansy View, interview with staff

And the costs are just colossal all the time, everything. And all the health and safety issues, the stuff we've had to do this year because of health and safety has made my budget go pear-shaped. Thyme View, manager interview

Financial pressures also came into play less directly such as through changes in boundaries and service provision by the NHS. This could have an impact on the assessment, advice and support that the home had in caring for residents with complex needs.

Money, it's all down to budgets and money. Because if we want a mental health team to come in for instance, that comes out of the doctors' budgets. So we have to really fight to get mental health involvement into the home, really, really fight. When we were in [names county] we didn't. In [names county] the mental health team, they had CPNs that were delegated to so many homes, so if you had a problem you'd just phone up the CPN and say "I've got this problem, could you give us a bit of advice". They'd come down and see and then they'd say "oh I think we need to get the psycho-geriatrician out just to come and have a look". And that was superb, it was wonderful. Here, it's just a kind of nightmare. Tansy View, staff interview

The managers' scope for mediation did appear to bear some relation to the business model of the home. In some homes run by charitable organisations there was the possibility of running 'at a loss'. Care home staff have discussed with researchers some occasions when residents have not been in a position to pay their fees. In all such discussions the homes have somehow made provision for the resident so that they do not need to be moved from the home, except on the occasions when the health of the resident was such that the home could no longer meet their needs.

But we don't ever stop somebody staying in the home if they run out of funds, and we also recognise that not everybody can pay the top-up. So we then look to, again, back to our church help and to charities within the church to try and meet some of the shortfall. Because now, with people coming in later and living so much longer, their relatives are often retired by the time they're supposed to be topping-up, which is quite hard. So it can be a bit difficult when they've given all the money away but.... So we do ask our church to give us some funding to help. But it never meets all of it, so we're always running at a loss. Thyme view, interview with staff member

This home would also ask family members, the local church and other charities to contribute to individuals' care.

Well there's a lot of ways. I mean we don't make it a kind of, do you know what I mean, we don't say "well unless you pay the difference you can't come" but we will ask families perhaps if they can contribute. I mean sometimes even grandchildren will say "well I'll pay £10 a month", you know, so any contribution is accepted. Then we go to their church, because you know it's a church linked..... And then we also get donations from other charities within the religious community. Thyme View, interview with manager

Mediating funding pressures by asking for money from the owning organisation appears to be a common feature among the charity run homes:

We have a shortfall between the cost that we get and the cost that it actually takes to keep somebody in care. There is a shortfall between the private residents and the local authority funded residents, but we don't ask for a top up or anything like that so the Church absorbs that cost. Marjoram Place, interview with manager

The manager at the above home went on to describe the level of income shortfall they typically face:

Oh there is a shortfall, yes. For somebody who is, say, funded from social services, if it's somebody who is residential the shortfall would be a minimum of well over £100 a week, and that's the minimum. So somebody who perhaps has come in and runs out of money, but doesn't need a lot of care - yes it would be over £100 that's right - somebody in residential who needs a lot of care it would be £300 nearly, shortfall. And then in nursing of course you have got that uplift with £108, but we incorporate that into our fees, so you're still going to be £300 at minimum short, and it might be more, a week, and that's a week, you know, so that's a lot of money. [W1, interview with manager]

Although in the not-for-profit sector there might be the possibility of an individual home being sustained by funds from the wider organisation, it was clear that there were still concerns about viability, and a wish to invest in order to improve the economic viability of the individual home.

Oh yes, money's always a problem. The Church is permanently in debt. So, from that point, what's holding us back from doing all that, first of all, financing. We'd have to get finances. It has been spoken about but the Church moves in a strange and mysterious way just like the Lord, and in the Lord's timescales. So, [Manager]'s convinced that she'll be opening the extension to the unit when she's getting her retirement present. So, she'll have her zimmer in one hand and the shears in the other as she opens the extension for dedication.... the extension out the back, if we could get the finance for that we could bring in more residents which would make us in a more able financial - at the moment it's a 24 bedded unit, we are in break-even. When we go up to this new staffing level it will be a break-even budget. There will not be an awful lot of falderals and there'll have to be lot of fundraising. Staff member in management role, Marjoram Place

Equally, managing costs while also trying to continue to care for residents without sufficient funds, was also important in the not-for-profit sector. The following example shows active mediation, with the manager choosing to involve senior care staff in budget planning as a way of managing costs:

I mean obviously, especially in the residential part, the majority are self-funding. But once they've been here a while, they deteriorate, they end up here and the money runs out. So really, the ones that are, the shortfall is for the highest dependency really. But to make them more aware of the financial side of things, when [staff member] and myself do the budgets each year, last year and this year,we've also brought the Care Managers in and shown them how we make up the budget and what is spent and that. So it's made them more aware of looking what they spend and do they really need that. Tansy View, interview with manager

In a home that was part of a for-profit organisation, the manager also had a level of discretion over the funding of individual residents' fees, but this operated in a slightly different way:

Researcher - do you also have a role in for example bed occupancy?

'Yes, marketing, accounts, budgeting, training, all of that is down to me. The company are there for advice. But they tell me to run this like it is my business.' Bergamot Place, interview with manager.

In common with many of the homes there was a wish to provide continuity of care, and the manager described accepting a resident at lower rate:

'Social services will pay £425 per week, plus there is £108 funded nursing care. Some people have top up from the family. We try to keep people in [name of the overall complex that includes residential care].' Bergamot Place, interview with manager.

The resident was accepted in the home, but with approximately £200 a week shortfall in the fees. In a much smaller for-profit organisation, the owner appeared to take an active approach to public funding for care home fees:

I mean it's a tough industry at the moment, you know, and we're fighting fees, as you know, in each county. The good thing I've got is I'm involved in three counties, which are the main three counties together, so I know what's happening in each of the counties. So there's always a fight to get the fees, but as you mentioned, the rules and regulations have become quite stringent in the last five or six years, which is obviously why we are fighting the fees to pay off all these rules and regs. Chamomile Place, interview with owner

In a local authority home the recently-appointed manager described the bureaucracy of budgetary management. In contrast to the earlier example of the manager of Bergamot Place having discretion over the income, running the home as if it were the manager's own business, here there is a sense of close scrutiny of spending, with perhaps less opportunity for manager mediation of financial forces.

What happens is all the care homes are allocated a budget and they put a certain amount of money for each different department, like you have a budget for your kitchen, so the food being ordered and things like that, then you'll have budget for your care staff and for your staffing levels. You'll have a budget for stationery. So, yeah, there's pretty much a budget for so many things, additional aids and things like that. So there's a budget for each different department, and that is closely monitored. I'm finding that out. It's closely monitored. People want to know what you're spending money on, why you're spending it, how much, for example, for care staff, why have you ordered agency staff. So it is scrutinised, the budget. But this is news for me coming in as a management. It's something that I've never had to do in the past. Obviously I'm running a budget in my own home, but it's a bigger picture here. So I'm having to go for training, since I've come here for budgeting, so I've got training for that in December. And you asked me earlier about what the challenges will be, and that will be definitely a major one, the budget. Chives Court, interview with manager

Wider organisational constraints on spending were also evident at Bergamot Place. Staff believed new hierarchy in the organisation that had recently taken over the home was slowing down decisions on expenditures that were aimed at improving care experiences:

I think it's because it's a bigger company and obviously there's more managers involved, there's more people involved. Before, it was basically the manager was here and then we had the owner, so he said yes and that was it, it was done. Whereas now it's like you've got your regional manager but then it has to go through an area manager, then it has to go to, I don't know, the Estates Department, then it's got to go to a finance thing, then it has to go here, then they send it back saying "yes you can, now can you do a [request form] now". So it's all slow motion sort of thing. [Bergamot Place, staff interview](#)

However, various steps have been taken by some homes to meet the care needs of residents and in some cases positively impact on their care experiences. For example, care homes such as Marjoram Place and Thyme View have attached to them Society of Friends or welfare committees that raise funds.

That's the extras. That's the Christmas presents, the Christmas meal, going out on outings. But they also help us fund equipment. [Thyme View, staff interview](#)

In one home it was the staff themselves who was raising funds to pay for items or events that improved the care experiences of residents:

The mini-bus, the staff raised the funds themselves for that mini-bus, £1,500 that's all it cost, and we just went and bought this old battered mini-bus. But it's one of the best things that we have ever bought. We did a beach day inside and the staff said "wouldn't it be lovely to have some sand in the garden". And our finance team at the time said "we'll come in and do it for you free but you'll have to go and buy all the stuff". And then [resident], because he loves his tools and everything, they said "oh can't we have a tool shed for him". So we priced it all up.....and the girls said "well we could do this, we could go bag packing at [supermarket], we could organise this little event" and something else, I can't remember what the third event was. So within two weeks they'd got three events organised and they raised [the money] so we could pay for it. [Hyssop Place, staff interview](#)

This demonstrates a sense of collaboration between different groups of staff, and loyalty to the home and the residents. However, the fact that homes are having to raise money for activities and events does suggest that such activities are regarded as an add-on to care rather than an integral part of it. This was commented on by the activities coordinator at Chamomile Place, who also admitted that she begged for equipment:

Everything we've got, I've got for nothing, near enough. And I get it all for nothing. I just know people. I beg, "Give me your stuff." We've spent a little bit of money. There wasn't any money in the activities budget when I came in. We had to start from scratch. But it's quite healthy now. So if they want something, they can have something. That is another thing I disagree with: having to raise the money for the activities when that should come out of their fee. I do think that because that is part of their care package. [Chamomile Place, activities co-ordinator](#)

Conclusion

Our case studies showed that care homes experienced a number of external factors that could influence the care experiences of residents. By examining what occurred in care homes in response to these pressures, we identified that when care homes (and particularly management of the homes) sought to mediate their impact on the day to day work of staff and daily life of the home, then residents reported and were observed to experience a preponderance of positive care. Mediation was still required even when external factors were initially intended to benefit residents.

However, when mediation did not take place (or failed due to the nature/weight of external pressure) then care experiences appeared to be poorer. Mediation occurred in a variety of ways, and was not simply about preventing impact. Instead it was about cushioning or translating the ways in which factors had effect, as opposed to merely transferring them directly. Nonetheless, mediation was not a one-way process; in order for managers to be able to mediate, the external factor (whether regulatory, owning organisation, family, or financial factor) needed to be receptive to such mediation and this was not always the case; particularly in terms of regulatory and financial factors. The role of management in mediating the impact of these factors on staff experience and practice implicates the next theme to be addressed; the role of management and leadership in enabling effective staff.

Theme Four: Staff are empowered to take responsibility for resident well-being by active management processes

The findings show that the extent to which care staff were empowered to be effective in their practice had an impact on care experiences for residents. Supportive management; responsive management; present leadership; leading by example; defining boundaries and expectations; united leadership; and strong management all served to increase staff taking responsibility in their work with residents and families

...they're all good and they will give you time, is what I like. If you've got a concern you say "can I see somebody before I go". If you've forgotten they will say "didn't you want to see me" or something, you know, they don't forget. (Tansy View, Interview with relative)

Our case studies showed that a complex relationship between staff actions and decision-making, management and leadership existed within the care homes, and the dynamics of this relationship were crucial to enabling positive care experiences for residents or contributing to poorer care experiences. This theme was examined through a comparative analysis of the effectiveness of staff (as shown through their actions and assumptions), the impact of management and leadership (as demonstrated in behaviours and articulated in interviews) and the observed and reported care of residents.

Positive care experiences for residents appeared to be linked to the efficacy of frontline staff in the home. In particular, staff efficacy was related to the extent to which they were autonomous and responsible in their actions in implementing person-centred care. Where care staff were observed to make decisions about how to care within the particular situations of their day-to-day roles, and demonstrated the freedom (and willingness) to carry those decisions out in a person-centred way, care experiences were positive. Importantly, levels of staff autonomy and responsibility varied across the case studies and these appeared linked to practices of management (as involving the tasks of planning, organising or directing others within the care home) and leadership (as involving patterns of influence on others to achieve goals within the care home).

The ways in which staff autonomy and responsibility impacted positively on care experiences could be seen to relate to a number of aspects of frontline care provision. For example, when staff demonstrated creativity or flexibility in responding to resident actions or needs, this resulted in positive experiences.

There is routine from the structure of the day – meal times. However this is not the overriding focus. Staff adapt to residents' needs. Lots of discussion about what resident may need and team work to keep each one informed and decide on action. (Tansy View, PIECE-dem Summary)

Member of staff stays with resident, he is clearly heading somewhere with purpose and the staff member goes with him. Says "[resident's name], can I do the jobs I need to do and then I'll come and sit with you?" No reply, the member of staff stays with the resident... the resident looks at his wrist and the member of staff says "are you looking for your watch?" she points to the clock on the wall and says "what time is it?"... Another member of staff comes into the room and over to the resident and says hello "I'm coming to do my paperwork down here, so can I sit with you?" (Thyme View PIECE-dem Observation)

Furthermore, when staff demonstrated a thoughtful approach to routine tasks, this again resulted in positive experiences.

It is clear that staff are very busy this morning and running late... In conversation with staff they agree that they are late today and accept responsibility for it (team leader says "it's our fault" to both me and a visitor). There is no desire to place blame for this situation on factors external to the staff, (such as people being off sick)...This lack of stress and desire not to rush seems to be backed up by resident's experience of being soothed and calmed by a carer even though they were in the middle of personal care tasks (with others)... According to nurse, 3 carers from this unit are off sick today, (Thyme View, PIECE-dem Observations)

You might have a variation of people washing you or showering you, but they always ask...they say that "it's up to you what you want, we're here to

do whatever you need” and that they do....And I mean they think for you, that’s the thing, they don’t just walk in and they start doing what they’ve got to do. Then they think of things, you know, what I might want to do, or what we’ve got to do. (Thyme View, Interview with residents)

Moreover, positive experiences resulted when staff were seen to take responsibility for problem-solving.

...The resident didn’t eat any of it. The member of staff came back into the dining room saw the mashed potatoes and cheese sandwich on the resident’s plate. She bent in close to the resident, lightly touching her shoulders and spoke closely into her left ear. Her voice was warm and gentle. I didn’t hear all she said but caught bits ‘one sandwich, for me please’. The member of staff used touch, proximity, voice...The resident moved her arm and her hand appeared from under the table and picked up one of the triangles of sandwich and she took a bite. The member of staff touched her shoulders and said closely to her ear again ‘thank you’. (Tansy View, Ethnographic Observation)

Responsibility was demonstrated not only in approach and problem-solving, but also in how staff viewed their role in ensuring quality and challenging poor practice. In discussing how she would respond to a concern, this staff member echoed the response of five interviewed staff members in Thyme View:

But I knew something was amiss and it just didn’t feel right, and I reported it. I would have to do that. I could never turn a blind eye to something I didn’t agree with, it wouldn’t be, I might as well not be here then either...It wouldn’t matter if it wasn’t my responsibility, I would still make it my responsibility. (Thyme View, Interview with team leader)

Conversely, in care homes where the actions and interactions of staff did not appear to exercise autonomy and/or take responsibility in their actions, care experiences were observed and reported to be less positive. Again this could relate to the way in which routine tasks were carried out, or a poor response to challenging situations or circumstances.

For example, at Hyssop Place, whilst staff showed some personal responsibility in their actions they did not demonstrate autonomy, and were seen to carry out actions because it was a task of care, without thinking them through or reflecting on consequences for residents. This led to less than positive care experiences for residents, particularly those whose behaviour could be hard to interpret and presented challenges to staff.

Carer offers resident B a drink, they give it to her but place it on resident F’s table. This continues for the afternoon, B picking stuff up and F getting angry. F is showing remarkable restraint... I cringe on a few occasions, thinking he will hit out. (Hyssop Place, Ethnographic Observations).

At Angelica Court, it appeared that certain staff demonstrated a great deal of autonomy, but without any responsibility in how they carried out their actions. This led to frequently poor care experiences for particular residents, observed throughout the research.

(In a discussion about why certain residents were not up) carer commented that ‘told off’ about not getting people up, (by deputy). carer said “what’s the point of waking people up to walk up and down the corridors all day’? There did not seem to be a sense from the carer that

there was anything that could be done to change the daily experience of P1 and others like her. (Angelica Court, researcher's Field Notes)

A lack of autonomy and responsibility could also relate to poor observation or thoughtless action with regard to routine tasks or actions.

The (resident) did not look so comfortable; her head was not supported fully on the pillow and it was at an uncomfortable angle...The overhead light was on and was glaring into her face. These were not spotted by carers. (Chives Court, PIECE-dem Observations)

By examining the efficacy of staff within the care homes and how this linked to quality of care, our case studies demonstrated that this feature of care home culture was highly dependent on whether management and leadership empowered staff to take such an approach, and how they facilitated it on a daily basis. This was not about a particular structure of staffing or management, indeed, homes were often very different in this respect, rather it concerned a collection of interrelated features that appeared to create and sustain a degree of autonomy and responsibility in the way frontline staff carry out their work. This was facilitated through the support of a well-defined and responsive senior team. These elements together, helped staff to enact positive care experiences for residents.

It is important to note that presence of these features did not absolutely guarantee positive care experiences, and occasions of poorer care were observed and reported within homes demonstrating these. However, what it did seem to create was a culture in which positive care experiences were the norm, and in which poorer care experiences tended to be unusual and isolated incidents, related to individual staff action, and which were often counteracted by other events within the home.

These features of management and leadership are as follows: Supportive management; responsive management; present leadership; leading by example; defining boundaries and expectations; united leadership; and strong management. No one of these was more important than another; they interacted and reinforced each other. Each feature is discussed below.

Supportive management

Firstly, our case studies illustrated that the extent to which management were seen and experienced as supportive of their staff was a significant element in creating autonomous and responsible frontline workers. In particular, this was not simply about a rhetorical commitment to such an approach but a demonstration of aspects such as personal approachability, practical and emotional support of staff work, and concern for staff well-being.

With regard to approachability, at Thyme View, the perception of the manager as a person whom staff could approach for advice and support was directly linked to positive changes to resident care identified by all in the home. Importantly, staff members also linked the manager's approachability to their own ability to make changes:

Researcher: What do you think led to those changes? PS4:
(Immediate Response) " (manager)... because I think she's one, I don't

want to big her up too much, being too, do you know what I mean, she just is, she's very easy to approach if you want anything. (Thyme View, Interview with team leader)

The manager at Thyme View also highlighted that approachability was not about formal supervision arrangements, but about simply being available for staff on a daily and one-to-one basis. Her “open-door policy” was designed (and observed) to avoid problems in the home, (Thyme View, interview with manager).

The practical and emotional support for staff members in their work was identified as an important element in supportive management. At Tansy View practical support, in terms of responding to requests and concerns, providing one-to-one supervision and identifying training needs was seen as an essential component of creating effective staff:

...they would go to the person in charge of shift and say “look we’ve noticed so and so”...if we think they need the training, get the training sorted for them, you know. And have lots of supervisions and give them the support. I mean it’s no good saying “right, don’t do it like that”, but unless you’re prepared to sit down and explain how you want it done, it’s not going to happen is it? (Tansy View, interview with staff member)

Practical demonstrations of that support were observed at Thyme View:

Exchange between two members of staff – resident needing extra help and staff seem under pressure “I could do without this”. One went to inform manager. Manager appeared within 5 minutes. (Thyme View, researcher’s field notes)

Emotional support for staff in their work was also evidenced:

Interactions between manager, deputy and other senior staff re: issue/change in one of the units. Senior staff asking manager/deputy to praise the staff in the unit as they had been working under stress throughout the morning. (Thyme View, researcher’s field notes)

Finally, the supportive role of managers was not confined to work-related issues. In fact, the extension of this support to include a more generalised concern for staff well-being was a striking feature of those care homes where effective staff achieved positive care experiences for residents:

(Staff) have outside lives and sometimes, I mean it’s alright to say “oh don’t bring it into work” but if there’s something going on in the background. So you know, we try and pick up on things like that and say then we can help you with that, if you do your supervision and they’re having a particular problem at home, or they’ve got a particular health problem, or they’re worried about things like that. I mean we’re always talking about person centred care for residents, well that should be for everybody that walks in the building... You know when they’ve got something exciting going on “well how did it go” and “did you enjoy it” and “oh that was lovely” and things like that – take an interest. (Tansy View, interview with staff member).

...you always get back what you give. If somebody has helped me out with a situation, and say, if they wanted, they said "I've got to do..." Sort of like when the riots were on, two of our girls live down that way, no buses. But they are the ones who have put themselves out for me, and I'd say, if it was safe enough to do it I'd say "OK, yeah go on, go home"... And if you've done that for them, you always get it back. (Thyme View, Interview with nurse)

Conversely, in care homes where less positive care experiences were observed and reported, there was some evidence of a lack of supportive approach from management. At Hyssop Place, one experienced and passionate carer summed up a very common feeling across the staff team.

I come to work to do my job, to look after the residents and I never seem to get any praise for it...a thank you would be nice. (Hyssop Place, Interview with carer)

Moreover, a lack of support around difficult work issues could be seen to contribute to poor care experiences at Hyssop Place, precisely because the manager did not see this as her role. The researcher's experience within this setting showed that staff both needed and wanted this support, to the extent that they turned to the researcher for it. (Hyssop Place, Ethnographic Observations)

For a new staff member at Angelica Court, the lack of support from senior staff to problems she had raised, had begun to affect her perceptions of what she could achieve in her work, despite evidencing a positive approach to residents;

And they said "oh we're having a meeting, I'll make sure that's brought up", I've had no feedback...I think with people who want to get on and want to progress, that's just not a good sign for management...but management want to blame everybody else but when are they going to take responsibility for themselves? (Angelica Court, interview with staff member)

Responsive management

A second key feature of leadership and management that appeared to facilitate and reinforce staff autonomy and responsibility in our care homes was the responsiveness to frontline staff. This related specifically to the extent to which input from staff members was welcomed and acted upon:

Talking about whether care workers were able to influence the care residents receive a staff members at Tansy View replied:

To an extent, if they think that something isn't working properly then they by all means can come and speak either to the team leader or (head of care), and we're always open to new suggestions if it's something that's going to improve something...So no, if they come up with a suggestion or you know say "oh we don't think this is working, could we try it like that",

and we think they've got a good idea, then we'll act on it you know. (Tansy View, Interview with staff member)

At Thyme View, the influence of staff, particularly in relation to social and activity elements of home life, was recognised by relatives and residents, as well as senior staff:

Staff here are very good, because last year I think they took them all out for a meal. Somebody said "why can't we take them out for a meal" and they booked the restaurant and all the rest of it, they had paper hats and enjoyed it. And then I think it was (activity co-ordinator's) idea to have a trip – it might have been one of the staff, and they just arrange it, our local church then down (south) put on, as you probably know, fish and chips for them and stuff, and they took them out and they had ice creams and all sorts. (Thyme View, Interview with Relative)

This sort of responsiveness was seen as being essential for motivating staff in their work.

...even the carers, I mean they'll come up and they'll say "oh can we do this" and you're like "yeah definitely" because it's a team thing isn't it?...And so if people have ideas, and we always welcome ideas, then like you know we're like "oh yeah let's do that" or "that's a brilliant idea, you go ahead and do that"... So anyone can make an idea, a decision... (Thyme View, Interview with team leader).

Responding to input from others also appeared to have a self-sustaining impact on the life of the home. This was particularly so at Thyme View, where staff associated their ability to influence home life with a commitment to the home and desire to help support other changes as well. In discussing why she had applied for a new team leader position in the home, a staff member commented:

... well I've done loads of sensory kind of activities because of my degree so I thought "well I think that's an area of need at the minute" so I could actually contribute quite a lot and do quite a lot for people that don't speak and have got quite in the later stages of dementia... I just thought "I can make a bit more of a difference...I was quite excited about it because there's so many opportunities here and you've got such a chance to, you know, just improve things all the time haven't you...you've got good management who just want to improve things and make it like the best it can be. So you're just really motivated for the residents just to give them the best possible kind of home really. And I don't think you'll ever get sick of that. (Thyme View, interview with team leader).

In care homes where staff did not appear to relate to management as responsive to their input, care experiences seemed less positive, in part because staff were not facilitated to be active and involved in the care of their residents. For example, at Hyssop Place an incident in which management determined causes of behaviour without involving staff seemed to explain why staff appeared disempowered and unreflective in relation to this issue;

This incident was recounted several times by different staff and this led me to reflect that it was un-involving of staff, almost dismissive of what they and P2 are experiencing. Actually seems to have reinforced the norm here in which staff create their own constructions. Seem disempowered. (Hyssop Place, Fieldnotes).

Furthermore, in a broader conversation with the key worker of this resident about causes of his behaviour she discussed other suggestions made by the manager and deputy, commenting: "Well, we (care staff) don't know about those sorts of things,". (Hyssop Place, Fieldnotes). In the course of this research this member of staff was observed to have a very insightful approach to this resident and his difficulties.

Present management

The presence of managers (whether home manager, deputies or others with responsibilities for staff) was obviously crucial to both a supportive and responsive approach to staff members. However, presence was also shown in our case studies to be significant in its own right. In fact, it was often explicitly used as a strategy for tackling particular issues or enabling changes to the way the home provided care. Presence manifested in three ways;

Firstly in the use of physical space to signify presence

We decided right at the beginning that we'd change the Care Office round to make it more like an office for the Head of Care, so that straightaway there's that, you know, "this is the person who is in charge of all the care". And the team leaders are getting out on to the floor and they're able to lead a shift by working with them and seeing the strengths and the weaknesses of the staff that they're working with. And at the moment it's working. (Tansy View, interview with manager)

Manager and deputy discussed their office moves and explicitly stated that (head of care's) move was about keeping an eye on (unit 2) and trying to force their movement into the office in the main house. Interesting illustration of how they achieve change. Very explicit decision to do each unit at a time and that physical presence of self (and then other leaders) is necessary. (Thyme View, Researcher's Field notes).

At Thyme View the management were also physically present in the use of frequent memos and announcements posted on doors and notice boards throughout the home. These related to both poor practice issues (such as staff leaving early), or changes to routines (such as recording work for the maintenance staff). These notices were always written using the same format: an explanation of the issue, a (resident-oriented) explanation of why it is a problem, and the solution to the problem. These notices were always signed by the manager. (Thyme View, Artefacts)

A second manifestation of present management was through managers undertaking informal or routine checks as part of their work:

...by being in early I see the night staff as well, so I do see all the night staff. And then actually one of the first things I do is I check on the computer, everybody, you know, so I just check the report for everybody. (Thyme View, Interview with head of care,).

Thirdly, effective staff providing good quality care appeared to be facilitated by designated staff roles with day-to-day oversight responsibility. In both Tansy View and Thyme View changes had taken place to introduce this element:

...that's what the team leaders are supposed to do. That's our job being on the floor is keeping an eye on everything that is going on, checking what the carers are doing with the care in the mornings or in the afternoons, and keeping an eye out in the dining rooms, just checking that everything's ticking along as it should do, you know. (Tansy View, interview with team leader)

So there's another layer who can sort of watch what's going on, the nitty gritty really...we can see what it's done, and it's so much nicer ...people are bobbing about, and those staff who are a bit slack are being, you know, I just, Eta said last night "you can't do that!", but nobody had noticed before because they're just left to themselves. (Thyme View, interview with manager)

In homes where management or leadership were not seen to be physically present, care experiences could be poor, or were achieved only as a result of one-off staff action, rather than as a routine occurrence. At Hyssop Place, the manager was never seen to enter the unit for any purpose, and both staff and family members had noted this absence and this was linked to some of the difficulties they experienced with the home.

She never comes on the floor, you never see her walking around...I think if your staff can see you're prepared to muck in with them, they're prepared to do more for you. (Hyssop Place, Interview with relatives)

Management at Angelica Court acknowledged that recent pressures (a deputy on long-term leave and no funds for a senior staff member) had led to a lack of oversight of the unit and thus a concern that standards had slipped. They appeared to explicitly understand that effective staff teams required a presence from management and that without it care experiences could be less positive than they otherwise could be, (Angelica Court, interview with manager and researcher's field notes).

Leading by Example

In our case studies, an essential element of facilitating an autonomous and responsible frontline staff team that contributed to positive care experiences for residents was the extent to which managers and leaders set an example. This was reflected as both an explicit intention on behalf of managers and experienced by staff and others throughout the home. Whilst this factor related strongly to the physical presence, responsiveness and support provided by managers it was also about mirroring what standards were expected, or concepts introduced to staff through training,

Like my thing with people at end of life is, I use lavender quite a lot to settle them, make the place smell nice and everything, and pineapple, because it takes the crust off their tongue and everything. And staff used to watch me doing this and "oh here she is again with her lavender", and

when they did the training, the trainer also brought in the use of lavender aromatherapy, and the smell in the rooms and all that. And they come back and they said “hey, she said about lavender as well”.... one of the girls on nights, she came in with a little plastic Tupperware thing and she’s put a palliative care kit together, everything that you need when someone’s dying, for their tongue care, lavender oil, yeah. (Tansy View, interview with manager.)

I think it’s constant isn’t it, it’s constant. And I do think when they see your way, the way you are with residents, and also if you speak out straightaway when you see things not going right, you know, straightaway and don’t let things pass you by, then I think people will get the message, definitely. But you’ve got to do what you want other people to do...So I think you do lead by example. (Thyme View, interview with head of care,)

Leading by example also meant strengthening staff whose behaviour was identified as exemplary:

I like to lead by example, that’s what I try and do, you know, and head of care will quite often, if they do get someone they’ll give them to me for train for the week with, you know, and depending, and you can quite often pick up quite quickly on someone’s ability. (Tansy View, Interview with staff)

I do get good feedback about the way I work, and I would hope that some people would follow an example that I set because, well (manager) has herself said to me she would like people to follow my example... if I was just sitting there lazing about and not interacting with my residents, well the care assistants are going to say “oh well (she’s) sitting there doing nothing so I will sit... (Thyme View, Interview with team leader)

In our care homes, staff effectiveness could be seen to be negatively impacted by the absence of good practice examples in the workplace, particularly if managers actually demonstrated poor practice, either through absence or action. Moreover, this absence often led to staff creating their own understandings of care, or being influenced by others in the setting, and these did not always translate into positive care experiences for residents.

For example, at Hyssop Place, visitors to the unit were a powerful influence on staff. Whilst sometimes this was positive, observations showed that staff and visitors often developed shared understandings of the causes of behaviour that may have benefitted from more informed perspectives. Additionally, where visitors disagreed with staff approaches, staff developed different practices when the visitors were present. Overall this confusion led to several incidences of poor care experienced by residents at Hyssop Place, such as failure to reflect on the causes of apparent anger from residents, failure to prevent frustration or protect residents from the actions of others, (Hyssop Place, Field notes & Observations).

Defining Boundaries

A key aspect of home life that enabled an effective staff team, providing positive care experiences to residents, was the extent to which management and leadership defined and

enforced the roles of staff and the boundaries inherent to them. Within our case studies, clear roles and boundaries appeared to actively facilitate freedom of action within those roles and to support appropriate interaction between staff in different roles. Significantly, this feature was not simply about creating and defining roles, but about ensuring appropriate individuals (in terms of skills, values and approaches) were fulfilling these roles.

Firstly, management, by defining roles and responsibilities, appeared to set up expectations which staff and others acknowledged. For example, changes to staff structures at Tansy View had been made to ensure that staff's focus was on residents rather than organisational processes such as handover;

It means that we can get on the floor quicker rather than the residents sitting there for a bit longer, and I feel that they get more of our time. And then say if a resident needs, certain residents need to go to the toilet dead on the dot and if they're not there then they get more embarrassed, needing like to be completely changed and things like that, so if you're there on time or a bit early then they're fine, they don't get embarrassed and it makes your life that little bit easier as well. (Tansy View, interview with staff member)

Obviously it's important that they (managers) make any decisions, you know for the care, but on the smaller things, which there are so many small things if you do it as well as you can, but a lot of the time you are deciding and basically deciding how good the care is for the end of it I suppose. (Tansy View, Interview with staff member)

At Thyme View, staff work plans were organised in advance by senior staff, defining the types of actions to be completed and by whom. However, far from restricting staff flexibility, what this approach created was the external boundaries within which staff were able to exercise their decision-making and judgement:

...every morning there is a work list, or whatever shift you come on there is a work list, so you follow the work list. But you don't have to follow it rigorously, it's there as a guideline. And it will state who is on which particularly section of rooms and it will also, well the team leader role. (Thyme View, interview with team leader, PS4)

Clear expectations of different roles, also appeared to aid staff in communicating across different roles and knowing what to expect of each other because responsibilities were shared understandings:

It is okay for staff to instruct team leader: A carer went to team leader and asked if she was going to give a resident his cough medicine as it was bad today. (Thyme View, PIECE-dem Observations)

Early observations show that 'younger more inexperienced, unqualified care staff' may spend their time on some of the more routine activities. More senior/more experienced care staff are involved in this too, but if specific more complex needs for some residents may emerge it is perhaps the more senior/experienced care staff who may work to meet these needs...They appeared to be automatic workings where more

senior/experienced staff moved into the foreground in the immediate situations and more inexperienced carers moved into the background and out of the immediate situation. They then moved on to care for other residents. (Tansy View, Ethnographic Observations)

Crucial to successfully achieving clear role boundaries and expectations of staff was ensuring the right skills of staff in those roles and this required a very thoughtful and reflective approach on staff performance:

Yeah. We have got a few, as you say, the core. There are a couple of them that aren't very strong in various things, but you can't all be good at everything, so we need to look at their weaknesses and try and bring out the strengths rather than just make them come up on their weaknesses, it doesn't always work like that. Because one of them, their empathy with the residents is fantastic, but put them in the dining room and – terrible. So you do have staff who say "well they need to go in the dining room more to make them do it", but I don't agree with that. I think if they're really bad at something, don't put them there to fail, give them something to do that they really excel at, try and do it that way. (Tansy View, Interview with manager)

This was best exemplified at Thyme View, where management had initially dismissed a potential candidate for a team leader role because she did not have requisite skills. However, the candidate's performance at interview and feedback from other staff led them to appointing her to the role and giving a chance to prove herself. In practice, she was observed to demonstrate a very powerful approach to leading other staff and instituting change; so much so that the researcher did not believe she was the person to whom managers had referred. (Thyme View Interviews & Observations)

Essentially what successful homes appeared to create through the use of role expectations and boundaries was a distributed approach to leadership, in which roles and individuals other than the manager and deputy/head of care were able to manage issues within their remit and lead those around them. In addition, this distribution of influence seemed to facilitate many of the features outlined above, such as presence, support and approachability. This is because it enabled these tasks to be carried out by others in addition to the manager/deputy and therefore maximise their impact.

Where care homes evidenced a lack of clear boundaries or expectations of different roles, or where inappropriately skilled individuals were placed in those roles, then staff appeared to be significantly less effective in their practice and as such poor care experiences could prevail. At Angelica Court, roles were unclear with no one person responsible for the staff team on duty during each shift. Staff explained that someone would usually step forward to run the shift and researchers observed this to have drastically different impacts on care experiences depending on who this individual was. Essentially this became 'leadership by personality' with the tone of that person's approach determining the tone of the care residents received, and on several occasions was observed to have a negative impact on care experiences of residents, as well as the practice of other staff. (Angelica Court, Observations & Field notes).

In one care home, staff appeared to be prevented from being autonomous or responsible because they simply did not know what role they would have or where they would be placed in the home following breaks or shift changes;

Staff member was keen to inform residents that they (staff) were soon to be leaving the floor in order to take their break, they did not know whether or not they would be returning to the (unit) afterwards. (Chives Court, PIECE-dem Observations)

At Hyssop Place, the team leader role was clearly defined, but the individual in post (though well-meaning in approach), did not demonstrate a particularly sophisticated approach to dementia care and this led to some less than optimal care experiences. For example, she was creating a new garden but it was to include a child-sized bench as opposed to one the residents could use.

United leadership

A possible difficulty within distributed leadership is that it has the potential to create divergent (and conflicting) centres of authority in the care home. In our case studies, those care homes that appeared to provide positive care experiences to residents through effective staff, exhibited a unity in terms of value-base and a consistency in action of leadership that was striking. Significantly, this was something that was actively sought and recognised in creating roles, appointing individuals and experienced by all involved in home life.

In discussing the overwhelmingly positive experiences of care observed and reported at Thyme View and how they were achieved by care staff, a relative and committee member of the home explained:

I think they've got a very good team of management here. I think the way (manager) and (head of care) work, pull together, they care for the staff, they're very fair. I think that gels, it sets the tone, and they know exactly where they're going so that obviously is shown down to the staff, which of course is then shown out to the residents. So I think good strong management at the top. (Thyme View, interview with relative)

Moreover, all senior staff interviewed (three team leaders and a nurse) reported consistent stories of how they would tackle issues, when they would escalate an issue to a more senior level and confidence of the support they would receive from management when doing so. These accounts also married closely with care staff understandings and those of the manager:

...they're telling the other staff. And then they've said to me "as long as you're supporting me I'm prepared to stand for the flak". And that's what they feel, that if they know they can come in here and say "am I doing this right, is that what you want" and if I'll say "yes it is and I'm behind you" then they're prepared to go out and say "I don't care what you tell me, I'm right". And that's nice to know that that's what they feel. (Thyme View, interview with manager)

Where care homes struggled to facilitate an autonomous and responsible frontline staff team that provided positive care experiences, a division or tension within senior staff and management was evident. At Angelica Court there was a division between senior staff and a carer who was often given an 'unofficial leadership' role in the unit, (and had previously been the senior carer). This division contributed to the member of staff actively contradicting instructions from management in her practice, and her approach was seen to negatively affect the tone of care experiences whenever she was on duty, (Angelica Court, Ethnographic Observations). At Chives Court these divisions had persisted over time and contributed to poor quality care: As a previous manager explained;

They had been through a few managers in the course of eight years...I was quite looking forward to the job...(but) my assistant managers were quite resistant to a lot of immediate change...I left there wanting a whole new management team to drive things forward. (Chives Court, interview with previous manager)

Strong management

The final feature illustrated by our care homes to be significant in enabling effective staff to provide positive care experiences was the strength shown by managers in their own decision-making. This included decisions across a whole range of day-to-day activity, but notably a willingness (and ability) to take disciplinary action, and a perception of fairness in their judgements.

Firstly, managers evidenced a desire and ability to take appropriate disciplinary action when required, recognising the impact it had in enforcing values throughout the home and the different options they had available to them to take action and prompt change.

...we have had disciplinaries... right through the process of they come and see me and I say "look, this isn't working right, I'm going to give you a...." you know, so it's a verbal warning right through to the... where things have gone really pear-shaped because somebody hasn't listened and made any difference... it's been basically around what I term "abuse", not, I mean some people might not call it abuse, but it is abuse if you're not doing what's necessary for that resident, it's abuse and I'm not having it. And that wakes everybody else up doesn't it as well if they realise that you are not going to stand for that, then they either decide that it's not for them – and that's what's happened with one or two. (Thyme View, interview with manager)

...bring it to the management's knowledge and then that would be something that the management could deal with in a supervision and delve a bit deeper as to why. I mean if there's a reason which is correct in that staff member's eyes we would then need to say "look is this really what you want to be doing". If it's not and they just can't tell why then it's something that we need to perhaps work through with them in either training or more regular supervisions to make sure that that is overcome. (Tansy View, Interview with head of Care)

It was also notable that, far from causing anxiety or division amongst staff, these approaches were often accompanied by a perception of managers and management action as fair.

...has been here for 10 years and loves it "it's a good one. This is one of the best"...in discussion about what makes the home so good she says "if you do something wrong, you'll be told about it. But it's done well" thinks you need that because we all make mistakes "at the time you think you're being told off, but later you realise you're not, It's never held against you.
(Thyme View, Ethnographic Observation, discussion with night staff)

Significantly, accompanying these aspects was a sense that these managers had a degree of freedom in their own decision-making around issues such as recruitment, staff management or changing staff structures, as opposed to other homes where pressures from external issues (wider organisational requirements, difficulties recruiting staff etc.) were seen to limit managers' ability to act in this way.

Conversely, where managers did not demonstrate strength in decision-making, (whether because of their own approach or external restrictions) this seemed to impact on the effectiveness of staff on the ground to facilitate good care experiences, particularly as it could result in individuals who had a less than positive effect operating unchecked within the staff team. At Angelica Court, a member of staff was observed to have a negative impact on the quality of care when she was on duty. This was acknowledged by management, but she remained working in the unit. The staff member explained her background;

Used to be a senior on this unit until she 'made a mistake'...She said she gets 'no support' from management. She gets asked to do senior tasks and extra jobs (by them). She said it was hard to be here after being a senior because 'still expect me to be in charge'. (Angelica Court, Ethnographic Observations).

Conclusion

In our case studies, those homes that appeared to achieve a predominance of positive care experiences for their residents evidenced frontline staff who demonstrated autonomy and responsibility in their day to day actions within clearly defined boundaries. Crucially, this effective staff action appeared to be facilitated through the actions of management and leadership in a variety of different dimensions, as outlined above. No one dimension was overwhelmingly important, instead all contributed to the cultural impact on staff actions. Individual homes often appeared stronger in some elements than others but, when examined holistically, the practices of management and leadership served to facilitate and empower frontline staff.

In those homes that were inconsistently successful in providing positive care experiences for residents, or evidenced a preponderance of poor care experiences, staff autonomy and responsibility was often absent or inconsistent, dependent on the will and skill of individual staff members. These situations were accompanied by an absence of some or all of the facilitative aspects of management and leadership described above. Indeed, even in those homes where positive experiences predominated, occasional absences of these facilitative dimensions often coincided with unusual incidents of poor care experience.

In examining the practices of management and leadership that facilitated effective frontline staff, it becomes clear that there is a link to the previous themes of shared values connectedness and mediation of external factors. Where management and leadership contributed to effective staff, this was often through practices which demonstrated shared values (such as leading by example), enhanced connectedness (such as responsiveness to staff input and being present in the home), and mediated the impact of external factors (including supporting staff). Moreover, the presence of an effective staff team enabled by management and leadership practices such as defined boundaries, unity and strength served to reinforce these aspects of culture by ensuring that individuals who demonstrated shared values and connectedness were able to influence the home on a daily basis. In addition, it appears effective staff and enabling practices of management and leadership may also be significant in terms of how change is viewed and pursued within the home and this is the focus of our next theme.

Theme Five: Openness to Change for the benefit of residents

Findings suggest that way in which a home views and pursues change impacts on care quality. Change pursued in a gradual and on-going way, towards a resident-oriented (rather than organisation-oriented) goal, appeared to be associated with positive care experiences.

You know, when we first had animals I had terrible trouble upstairs with the Committee because they said “we don’t like animals, why have you got them in”. So we talked to them about it and then we wrote it in the Newsletter, the benefit that it gave to residents and things like that, and just kept talking about it and saying “but it’s not going away, whether you think it’s good or not, we know it is”. And eventually they came in. But it can be difficult. (Thyme View, Interview with manager)

The case studies indicate that a culture that pursues change towards the goal of person-centred care experiences rather than organisation-oriented needs is more likely to achieve positive care experiences for residents than an organisation that puts its goals and needs first. However, how change is managed is crucial for its success both in terms of achieving the goals of change and for ensuring the welfare of those for whom change will have an impact; care home staff, residents and families. Pace of change, commitment to change, recognition of need for change and whether change is forced on, or managed by, care home staff, all appear to impact on care practices and the care experiences for residents. This theme was examined through a comparative analysis of the care experiences of residents and the ways in which change was spoken about, managed and experienced by those in the home.

Pace of change

In Chamomile Place the management had a good understanding of the need for change (physical, staffing, reputational) and worked very quickly to instigate major changes to the design of the building and to the type of staff employed in the home. Immediate changes to

the design and decoration of the building were appreciated by staff, residents and relatives as this member of staff reported:

He wants new furniture. There's no point in having new furniture when the carpet needs changing. So we're having prices for changing all those carpets, and then we'll have new furniture for them and new chairs all round because those chairs are eighteen years old, you know. So we'll have all new chairs in there and new tables as well. And then when he does the bathroom upstairs, we're going to change the carpet in the whole hallway. So it's [changing] all the time, you know. It's good. (Chamomile Place, interview with staff)

However, immediate changes to the staffing of the care home were not viewed quite so positively, particularly because this was done quickly resulting in a rapid change of staff, as the researcher noted:

There was a lot of turmoil with staffing levels for a time in the home. During this period the home utilised a lot of agency staff to maintain staffing levels but this caused a lot of disruption to team relationships and also for the residents as there were a lot of different faces for residents to get used to. (Chamomile Place, researcher's field notes)

The importance of familiar faces and family feel created by this staff group was described by one resident and the loss of the connection to family with their departure is clear:

And the one that lived there, he had a little girl, a three-year-old. Ooh, she spent days sitting out there with me. And if anybody gave me chocolate or anything, I used to pass it on to her. And then she'd come, "Chocolate. Chocolate," and she'd sit on the seat with me and talk and laugh. I'd laugh with her, but I didn't have clue what she was saying. (Chamomile Place, interview with resident)

These examples of different responses to rapid change (either embracing it or mourning loss) indicate that while some rapid change was viewed positively, other changes may need to be phased in more slowly to allow residents, or those most affected, to adjust and to experience the outcome of change positively. This member of staff reiterates the point about the need to be careful with the pace of change:

Because nurses and carers, traditionally don't like change at all (Lovage View, interview with staff member)

An example of a phased change comes from Hyssop Place, where various changes to meet a local authority dementia care plan were initially tried on one unit of the home before being implemented across the care home, as this staff member explains:

Yeah "we'll try downstairs first". I mean top floor wasn't classed then as residents with the beginning of dementia, although they did have some residents up there did have dementia "we'll try it in downstairs first to see how it works". And we said, you know, it was nice for the staff, it was nice for the residents. Some relatives were happy with it.

And then, yeah it went upstairs, it worked for the whole building. And then with the locks coming off the doors, although the staff in the unit haven't got uniforms on, residents started going upstairs. So they were seeing some in uniforms, some not in uniforms, so we'll bring it all together and now none of us...(wear uniforms). (Hyssop Place, interview with staff member)

However, observations revealed that the care carried out in this home did not always meet residents' needs, suggesting the need for more fundamental change in care practices and staff understanding of dementia in this setting. This raises the point that any change needs to have as its goal improving care experiences rather than implementing change because change is due or, as in the case of Hyssop Place, to fulfil external standards. Notably, there was a sense at Hyssop Place that because changes had been made to meet an external standard, and that standard had now been achieved, that there was no longer a need for change in the home (Hyssop Place, researcher's field notes).

Top-down or bottom-up change

Our case studies suggest that top-down change (change ordered by the owning organisation) could be construed as burdensome by staff and, if imposed rather than negotiated, could result in staff stress, as this staff member indicates:

Head office are now getting on our, our paperwork is behind, they brought out these new folders....., very detailed care plans for each individual resident, a good idea but a lot of work, hours and hours of work to get them done and we've just not got the time to do it. (Lovage View, interview with staff)

In Lovage View, staff did not feel able to instigate change due to their recognition of lack of responsiveness of both the management and the Organisation:

I: And is there, I mean, in terms of management structure, I mean, are you, do you have much say in what you can do in terms of... (staff) Yeah, I can say something, but it's up to them...if they will take it on board. I: Yeah, and do you think they listen?(staff) Hmm, no, not really. (Lovage View, Interview with staff member)

In this care home, partially because of perceived inability to make useful change and imposition of burdensome change, staff were observed to be tired and missing work due to sickness, therefore leaving the home short staffed and compromising quality of care as already noted.

However, a sense of being able to make change emerged as an important factor in enabling staff at all levels to provide for individual or changing needs of residents, a changing population within the care home or a change based on new interventions. For example, this manager successfully pushed the management committee to allow animals to visit or live in the care home.

As illustrated, our data indicate good quality care in this care home, with staff constantly striving to make changes to benefit residents.

The process of change, whether imposed on the home or negotiated/instituted by the home itself, illustrates a connection with a previous theme; the ability of management to mediate the impact of external factors on the home. Where this was possible, then the impacts of change could be mediated successfully and could result in positive care experiences. However where it was not possible then change could be troublesome and lead to less positive care experiences.

Commitment to change or ignoring the need for change

As identified previously, empowering practices of leadership and management are essential for promoting positive care experiences through creating effective staff. How change is managed, i.e. how care home managers are able to promote or achieve change, also impacts on the experience of caring and on the experience of those being cared for.

In Tansy View, a change in leadership structure was implemented in response to the care home management's recognition that the current leadership structure was not working efficiently. In response, the organisation has phased a new leadership structure into their homes, with Tansy View being one of the homes to start off with the change. This new structure was reported as working surprisingly well. The organisation's commitment to supporting change is reflected in their provision of staff leadership training.

Further change was underway in Tansy View to train care staff in palliative and end of life care, to avoid residents being transferred to hospital to die and to ensure residents received as good care as possible in familiar surroundings at the end of life. The outcome of making changes in response to a recognised need is recounted by a member of staff:

We had one man who died recently, he was an ex-Army Officer and he wanted a dog. And people thought well that was an impossibility – but we have a little pet dog that comes round the home, so we phoned Phillipa (owner) and Rover (a 'pat' dog), and the day he died Rover was on his bed for an hour or more, and then the resident just went into his sleep and he went off to sleep. (Tansy View, Interview with staff)

Incongruence between a manager's perception of their ability to manage or effect change and others' (staff or relatives) perceptions of the approachability or responsiveness to requests for change was noted in one care home and indicates that there needs to be more than rhetoric of change. Here the manager explains her response to ideas for change presented to her by staff:

Well they'll come in to me usually and say "what do you think of this X" and I would never ever say "it's a bad idea" or anything like that, you know, I applaud whatever they do. I love the fact, when they come in with ideas I love it, I might not always agree with it deep down but I love them coming in with new ideas. (Hyssop Place, Interview with manager).

However, a member of staff at Hyssop Place, who had attended extensive dementia training found it difficult to change practice amongst staff and received little support from management. This had prompted her to leave and find work elsewhere, ([Hyssop Place, interview with staff](#))

Lovage View was a care home where leadership was ineffective; contributing to an environment where change did not occur easily and where staff struggled to cope. In this setting, chronic understaffing was raised as a serious issue by members of staff, with failings at organisational level and lack of responsiveness to change at management level being cited as contributing factors. Here, in response to why there were only two staff on duty on this particular day, a staff member said:

We've got two staff on annual leave and the manager has allowed those staff to be off on annual leave, so that's already putting us short, you know we're running on the wire anyway and then a member of staff went off sick. We're supposed to have four and four, we're supposed to have four staff on in the morning and in the afternoon and we've been running with three staff on, so we're short all the time, for months now and em we can cope with three staff on, which means you're cutting it down, we're not supposed to just have three staff on, it's not safe, you can do it on night shift, but not during the day. (The Organisation) don't like using agency staff because it costs too much, they'll have you working short. They know that they can... they've known about this staffing shortfall for a long time but they're very very reluctant to get agency in. ([Lovage View interview staff member](#))

This point is elaborated by another staff member, in the context of seeking an immediate or short term solution to the staffing situation by phoning other care homes in the vicinity owned by the Organisation, to ask:

If they got some extra staff to help us, but sometimes they said...they said that they are understaffed also. ([Lovage View, staff member](#))

Our observations in Lovage View revealed that understaffing resulted in residents being unattended for long periods of time:

There was not enough staff on to see to the immediate work of getting people up in the morning while also seeing to the needs (physical and social) of those who are already up. Very very quiet in here (sitting room) – no staff around, not even in corridors. ([Lovage View PIECE-dem Summary,](#))

There seems to be no room in the routine for socialisation. The sitting room is very isolated feeling. ([Lovage View PIECE-dem summary](#))

In this setting, it seemed that the Organisation had little regard for the welfare of its residents or its staff, no desire to change in response to staff need and no understanding of, or concern for, the impact of its policy on care practices or the experiences of residents.

Conclusion

This theme emphasises the significance of change in care homes and the impact it has on care quality; whether in response to changing resident needs, policy directives or in recognition of changing focus of care. Change may be implemented immediately or gradually and it may be instigated from above (the organisation) outside (local authorities or regulation) or from within the care home itself. Our case studies illustrate the negative impact that change imposed for the sake of organisation-oriented needs as opposed to resident focussed needs can have on care practices and thus the care experiences of residents. In addition, when a care home does not value change or recognise the need for it this can also impact negatively on care experiences. When a care home is responsive to the need for change, sensitive to the impact of change on staff and residents and puts the residents' welfare at the centre of change then care experiences are more likely to be positive

In examining the role of change in our case studies, other aspects of care home culture become apparent. Most significantly, the role of care home management in mediating the impact of change caused by external factors (such as organisational or regulatory requirements) is shown to be crucial, but also dependent on the recognition and freedom of care home management to be able to mediate. Also apparent is the benefit of shared values and connectedness in the home in rationalising and facilitating change based on improvement of person-centred resident care. This successful change then reinforces the shared value of person-centredness and enhances connectedness within the home. A home's approach to and experience of change are also demonstrated in the next themes emerging from our case studies as these two themes were often developing understandings within the care homes and staff action: the use of the care home environment and the position of activity and engagement within care work

Theme Six Using the care home environment to the benefit of residents

The findings suggest that the ways in which the environment is used in care homes is shown to have an impact on the quality of care experiences. Where conscious reflection on the environment and its use is evident in a home, it can contribute to positive care experiences.

The room seems again to have been transformed from a dining area to one set up for activities. The dining tables have been cleared and there are now items on them, one member of staff is encouraging some residents to do a jigsaw. (Thyme View, PIECE-dem Observations)

This theme addresses the ways in which use of the care home environment impacts on the quality of care practices and experiences of care. Our case studies suggest that conscious

reflection on the environment by staff in care homes is required to positively impact care experiences. Design, layout and use of space appear to interact with care practices in a way that implicate the values of the home, and those working within it. This theme was examined by a comparative analysis of the care experiences of residents and ways in which use and awareness of the environment were demonstrated in staff practices, behaviour and assumptions.

Existing space and using space

Care homes in our study were either built for their current purpose or converted to care homes and ranged from old to very new buildings. The 'fit' of buildings for changing needs is an issue, particularly when not originally designed with frailty in mind. For example, Chives Court was built as a retirement home for people with minimal needs, but the level of need has risen and now most residents have moderate to high needs. The bedrooms are small, with no en-suite facilities. They are so small that they hardly accommodate necessary equipment as needs increase. For example, as the manager said:

If you get someone in a room in a wheelchair and a stand aid, you've hardly got space to help them sit on a chair, because the rooms are so small. So, it's not fit for purpose. It is a challenge for the staff because they have to keep taking commodes out of rooms or stand aids in and out the rooms to get a chair in, to get the wheelchair in. So there's a lot about the layout of this building. I don't think it's ideal for group living, (Chives Court, interview with manager)

Lack of en-suite facilities in this setting meant residents had to share bathrooms and this was acknowledged by the manager to compromise their privacy:

It's not dignified when you're taking somebody along, say, for a bath, when you've got all their bits and pieces and they're getting transferred. (Chives Court, interview with manager)

It was not possible to observe whether this impacted on care practices and residents' care experiences, however it clearly was seen as a design issue by the manager. Although little can be done to alter the structure of a building, there is a lot that can be done with its decoration and furnishing. To improve the immediate environment of Chives Court as best he could, the manager made funds available for care staff to buy pictures, items to engage senses or to provide stimulation and encourage positive interaction with residents. However:

It just didn't seem to pay off, I don't think people, the staff knew where I was coming from. I don't think it really changed their thoughts on the task-centred practice as much as I tried. (Chives Court, interview with manager)

In this care home, despite attempts to encourage staff to take responsibility for their use of the physical environment, staff appeared unable to make the link between good use of space and good care experiences for residents. This suggests that environment alone is not sufficient to ensure good care, and that staff practice, understanding of resident need and willingness to change is more significant.

In other settings, thoughtful use of space was demonstrated as an on-going need in an environment, rather than a one-off decision of decoration or purpose. For example, in Thyme View, a small lounge was often used for those residents with high dependency needs, who were cared for in large chairs. It was designated for them as it allowed a quieter, more relaxed environment in which sensory equipment could be used, (an alternative to a busy, noisy dining room). However, due to its small size, residents had to be moved from one area of the room to another when others were moved in or out and this was disruptive to them. It also meant the room became cramped as it filled up, resulting in difficulty interacting individually with residents, ([Thyme View, Observations](#)). Thyme View, on the whole demonstrated excellent care experiences for residents, so it is notable that even in an environment with positive care norms, the issue of thoughtful use of space is a constant need.

At Angelica Court, the use of space demonstrated the dominance of staff and organisational needs above those of residents: Researchers were informed that the 'quiet corner', where residents could sit and watch what was happening, had been moved from the centre of the unit to the end of the corridor because it became too busy following installation by organisational staff of a computer in the central space. Since the quiet corner has been moved it was not used by residents, and residents were observed to still gather in the central area, but with few chairs to sit in. ([Angelica Court, Observations](#)). In this example, the value to residents of a central hub had been overlooked by management in their implementation of organisational change, and it appears that care staff were not able to advocate for the residents, suggesting a prioritising of organisational needs over residents' everyday social needs.

In Hyssop Place the lack of sufficient space was recognised by researchers as being an issue for one participant who needed more personal space than the setting allowed for. The layout and size of the rooms had an impact on him, as he was forced to be in close proximity to others, who frequently stepped into his personal space in a way that he found difficult to cope with. In this example, there seemed to be lack of reflection on how the space might influence this participant's well-being and lack of ability to use the existing space more creatively to protect him against the invasion of space that he experienced. This example is particularly notable as the small, intimate design of this unit (a small, self-contained unit with seven bedrooms) was often spoke about as an advantage and demonstration of their up-to-date approach to dementia care. This again highlights that use of space may be more significant than design in and of itself.

Another use of space in Angelica Court demonstrated how staff's understandings and values can influence the way the environment impacts on care experiences. The large lounge had two sofas and a double line of chairs, arranged with a 'waiting room' feel and resulting in residents in the back line of chairs facing the back of other chairs. The manager and deputy reported that they had tried to institute small groups of chairs in this lounge but the care staff kept rearranging them back. Care staff did not appear to reflect on how the environment

might impact on residents' sense of community or ability to socialise, or on how alternative groupings might improve residents' day to day experiences, instead focussing on how best to serve their own needs through the use of space. ([Angelica Court, Observations and field notes](#)).

However, an example of finding a solution to difficulties with the design of a space was noted by the researcher in Mantle View. In this setting, design constraints resulted in difficulties in interacting sufficiently with residents, as noted by the researcher in Mantle View:

The point was made (by care home staff) that due to the physical built environment of the home it was difficult to provide residents with enough time for all the interaction that they might require in a perfect world. ([Mantle View, Ethnographic observations](#))

However the staff had developed various strategies for addressing this, such as completing paper work in the communal lounge area, signifying reflection on the potential impact of poor design on residents' experiences and taking steps to find workable, day to day solutions.

[Physical environment and potential for poor care experiences](#)

Our research identified that there was not always conscious reflection on how residents' immediate environment may impact on the quality of their care experience. For example, in Chives Court, during a Piece-dem observation it was noted that one participant was:

on her left side, slightly upright. She does not look very comfortable – her pillows are not supporting her head properly – one of them is awry and her head is at an uncomfortable looking angle ([Chives Court, PIECE-dem Observation](#))

Although carers attended to her briefly on two occasions; to feed her and offer her a drink, they had not spotted her awkward positioning, nor had it evidently been spotted by the person who had positioned her in the first place. It appeared that the task focused nature of their interactions with her prevented staff from recognising how her immediate environment might influence her comfort and well-being.

There is also a need for reflection on whether residents can engage with the environment independently, or whether they need support to engage with it. For example, Thyme View had many objects and opportunities for activity, occupation and engagement in life activities and staff worked well to use ones that would interest or benefit residents. However, some residents required prompting and support to engage with them, and in the absence of support they did not engage with them a way that seemed therapeutic to them. Thus, while for the majority of occasions, staff's use of objects led to good care experiences, on some occasions lack of reflection and thought resulted in one-off poor experiences. At Hyssop Place researchers noted that the area contained items that could be a risk to the residents if left unattended (such as china and particularly glassware) and during observations the researchers intervened on a number of occasions to prevent a resident coming to harm, as staff were out of the communal areas for long periods. Both of these examples illustrate the

need for continuous reflection on the environment within the context of day-to-day activities (of both residents and staff) that occur within them, particularly when staff cannot be present.

Furthermore, an absence of reflection on space and how it impacts on residents was evident in Hyssop Place, where private information was spoken about in communal areas. Whilst this was, to a certain extent, due to the small size of the communal area it was apparent that staff and visitors did not appear to acknowledge privacy as something to consider. This suggests that space can be both implicated in and determinate of staff values and practices.

Lack of reflection on impact of noise on care experiences

In some settings (Chives Court, Hyssop Place, Angelica Court) there appeared to be little reflection on the potential impact of noise on residents. This seemed to be particularly the case for residents who spent all or most of their time in bedrooms and where care staff seldom lingered beyond the time required to carry out tasks. Intrusion of noise became obvious during observations in some care homes:

It is noisy outside with people gathering for lunch, Hoover, beeper, squeaky door, crockery clattering. Partially drowned out by the radio in her room. (Chives Court, PIECE-dem Observations)

Similarly, observation of another participant in the same setting experienced:

Loud pop music playing on the stereo next to her where she is dozing. Banging in the kitchen – bins? Hoovering and banging in hallway/kitchen. (Chives Court, PIECE-dem Observations)

At Angelica Court, researchers were present when the fire alarm was activated. Staff responded immediately in terms of fulfilling procedural tasks, but they did not check on any residents who were in bed at the time, despite reflecting to researchers that they would all be awake following the alarm, (Angelica Court, Observations).

In all of these cases, care staff attempted to provide a therapeutic environment for the resident, but in the absence of reflection (which would require a degree of immersion in the environment) the intrusion of external noises went un-noticed.

Physical environment and positive care experiences

Use of creative design and using space creatively

Several case study sites were designed to offer small group living with consideration given to design that suited needs of people with dementia and in some instances these were seen to contribute to positive care experiences for residents.

For example, Bergamot Place has 25 en suite bedrooms on the outside of a square, with small sitting areas, sitting rooms and an activity kitchen on the inside of the square enclosing a small courtyard garden. The sitting areas have French doors leading into the garden

which is well-maintained and has plenty of visual interest. Each corridor has a theme with tasteful, discreet, decorative objects – including music, sport, travel – with the aim of orienting people and also to give something to talk about between residents and staff.

Mantle View, was a purpose built setting, designed to be small and homelike while also well equipped to meet different needs of residents (grab rails in corridors, adjustable height beds, pressure relieving mattresses, specialist chairs, moving and handling equipment, wireless call system). There is an emphasis on small group living (6 units each with a lounge, dining room and kitchenette) and conscious effort to create pleasing outdoor spaces, for example there are inner courtyard gardens with fish ponds and scented and herb gardens. There are also more extensive grounds through which residents can stroll. All the single, en-suite, bed-sitting rooms overlook a courtyard. The dementia unit used dementia friendly principles. However, as noted by the researcher, the fact that many residents due to their physical condition spent a lot of time in their rooms, caused staff to leave the main part of the unit to attend to them:

(it is) very difficult for them to have any chance of interaction with the residents in the lounge, (Mantle View, Observations)

This meant that residents in the lounge were unattended for lengthy periods as staff attended to residents in their rooms. This highlights that apparently purpose-built design was not a guarantee of positive care experiences, and that reflection on the routines of residents within the space, as well as staff practices, is needed.

Thyme View, was the oldest of our care homes, and, with the exception of the newer dementia unit was built in an institutional hospital style. However, care experiences were overwhelmingly positive, notwithstanding the few incidents showing lack of reflection on space highlighted above. Conscious attempts were made throughout the home to provide for a more home-like feel,

“with animals, plants, people, children, everything you can get in really”
(Thyme View, interview with manager).

There were also small items of interest on tables and shelves in the lounges, decoration on every wall, including pictures of residents and staff, and chairs arranged to encourage small group interactions. In addition, during the course of the research staff transformed a dead-end corridor into an additional meeting place for residents, with chairs, a fish tank and small table with an activity on it. It was also common to see the environment change on a daily (and hourly basis). All of this resulted in Thyme View having a ‘lived in’ feel to it, and contributed to the sense of the home as a wholly connected community. This illustrates that the use of space and actions of staff within it can actively facilitate another of our cultural themes: the sense of community within the home.

Chamomile Place also demonstrated creative use of existing space, for example making a lounge into a cinema and giving residents ice creams while watching a film, (Chamomile Place, Ethnographic Observations). In these settings, there was awareness of the importance of using design creatively to enhance residents’ experiences

Some care home managers and owners had invested financially to improve the environment, reflecting an awareness of the importance of environment to good care experiences. In Chamomile Place, there was financial investment to maintain and upgrade the building from the new owner:

*“You have to improve it because, you know, everything looked dated here.
(Chamomile Place, interview with new owner)*

However, again this was no guarantee of good quality care experiences, unless it was also accompanied by reflective practice of staff within the (new) environment. Hyssop Place had recently been awarded a grant from the local authority and had used it to provide items of interest for corridors, redesign certain rooms and to buy a reminiscence pod. Care experiences at Hyssop Place were inconsistent in quality and a number of these rooms or objects were never seen to be used.

Use of outside space

Access to outside space varied between care homes, again suggesting that it is the use of such facilities that determined quality of care experiences rather than simply their presence or absence. For example, although Mantle View had courtyards and extensive gardens, these were not used extensively by residents during the period of the research, possibly related to it being the winter season. Hyssop Place had a flat, secure garden area to the rear of the building, with a mixture of paving and grass. There was a sandpit, tool shed, greenhouse and seating as well as two rabbits that belong to the home. Access to this garden area was available from the downstairs corridor. However, the researchers did not observe this door to be unlocked at any time during the research, and during periods of good weather only one resident (who could do so unaided by staff) was observed to go outside. (Hyssop Place, Ethnographic Observations).

In Chamomile Place residents could look out of the windows onto the garden, and the more able often sat in the garden. The pleasant grounds contributed to the care experience as the researcher noted:

The staff bring in one of the residents who has been in her room for some time. This particular resident is terminally ill and is very, very frail. She appears very close to death but she has requested to come into the lounge to get a bit of fresh air and see the garden. She is too ill and weak to interact with the other residents but just sits quietly in her seat with a blanket over her. (Chamomile Place, Ethnographic Observations).

At Sage Court, use was also made of the gardens when the weather was good and residents were supported to sit in the sun:

After lunch it is a very pleasant March day and about ten of the residents go in to the grounds at the front of the home and sit in the sun and also one of the carers sits with them. (The home) looks down on the lush green valley surrounded by lush green fields filled with cows and spring lambs while we eat cakes and drink tea. Together with the beautiful

weather the setting is quite idyllic. (Sage Court, Ethnographic Observations)

At other care homes, such as Lovage View, Residents in who lived on the top floor had no independent access to outdoors.

Conclusion

Examination of the use of space within our case studies has demonstrated that there is a complex relationship between design, space and practices within that space. Our case studies suggest that the degree to which staff are able to reflect on the use of space within their homes has an impact on the quality of care experiences of residents. In homes where staff demonstrated a will and ability to reflect on the environment (whether holistically or in relation to particular residents' perspectives) and how it may impact on care experiences of residents then care experiences appeared to be more positive.

Moreover, this theme indicates that an aspect of the complex relationship evidenced by use of space is the extent to which the values and behaviours of staff within the setting contribute (or detract from) their ability to reflect on the environment. This implicates a connection to previous themes. Where a home demonstrated shared values related to person-centred care, then this value shaped reflection on the environment within that home. Moreover, the extent to which care staff were enabled to be effective in their role also appeared to determine the extent of their reflection on the environment of the home and its impact on resident experiences.

Significantly, this theme illustrated that actions such as reflection on environment in relation to values or as an action of effective staff was an on-going need rather than a one-off event. Good design or thoughtful purchase of decoration or equipment only led to good care experiences where staff thought about their use at all times. Poor care experiences could still occur, even where they were not predominant overall if staff practices did not consider and facilitate their positive impact from moment to moment. This factor implicates the final theme of care home culture emerging from our case studies: The extent to which activity and engagement were enabled to be integral to care work.

Theme Seven: Person centred activity and engagement is integral to care work

The extent to which activity and engagement are viewed as care work impacts on care quality. When activity and engagement are embedded and integral to care work then the impact on care experiences of residents is positive.

Engagement and occupation seem to be a rule here and staff seem to view that as their role. There was no feeling apparent that activity with residents was not 'proper care work'. (Thyme View, Ethnographic Observation).

The case studies have shown the challenges that exist in ensuring all of a home's residents get the appropriate and meaningful level of activity and engagement to positively impact on their care experiences. It appears evident that the level of positive care experiences for residents is associated with the extent to which activity and engagement is viewed by staff as care work and, crucially, enabled to be part of that care work by practices, resources and arrangements within the home.

This theme was examined through a comparative analysis of the care experiences of residents and the ways in which both activity for residents and engagement with residents manifested in day to day interactions, behaviours and assumptions in the care home. Activity in this sense refers not simply to scheduled activities or events, but to any activity or occupation undertaken by or with a resident that appeared meaningful to that resident. Engagement concerned the presence (or absence) of meaningful interactions with residents that were experienced positively by them.

It is significant that, in examining activity and engagement within our case studies, it was apparent that in some care homes, activity and engagement are considered only in terms of structured activities offered to residents. It was not that these did not have positive impact on some residents, but that our observations and discussions in care homes highlighted other opportunities that had positive impact for a wider range of residents and on a more consistent and regular basis. These related to everyday activities in the home and the interactions between staff and residents in the course of carrying out more traditional tasks of care. Where these sorts of activities were recognised as significant by the home and enabled to be integral to the work of staff in the home then positive care experiences were more consistently felt by residents than where activity and engagement focus was on structured approaches alone.

Structured activities

Observation at our case studies has provided ample evidence to suggest that structured activities can have a huge positive impact on the wellbeing of residents:

we went out to hear the Choral Society singing the Messiah, and we took 15 of them on the minibus. And just to see them there, singing, crying, and coming home in the bus...it was just buzzing in the back

of the bus, they were all talking to each other. (Thyme View, interview with staff,)

The dogs are great fun and everyone is delighted to see them. Great buzzy joyous atmosphere. (Marjoram Place, Ethnographic Observation)

All of the care homes in our study offered structured activity programmes with all but two of them (Lovage View & Sage Court, although the latter intend to appoint one soon) having a designated activities co-ordinator or team employed to produce these programmes. However, observations suggest that although such programmes are produced and displayed on notice boards they do not always get carried out. Several care homes have acknowledged that their activities programme, be it structured or otherwise, is usually the first thing to be dropped when they have staff shortages. Put another way, activities only occur when time and staffing arrangements allow.

“At the moment it’s just when we’ve got time. I used to come in early and do activities...but I can’t keep coming in early all the time” (Hyssop Place, interview with staff)

We do have an activities programme [but no activities co-ordinator], but, unfortunately, the first thing that seems to be affected if you’re short staffed is the activities. (Lovage View, interview with Manager)

The impact of being short-staffed at Lovage View was witnessed by the researchers during observation sessions:

There was not enough staff on to see to the immediate work of getting people up in the morning while also seeing to the needs (physical and social) of those who are already up. Very, very quiet in here – no staff around, not even in corridors. (Lovage View, PIECE-dem Observation summary)

Notably, the actions of one (agency) staff member was seen to transform the experiences of some residents within the setting:

This staff member took the initiative to run activities with five or six residents in the TV lounge and used the activities sheet as a guide to provide activities that the residents were familiar with. They have settled on dominoes followed by a singsong. The spontaneously arranged sing song was really great and everyone who joined in did so with gusto. [Lovage View, Researcher Observation]

These incidents highlight that when structured activities are viewed within the home as the main vehicle for activity and engagement with residents, then it is dependent on either the presence of designated staff members to provide for them, or reliant on the will (and ability) of individual staff. Whilst it does not mean that positive care experiences will not occur as a result of these events, this situation increases the inconsistency of such occasions.

This issue was further illustrated in other care homes, even when activities staff were employed and present. In some instances the availability of an activities co-ordinator

appeared to encourage other staff not to have involvement in activities; creating an assumption (and behaviours stemming from that assumption) that activity is not care work and is someone else's responsibility. At Chamomile Place, the activities co-ordinator had left material to be used when she was off duty.

It's a big trolley and it's full of games and puzzles and I've printed off loads of word searches, crosswords, and colouring pages for some of the ladies. They like doing that. There's all sorts in there and I bring it out and then it gets put back in the conservatory. And I think, that's out for you [other staff] to do things with them. And I do put notices up on an afternoon when I'm not here – Wednesday is this day, Thursday is that day – but it doesn't get done. Yeah. I can't work out why. Is it because they don't want to? Or is it a confidence thing? I don't know what it is that's stopping them from doing it. (Chamomile Place, interview with staff)

At Marjoram Place, a similar situation occurred when the activities co-ordinator was on duty.

“but quite often I feel I'm kind of left to it, because it's [seen as] my job”. (Marjoram Place, interview with activities co-ordinator)

The perception by other staff that 'activities' was the role of the activities co-ordinator meant that when she was in the sitting room doing activities, no other staff joined her, therefore when a resident expressed a need, she had to stop the activity to attend to them. On each occasion the positive care experience enjoyed by those residents taking part was interrupted because the activities co-ordinator was working in isolation.

The activities coordinator has been arranging games of darts and a quiz but at times being the only member of care staff in the room has had to stop activity to assist with for example personal care (Marjoram Place, PIECE-dem Observation).

In stark contrast to these examples, Thyme View appeared to have effectively integrated activity and engagement into care work as well as having an activities team: This led to the researcher reflecting that

Engagement and occupation seem to be a rule here and staff seem to view that as their role. There was no feeling apparent that activity with residents was not 'proper care work'. (Thyme View, Ethnographic Observation)

Crucially, there were several factors at play in Thyme View that appeared to facilitate this integration. Firstly, the activities co-ordinator's role was not viewed (by anyone in the home) as distinct from a care role and the care and activities team were frequently seen to take part in actions across both roles and the activity co-ordinator's role was to support staff to provide activities for residents.

I appreciate what they have to do and, you know, it is tiring and I do feel that to then come on board with activities and think, is quite hard for them. So at the moment I'm trying to support them as much as I can with giving them lists of ideas of things they can do, making sure that although I've given them a list that I've actually got the equipment or the stuff in our room or in the basement that they can come and say "look, we want to do this today, where do I find such and such?" (Thyme View, interview with activities co-ordinator)

Secondly, and perhaps more crucially, there was a shared understanding across the home of the importance of activity and engagement in the quality of life for residents and actions were taken to facilitate its presence in care work, such as the appointment of team leaders to units with implementing this as their main role, (Thyme View, interviews with staff and manager). This highlights the link between the themes of shared values, effective staff through leadership and enabling activity and engagement to be integral to care work.

To a slightly lesser extent this emphasis on activity being integral to care work and all staff having responsibility to carry it out is echoed in the recently revised activity provision at Mantle View:

at about this point [activities co-ordinator] comes in and....it sounds as if her nose has been put out of joint because of the change of activity provision in the home. One of the changes that have been brought in is that staff have been told to spend more time in the lounge sitting with the residents....It sounds like as well that rather than just activities being confined to [activity co-ordinator's] activities that staff are encouraged to build it into daily activity. (Mantle View, Ethnographic Observation).

The impact of this change in activity policy and resulting positive care experience for the resident was observed by the researcher at Mantle View:

Care assistant 1 and care assistant 2 are sitting with J in the lounge playing quoits. This appears to be a case of staff developing their own activities with residents in practice. (Mantle View, Ethnographic Observation)

However, simply stating that activity was a task of care did not guarantee that it would occur, unless there was active consideration of practically enabling this action by staff. At Hyssop Place manager and staff recognised that activity was part of care work, but care staff frequently (and regretfully) indicated that they did not have time to do it and the physical care needs had to be prioritised, (Hyssop Place, interview with manager, interview with staff, Ethnographic Observations)

Our case studies suggest that where activity and engagement is integral to care work then the structured activities offered within a care home will be more likely to be appropriate to and welcomed by residents. When care work is seen to involve engagement with residents and consideration of activity and occupation staff are more likely to know what interests a resident has, their hobbies, and things they liked to do in the past:

I think that's when it's really important to know their life history. Because if you know the history of someone, you know their hobbies, you know what they like, maybe they had a cat. And you're thinking "ah" and you can bring all these things into play. (Thyme View, interview with staff)

However, where this connection between care work, engagement and activity was not obvious, it became apparent that even structured activities failed to meet the needs of some residents. In particular, activities or events seemed to be inappropriate for some residents' physical or cognitive abilities or not actually wanted by residents. As one resident at Chamomile Place put it;

"a lot of them [the activities] now are a waste of time" (Chamomile Place, interview with resident)

This lack of interest at Chamomile Place was noticeable during one of the observation sessions when after lunch the activities co-ordinator was having difficulty getting anybody interested, in part perhaps as everybody was sleepy after lunch. The researcher gained the impression that a lot of the activities here are developed around the interests of the activities co-ordinator rather than the interests of the residents. A couple of the residents had mentioned to the researcher in passing that they don't have bingo or sing-alongs like they used to. All of the activities now are mainly centred around art, pottery and a bit of cookery, as this resident commented:

Yes, it's more on the arty side. And they do cookery. Well I told her, "I'm not cooking. I've cooked all my life. (Chamomile Place, Interview with resident)

At Angelica Court, a member of care staff highlighted that few of the scheduled activities were attended by residents in her unit. She went on to say that she thought this calendar of events was totally disconnected from her unit. In addition, the activities coordinator was only seen to engage with a few residents, with those who were more severely affected by their dementia receiving no contact at all during the course of the research, (Angelica Court, Ethnographic Observations). This disconnection was perpetuated throughout the care staff team, who appeared to also adopt this focus on only a few more cognitively able residents, and even then did not consider their needs in depth. When asked what activities care staff did with residents in her unit a staff member said:

"knitting, cross words, word searches - they photocopy the same page, they can never find anything, but" (Angelica Court, conversation with staff member)

The researcher noted that these seemed poorly pitched to the residents' abilities, with a lack of consideration of the impact success or failure can have on an individual. They also completely ignored other residents with more complex needs.

In other homes similar issues were observed, such as residents losing interest during the session or completely ignored what was going on about them. This was most noticeable

among the more cognitively impaired residents who perhaps cannot sustain the attention or energy required for such structured activity.

At the moment it's (Activities Coordinator) isn't it who does most of the activity work? [That's right, yes.] She's working with quite big groups ...half of whom are asleep. (Marjoram Place, Interview with relative)

quiet apart from the four women playing bingo with the care worker – they seem to be having a lovely time – they are very engaged in the game. Three other women (including P1) are not engaged in bingo – there has been little engagement for them. (Lovage View, PIECE-dem Observation)

Ensuring activity and engagement is an integral part of care work appears to reduce the chances of the activities programme centring on just a few topics and causing the lack of interest as illustrated above. This also means that there is a greater chance that activities appropriate to resident wishes and cognitive abilities can be provided. Thyme View's activities team reflected this

I've got strengths that S and A haven't got. So, you know, as a team we work really well. Because we're not all wanting to just do music, we're not all just wanting to do the pets, we're not all just wanting to do art group (Thyme View, interview with activities co-ordinator)

Arranging structured activities that are appropriate to resident's cognitive abilities appears to have a bearing on the degree of positive care experienced by residents and in this example also has a knock-on effect of easing inter-resident stresses:

I found that the tolerance wasn't there from the residents who didn't have any behavioural problems. So I took it upon myself to try and split them up so that I would take a trip out or do an activity with people who were all very similar in capabilities and then doing an activity for those who needed assistance or more time spent with them, it gave me the chance then to break them down into smaller groups. So rather than trying to do maybe 10 or 15, which was....what was expected, we've now come down to about three or four because each resident needs that little bit more time spent with them, which I can now give them, it's so much better. (Mantle View, interview with staff)

Lack of engagement in structured activities highlights the importance of one-to-one activities and it is here where a care worker's knowledge of the resident, (as well as their autonomy and responsibility in their role) can have a huge bearing on the success or otherwise of that interaction.

I mean I go into the resident's past and what they've liked to do in the past 'cause we read their notes and we know that one resident used to be fantastic at knitting. And it's something that, even now, she can pick up the knitting needles... (Mantle View, interview with staff)

And family, it's really important to speak to family as well because they will tell you so much about the resident which can uplift you so much. Like we have a resident with dementia and he, you know, he will just sit there for a bit and until his family actually mentioned that he used to play football ever such a lot, all of a sudden we get all these footballs coming in, he's kicking it down the corridor, just, you know, if you need him to get to his room or something in the evening, he says he wants to go to bed, you say "well your room's down there". He looks down the corridor and he's like "oh no". Put the ball on the floor and he'll kick it all the way down, and you'll walk him there fine. (Thyme View, interview with staff)

Most of the one-to-one activities in our case study care homes have not been observed by researchers, due primarily to their private nature. However, several one-to one activities have been run by staff, including:

Well sometimes they'll just have a sit and pamper, they'll have the manicure done or a little massage of their feet in the hot steam bath. Personal things like that. Or sometimes they'll be read to. Downstairs it was "let's play Scrabble". So all sorts of things like that really. (Thyme View, interview with staff)

And these one-to-one interactions can have a powerful impact on residents, particularly those with any form of cognitive impairment:

But my experience here, everybody just has a few little triggers which can actually do it, normally with D its flowers but it didn't work this morning. Normally there's something, just a flower somehow takes her back to something in her past and she just has little moments of recognition and you hope some kind of pleasure. (Sage Court, interview with staff)

Carer begins arm movements she copies. Laughing, interacting with carer – very reciprocal, she puts paper on her head again. Continuing to enjoy one to one time with carer. (Tansy View, PD Observation)

However, as with the provision of structured activities, staff availability or staff shortages can prevent this occurring.

At the minute we don't have enough time to sit down and read an article in a newspaper (inaudible) there's a lot of them that, especially like X and Y who would benefit from one to one and they don't get it and that's, it's not good, it's not good enough really. (Lovage View, interview with nurse)

Everyday activities

Everyday activities were shown to provide opportunities for both occupation and engagement of residents outside of structured activities and seen to have a positive impact on care experiences.

Sometimes they have him cutting up vegetables and helping to make stew, or little crafts. Or he loved his garden, so maybe planting a few flowers. It's up to him, they leave it, you know, it's not forced on him or anything, yeah. (Thyme View, interview with relative)

Care Assistant then engages D to help her lay the tables. Gives him 4 spoons, 4 knives and 4 forks and he begins to lay one table. Later D and another resident wash up together, this is allowed to happen and it seems a very natural and relaxed arrangement (Thyme View, Ethnographic Observation)

In contrast to this, the following illustrates a missed opportunity for a resident at Tansy View:

Now when Betty comes home [on visits] she can't cook dinner but she helps me to do it, and loves helping me to do it. And when the meal's over the first thing she wants to do is get to the sink and wash the pots. And she used to love crocheting and has made all sorts of things in crochet work, and she loved reading but can't manage that any more. But none of these things are encouraged, you know, there's no emphasis on what is possible and what can they do. (Tansy View, interview with relative)

Sometimes the ancillary work of the care home offers an opportunity for staff to engage with residents. Here the link between activity and engagement and care work is obvious:

The laundry block is located in the garden so staff are using the opportunity of the residents being outside to take laundry in and out. Some of the more able residents also help out with the laundry as they are sat outside and it provides an opportunity and focus for staff and residents to interact. (Sage Court, Ethnographic Observation)

At Marjoram Place the home has put the past work experience of one of its residents to good use to run a tuck shop:

The resident in charge of the tuck shop sells the other resident a bag of sweets and a bar of chocolate, hands over her change and records the resident's name and amount spent in a small notebook. This resident told me she had worked in a furniture shop for 20 years and was well used to handling money. She certainly looked very proficient. (Marjoram Place, Ethnographic Observation)

Significantly, the events creating the positive experiences gained by residents from these are reliant on both action from staff (in terms of will and ability) and knowledge of the residents concerned. Knowledge of residents was not sufficient by itself. At Angelica Court, the

researcher was told several times about a resident's love of sport and that she used to engage in dusting in the home, however this resident was never seen to be involved in any activity other than walking the corridors, ([Angelica Court, Ethnographic Observations](#))

Interaction and engagement during care work

The many care tasks that staff perform offer opportunities to interact positively with residents and our observations suggest that where engagement is considered and facilitated to be part of the care task then positive experiences predominate for the resident:

There is a lot of banter and joking going on as they bring the standing device into the lounge and get him to stand into it. He seems to enjoy the banter and joking and seems at ease although a little nervous of the standing device. The staff get him into the seat and then make sure he is comfortable and he chats and interacts with them and he seems particularly contented. ([Chamomile Place, PD Observation](#))

Or just sat holding hands, which is sometimes what we all need don't we? I mean I've gone into the little lounge up here and I've seen a member of staff just sat there holding, and talking quietly to a resident, calming them and making them feel wanted and loved. So what more can we ask? ([Thyme View, Interview with relative](#))

On one occasion when resident was disengaged, she became much more engaged having had some chocolate buttons – she was sitting upright, looking around. The key worker was very responsive to resident's changing body language and seemed keen to maximise resident's alert moments. ([Marjoram Place, PD Observation](#))

The above example is for a resident with severe mobility and communication difficulties who had previously exhibited behaviour that challenged care staff. Through prolonged engagement with this resident, care staff discovered her like for chocolate buttons and also identified ways in which this resident signalled to staff personal care issues. Once these had been established the behaviours that had challenged staff reduced considerably.

The contrasting impact of two different approaches to care tasks in the same care home can be seen in the next two examples. These both relate to the same resident but with different care staff:

Resident slowly eating his scone and drinking his coffee, seems to be enjoying it, making lots of eye contact with the staff member. Staff member encourages resident to pick up a piece of scone, makes direct eye contact with him and resident smiles! Nice gentle pace, chatting to resident while feeding him bits of scone, offers him coffee. Gentle pacing, eye contact, offers him some more scone, checks if he has had enough ([Chives Court, PIECE-dem Observation](#))

This contrasted starkly with a brief interaction a short while later with a different care worker who on this occasion saw no need or desire to engage with the resident. This resulted in a much reduced care experience for the resident:

[one interaction] with agency member of staff when he handed him a biscuit, minimal impact. Minimal attempt to engage. (Chives Court, PIECE-dem Observation)

These differences illustrate again that engagement being integral to care work is dependent on both the will and ability of care staff to carry out such tasks. This requires both an understanding from management of its importance, and practical efforts to support it in practice. This implicates a previously identified cultural theme; the importance of autonomous and responsible staff created through practices of management and leadership. It was not sufficient to acknowledge its importance, but to actively facilitate it through staff actions. The difference observed between Hyssop Place and Angelica Court highlighted the different elements necessary to this facilitation:

Difference with Hyssop Place [where they] knew it [activity and engagement] was important but didn't have the time. Here they have the time but don't know it's important. (Angelica Court, Ethnographic Observation)

It was not that positive experiences events did not occur at homes in which engagement was not seen as integral to care work, but again that they tended to be reliant on the skills and will of individual staff, unless it was enabled and enforced as a task of care

It is the actions of one staff member that has created the energy here...[she] has skills here that seem to be innate to her rather than the home.....the energy/activities here are all to do with one member of staff's willingness. (Angelica Court, PD Observation)

At Lovage View, a care worker starting his night shift made a point of chatting with every resident in the TV lounge. The change in atmosphere in the room was palpable, with residents smiling and joking and the response the care worker received was noted by the researcher:

The new care worker was warm and friendly and he received a lovely bright response from P2. (Lovage View, PIECE-dem Observation)

These latter examples highlight that, whilst a predominance of positive care experiences in a care home result from engagement becoming integral to care work as a whole, in environments where this norm is not apparent, positive care experiences may still occur when individual staff have integrated activity and engagement into their personal approach to everyday care work.

Conclusion

The understandings of, and behaviours related to, activity and engagement in our case studies appear to demonstrate that in order for residents to experience a predominance of positive care experiences, care homes must enable activity and engagement to be embedded into their staff's work. This required not only a shared understanding across the home of its importance, but also a shared understanding of whose responsibility it is and, crucially, the practical circumstances (such as sufficient staff, resources etc) to make it

happen. Where homes were inconsistent in providing positive care experiences, or exhibited a preponderance of poor care experiences, activity and engagement were not integral to care work and to an extent depended on the availability of sufficient staff and the abilities and skills of individual staff. Care staff shortages impact on the provision of structured and one-to-one activities but positive care experiences can still predominate if activity and engagement is integral to care work.

In exploring this aspect of care home culture a number of other themes are implicated. Notably, the extent to which there is a shared value in the home that incorporates understandings of activity and engagement appears to be significant in enabling staff to take action and support each other. Moreover, the actions of managers and leaders in creating effective staff, are necessary to create staff who are autonomous and responsible in considering activity and engagement throughout their daily work.

Conclusion: A culture that facilitates positive care experiences

The above discussion has identified seven key themes of care home culture and demonstrated how they each impact on the quality of care experiences for residents in the care homes participating in the study. In addition, each of the themes has connections to the others, and serve to facilitate and reinforce aspects of each other. It is apparent that no one of these themes is more important or significant than others in creating positive care experiences. Indeed, when looking holistically at the care homes within the study this becomes more obvious. Those homes that were consistent in creating a predominance of positive care experiences for their residents are shown to demonstrate all of these themes and illustrate their connection in action throughout their work, albeit with different emphases. However, for those homes where the quality of care experiences for residents were inconsistent or poorer some of these aspects may be present, but their impact is undermined by the absence of other aspects.

It is not that consistently evidencing each of these themes guarantees negative care experiences will never occur. Instead, what having a facilitative culture creates is a norm of positive care experiences for residents, reinforced by different aspects of the culture, in which poorer care experiences are both less common and more likely to be counteracted by other cultural aspects. For example, in a care home with a positive culture there may be instances of poor care related to an individual staff member failing to reflect on the impact of the environment on a resident. However, other cultural elements such as a connectedness throughout the home, shared understanding or purpose or autonomous and responsible fellow staff are brought to bear on that incident or action in a way that minimises the impact on a resident (it is seen, identified as being less than positive and corrected) and possibly to prevent its reoccurrence (through action to change the situation leading to the incident).

Equally, not demonstrating a facilitative culture does not mean that positive care experiences are wholly absent. Instead what it creates is a situation in which positive incidents are reliant on individual action as opposed to being the norm. These fail to be reinforced because of the absence of impact from other cultural aspects, or, in more extreme examples are actively discouraged by the presence of opposing cultural aspects. For example, positive care

experiences for residents through meaningful engagement with individual staff may be present. However, in the absence of empowering leadership creating other effective staff, or if external pressures are transferred directly on to staff preventing this action, then the positive occurrences fail to be sustained beyond the individual staff action, or the staff member is prevented from carrying out the positive action in the future.

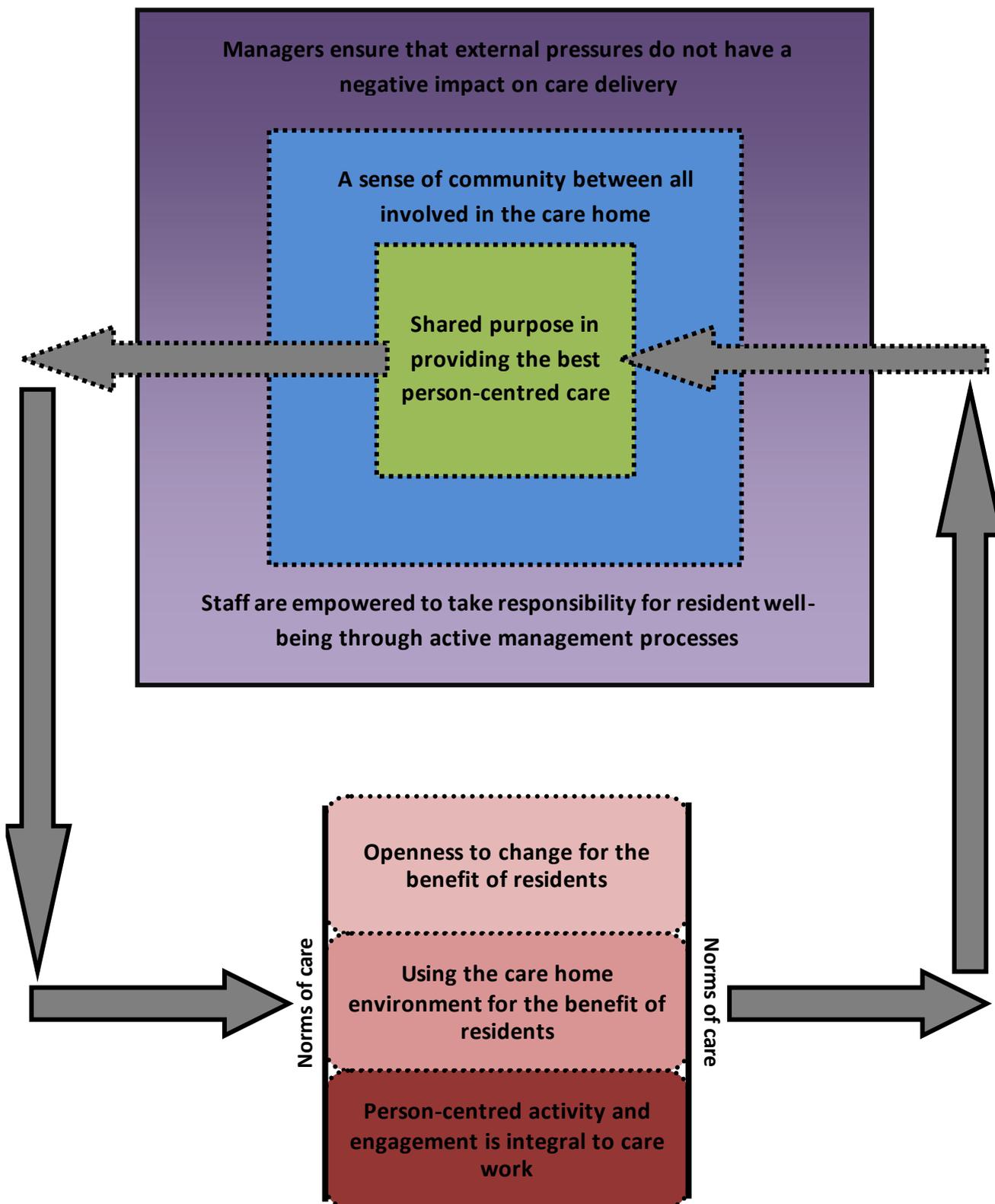
The connections between each theme have been addressed throughout the above discussion. Figure 3 below illustrates an holistic view of the seven themes of a positive care home culture. The following discussion addresses these findings in the context of our existing understandings of care quality in residential settings.

Figure 3: Representing the relationship between values, assumptions and norms that impact on the care experience

Figure XXX: Representing the relationship between values, assumptions and norms that impact on the care experience

Positive Care Home Culture

Dotted lines indicate permeable boundaries with two way interaction between cultural aspects



DISCUSSION

As set out in the background and rationale for the study, development of expertise about organisational culture in care homes, and further knowledge about embedding person centred approaches in organisational cultures is needed (Meyer and Owen 2008, Kirkley et al 2011). In the USA, there is a growing body of research investigating the spread of 'culture change' through nursing homes for older people. Building on this are calls to begin to examine links between care home culture and outcomes (Harris et al 2006). This study has linked the 'outcomes' for older people in terms of their experiences of care, examined with the detailed and structured PIECEdem observations, with care home culture, investigated through ethnographic research approaches. The discussion is structured in relation to the aims of the research.

The positive and negative experiences of residents with highly complex care needs: key practices implicated

Often the difference between experiences that were negative and those that were positive for residents with highly complex care needs was about the level and nature of the engagement between care worker and resident. For example, positive experiences for this group of residents frequently included the creation of a very personal one to one communication, such as by moving very close, speaking gently and quietly in a way just to be heard by the resident, making eye contact, smiling. One particular part of care, such as eating a meal, might involve more than one carer interchanging with other carers, each trying slightly different tone or words to encourage or reassure the resident. At its best we saw this offer residents distraction from distress, or support to settle and take time to eat, or to take pleasure in human contact. Similarly, often the negative care experiences we observed were characterised by a lack of contact. Some residents spent long periods of time on their own, looking physically uncomfortable, or attempting to move but unable to. We observed assistance to eat being provided without the carer communicating with the resident. However, the difference could be as extreme as needs going unacknowledged and unmet. Examples included a person asking for help when they needed the toilet and the message being given that the person would have to soil themselves, or a person sitting unattended obviously wet with urine and with food remains on their face (see examples on page 59).

We used the structured, detailed, minute by minute, observations of care using the PIECEdem process to help us to focus on practices in the care that were key to these positive and negative experiences. We were therefore examining the organisational practices in relation to staff and their values, assumptions and norms of behaviour in caring for residents through a particular lens of those with the most complex needs. As examined in theme 4, staff empowerment in taking responsibility for resident well-being, to achieve positive care it was important for staff to demonstrate a thoughtful approach to routine tasks, and to take responsibility for problem solving. Where leadership and management empowered staff, we saw autonomy of action, shaped by a responsible and thoughtful approach. This helped to develop norms, or unwritten rules governing behaviour, such as the collaboration between experienced and less experienced staff exemplified in the observation from Tansy View on page 95.

Such empowerment and autonomy is argued to be a necessary component for person centred and relationship centred approaches, with both residents and carers needing a sense of security, purpose and significance (Nolan et al 2008).

Person centred approaches to care are widely advocated and bring benefits including increased social engagement and integration for residents (Argyle 2012) and may be associated with less emotional burnout in care staff (Jeon et al 2012). All except one of the care homes in our sample explicitly espoused values closely aligned with person centred care, but as Argyle (2012) points out, the efficacy of a person centred approach can be undermined by contextual factors. McCormack et al (2011) argue that organisations need to develop 'person-centred cultures' which cannot come from individual practitioners alone, but need organisational commitment to facilitate culture change. Where this is facilitated, experiences of hope, choice, belonging and connectedness and meaningful relationships can increase for residents (McCormack et al, 2011).

In our research, where organisations both espoused values consistent with person-centred care, and staff demonstrated underpinning assumptions that were also broadly consistent with person-centred approaches, this was where the most consistent positive care experiences were found. The influence of assumptions (often unconscious and taken for granted) on behaviour could be consistent with person-centred approaches and help behaviours to generalise, such as where person-centred assumptions guided staff's behaviour towards each other as well as towards residents. This is not always the case, however, and this was particularly noted when 'activity' was understood as a separate activity, the domain of another worker.

Our findings show the real and specific human impact of the organisational culture, in terms of people's experiences. Where the elements of culture combine to support effective, person-centred practices widely and consistently among the care staff, the sensitive connections between residents and carers and also between carers, support attuned and timely care. If key elements in the culture are missing or negative, consistent positive care is unlikely to be achieved: needs may go unmet, residents may be isolated with little successful human interaction.

The individual circumstances, organisational cultures and practices most likely to encourage or inhibit the provision of high quality of care for older people living in care homes.

Using a case study approach enabled the circumstances, organisational cultures and practices to be related in a holistic way to the lived experiences of people with very high levels of need for care. This fine grained examination showed how variations in culture needed to be appreciated if a person-centred approach was to be successfully promoted. This means drawing from a range of elements identified as broadly important but needing to be realised in different combinations locally specified. Therefore, there is not a single recipe for combining these elements. The organisational culture is local to each individual care home, it has to be evolved in each care home. An element may be reduced in a setting, but there is possibility that other elements could make up for this in some way.

Our findings about the elements that are important in care home culture are consistent with other work in this area. A team examining the extent and effectiveness of culture change in nursing homes in the USA convened an expert panel to develop a definition of a positive

culture that could be used by the industry. They described that nursing homes that had achieved successful culture change, would have the following characteristics: care directed by the resident, living environment designed to be a home rather than an institution, close relationships existing between residents, family members, staff and community, work organized to support and empower all staff to respond to residents' needs and desires, management enabling collaborative and decentralized decision making, systematic comprehensive measurement-based continuous quality improvement processes (Harris et al 2006). In the UK an appreciative inquiry approach was used to review evidence for best practice in care homes. Eight themes were defined: managing transitions, maintaining identity, creating community, sharing decision making, improving health and healthcare, supporting good end of life, keeping workforce fit for purpose, promoting a positive culture (Meyer and Owen 2008).

Table 4: Comparison of care home analyses

CHOICE – elements of organisational culture key to care experiences	Culture Change in nursing homes in the USA	My Home Life, themes for best practice
<p>Shared purpose in providing best person centred care A sense of community between all involved in the care home Managers ensure external pressures do not have a negative impact on care delivery Staff are empowered to take responsibility for resident well-being by active management Openness to change for the benefits of residents Using the care home environment to the benefit of residents Person centre activity and engagement is integral to care work</p>	<p>care, and resident related activities, directed by the resident, living environment designed to be a home rather than an institution, close relationships existing between residents, family members, staff and community, work organized to support and empower all staff to respond to residents' needs and desires, management enabling collaborative and decentralized decision making, systematic comprehensive measurement-based continuous quality improvement processes</p>	<p>managing transitions, maintaining identity, creating community, sharing decision making, improving health and healthcare, supporting good end of life, keeping workforce fit for purpose, promoting a positive culture</p>

The majority of care home organisations in our study espoused positive values of care, such as demonstrated, for example, in the policies and documentation about the home, but varied in the extent to which these values were enacted in individual care practices. What was needed for the most positive care experiences was for individual staff to have values that were consistent with this and also to have understanding of how to practice person centred care, including for example the role of empathy, compassion and making connection. This finding is consistent with Kirkley et al (2011) who argued that care providers had to develop a shared, person centred, culture through all levels of the organisation.

In our study connectedness and community in the home appeared to be both facilitated by and reinforcing of shared values in the home, and supported by the active management of external pressures and facilitation of staff empowerment to enable effective staff actions. The role of these interactions in the culture would perhaps downplay Kirkley et al's emphasis on the importance of staff having the 'right qualities' when recruited. It is notable though that in our study the homes that evidenced this also all had no problems with recruitment, they were able to be selective about who they employed. Also, Kirkley et al (2011) researched respite care services where culture and cultural processes may be more diffuse through having less constant populations.

In examples of religious based organisations, we found explicitly shared values between the organisation and the people working there, including both those who shared that religion and those who did not. In other organisations, where the parent organisation was a run on a for-profit basis it was possible to see at organisational level a potential conflict between the espoused values of person centred care and actions bringing in less favourable terms and conditions for staff. Staff, however, both espoused values and enacted them in norms of person centred care as illustrated in data from interviews (see page 62).

Development of a community in which people can connect has also been identified as important for the experience of older people in acute health care settings, with 'connected' and reciprocal relationships with staff leading to feelings of safety and reassurance (Bridges et al 2010).

In our findings we examined how processes and activities of empowering leadership and management support high quality care. Tyler and Parker (2011) found associations between managers modelling positive values and attitudes in their behaviour, and direct care staff working effectively together. Banaszak-Hol et al (in press) concluded that key elements of homes making positive changes would be the response of staff to the values promoted by senior managers, and staff being involved in translating these values into new work practices. Our findings concur with this, showing how a leadership approach that empowers staff at different levels can be an important element of providing positive care.

The relationship between experiences of care and recording of existing measurable indicators of quality (e.g. falls, untoward events, safeguarding referrals, length of tenure of staff)

Where possible, data about recording of such indicators was collected, as part of the ethnographic data about the organisational culture of care homes. This data was used to inform the within case and cross case analyses, as contextualising data for the care homes. We did not find a clear relationship between such data and the experience of care in the home. It was clear that in homes providing extremely positive care, serious untoward events could and did occur. Where this did happen, clear processes appeared to be followed and appropriate steps taken, although even with such clarity there was still potential for uncertainty about accounts given and processes followed, as extracts from interviews with two relatives of different residents show (see pages 51 and 74). This is illustrative of the complex picture in relation to achieving and demonstrating positive care. Although the effective use of processes of recording was related to elements of positive culture, in particular managers mediation of external factors (see examples on page 78), the process of

recording could itself become seen as the primary action of care, with a negative impact on the care experience (see for example page 73). This indicates that such records can only ever offer a partial account of care and the data within them could be misleading in the absence of other contextual information. As highlighted in the contextual interviews carried out with stakeholders, representation of quality of care is a complex undertaking, and information needed to meet the requirements of regulators, commissioners and safeguarding can overlap and be poorly coordinated.

Examples of empowering practice

In developing the research project we aimed to identify examples of empowering practice both between individuals and at an organisational level. The relationship between positive care experiences and staff empowered to take responsibility for resident well-being emerged so strongly through the data that we interpreted this as a key element of positive care home culture and examined it as a key theme. Such empowerment was found to be facilitated by supportive, responsive yet strong management, leadership by example that is present at all levels yet united, and clearly defined boundaries. Such management and leadership was achieved by some of the homes in our sample, but in different ways. For residents, experiences of empowerment included those embedded within care activities, such as being asked each time about the assistance they would like with personal care (see resident quote page 86) and more explicit processes of empowerment such as, for example, mediation (see quote from interview, page 78). Where staff appeared empowered they also appeared confident in their role of challenging poor practice and ensuring quality (see quote from interview, page 87).

IMPLICATIONS

The current practice context and the findings from our study

We contextualised our case studies by undertaking 34 interviews with key informant stakeholders at the start of our study. These highlighted that care homes and provider organisations were working within a system where they felt unsure of what the future held in terms of the changing purpose of care home provision. In addition, there was a common feeling that care home work was not well understood, or held in high regard by society in general, or by commissioners, local and national government and regulators specifically. This context would appear to present a significant challenge to care homes with regards to several of our themes of positive care home culture. In particular, it may be testing, in the current context, for care home managers and staff (as well as residents and visitors) to develop and maintain a strong shared value base that is positive towards residents and care home life and that facilitates a sense of community in the care home. There is little outside of the care home to support homes, managers and staff in creating positivity towards care home life.

In addition, the key informant interviews highlighted the external pressures that managers experienced in terms of financial pressure, lack of available funds, competing expectations and inconsistency from regulation, quality monitoring and safe guarding. Our study suggests that the way in which management acts to mediate these external pressures to enable staff teams to get on with their job is an important factor in providing a positive care experience. On a day to day basis the main people that a manager has to speak to are their care team. Mediation was also shown to be a two-way process, which required not only the manager to take action but also receptivity to mediation from external sources. Notwithstanding the skill and personal resolve required of managers to constantly effect mediation on a day to day basis, our stakeholder interviews suggest that various external sources do not recognise the potential negative impact of their input (however well-intentioned) and so do not facilitate mediation, and in some cases, actively resist it.

The stakeholder interviews recognised that leadership is a critical issue but also that investing in leadership was challenging due to the financial situation in the sector. In addition, the problems around staff recruitment and retention that face providers make it a challenge to provide the shared value base and sense of community that our research highlighted as important. The actions of care identified in this study (openness to change, use of the environment and activity and engagement) are embedded in the standards that commissioners and regulators ask of providers but are not explicit or prioritised in any way. This makes it difficult to see, over time, how these will be prioritised by managers and care staff without a shift in emphasis of both expectation and methods of monitoring. There is currently a mismatch between external expectations, how those expectations are monitored and audited, and internal practice that promotes positive care experiences for residents.

Policy implications

Across the developed jurisdictions of the UK, long term care policy is promoting care at home for older people, to support independence, improved quality of life and also to control costs. The population of care homes is changing, partly due to this policy, and people who live in care homes have higher care needs and are more likely to have dementia than

formerly. All these trends are likely to continue. Thus there is a continuing demand for residential care for an increasingly dependent population. We have reviewed the quality controls in place for care home provision, including standard setting and regulation, and our findings suggest that the impact of these can be negative or positive: for some care homes with cultures in which external factors are not effectively mediated, they can become drivers of activity in the sense that the paperwork drives the activity in the care home, rather than providing a check or framework for quality. For other care homes, effectively mediated and where values are embedded throughout the staff, resident and relative communities, regulation and quality standards are met through activities of care. Our study thus demonstrates that to fully understand how effective quality assurance might work, it is necessary to move beyond simple assertions for example that 'there is too much paperwork' or 'over-regulation'. Really effective policy aimed at improving standards will need to be implemented, we would suggest, in ways which engage with and promote effective mediation of regulation. However, our study also cautions that current inspection regimes are not necessarily producing reliable information: we found homes with compliant reports in which care was poor, and vice versa. This calls into question the effectiveness and appropriateness of the information being reviewed, as well as emphasising the volatile environment in which many homes operate, including for example, high staff turnover, changes of ownership and frequent changes of management, all factors which can disrupt good care.

Residential care for older people is seen in policy terms as less desirable than care at home. Publicly identified examples of abuse in care homes can confirm negative expectations of residential care. The public image of care homes is not generally positive. Yet our study identified examples of consistently excellent care and support for people living in some of the care homes included. Whilst the policy focus on maintaining independence and support at home has to be welcomed, there is a need to promote the best possible residential care for those who need it, and to recognise and support good care practice where it exists. Our study showed that there is a fund of knowledge and expertise within care homes themselves which could instruct effective policy initiatives, such as improved workforce development.

The volatile conditions in which homes operate present important policy challenges. For example, in some areas, recruitment and retention of care staff present significant challenges. Our study highlighted issues with management skills and capacity. The changes in the care home sector whereby larger companies are increasingly significant mean that changes of ownership and management regimes have been a common experience. The nature of the market encourages care home owners to target affluent self-funders. There are significant financial pressures on care homes, whereby their income (some of which may come from public funds) is insufficient to provide good service: some have also argued that profit driven provision can be detrimental to care, but our study did not fully support this view. However, where organisations could appeal through external links, such as religious communities, for resources (including funding) these resources facilitated many aspects of positive culture. All these factors can act to the detriment of positive care cultures in care homes as our study has demonstrated. The policy priority of how long term care can be funded is fundamental to these issues: proper funding (from whatever source) could address wages, training issues and infrastructural issues. Our study suggests that a secure funding base is a necessary but not sufficient condition for improved care.

Implications for practice: using research findings

Our study focused closely on practice, mainly within the care homes, but also in terms of engagement with the external world, including relatives, owners and controllers, regulators and the labour market. All of these were implicated in our analysis of organisational cultures that can promote good care.

In terms of practice, our study has highlighted a number of implications that will contribute to improvements: the last phase of work in the study will translate the study findings into materials which will be used to promote and support improved care cultures for care homes across the UK. The audiences for these materials will be the range of stakeholders in care homes, namely: providers, managers, care workers, people who live in care homes, their relatives and friends, service commissioners and regulators. The material will be a reflective resource providing a practical guide to stimulate discussion about and reflection on the key findings of the study. We know from previous work (Tadd et al 2012) that staff in particular appreciate and benefit from training experiences that are shared and interactive, and our materials will take this form. From our engagement and feedback with care homes in the study we also know that practical examples of how good or poor care experiences are achieved are welcomed by all involved in home life. We anticipate that the materials will bring awareness of organisational culture to the surface, relate this to everyday practice, permit collective reflection on current practice in the care home, develop understanding of positive and negative processes and identify actions to support positive cultures and bring about change where needed.

The research group are currently (October 2012 to January 2013) working with stakeholder groups, consulting in depth about the findings. The aims of this work are to refine the messages to make sure that they are presented in terms that communicate the ideas and information clearly for each particular stakeholder group, and also to work out the most appropriate product or method of dissemination for each group. The groups to be consulted in this phase include care providers, trainers, safeguarding, local authority commissioners, family carers, older people and policy makers. The consultation work in this phase is a change from the originally proposed use of this phase to produce a reflective resource. This change of activity has arisen from negotiation with the PANICOA management group in October 2012, and will support the development of resources for enhanced impact.

The key implications for practice that arise from our study concern the need for a clearer focus on and understanding of the role of organisational cultures in supporting good care. This focus, with its new evidence base, provides both new knowledge and advances many previous recommendations for improving care (such as training, workforce support, management skills, use of evidence base in relation to person/relationship centred care, activities etc.) by embedding them within the context of organisational culture and its underlying , fundamental impact.

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APPENDICES

Appendix 1: Contextual information on policy and practice

The Regulation of Care Homes in Scotland: An overview of key statistics, legislation, policy and practice frameworks

Q: What is the extent of care home provision in Scotland?

At the time of the 2010 census date (31st March) there were 1,375 registered care homes in Scotland providing 43,887 places to 38,042 residents (ISD Scotland, 2010: 2). Of these, there were 943 homes providing 39,150 registered places for older residents (Ibid). The majority of care homes for older residents (67.6%, n=637) were privately owned. Of the remaining homes, 174 (18.5%) were owned by Local Authorities/NHS and 132 (14%) were in the voluntary sector (ISD Scotland 2010: 3). Areas with the highest rates of care home places for older residents (per 1,000 of the population) included: South Lanarkshire; Perth & Kinross; Inverclyde; Glasgow City; Angus; and, Aberdeen City (ISD Scotland 2010: 2). In relation to staffing, figures compiled by the Scottish Social Services Council (SSSC) show that, in 2009, 54,150 staff worked in 1,386 registered care homes for adults; 27.4% of the workforce overall (SSSC 2011: 4).

Q: What are the key pieces of legislation?

The regulation and inspection of care homes

Two key pieces of primary legislation currently guide the registration and inspection of care services in Scotland: The Regulation of Care (Scotland) Act 2001; and, The Public Services Reform (Scotland) Act 2010.

The Regulation of Care (Scotland) Act 2001 established an independent commission to register and regulate care services in Scotland (The Scottish Commission for the Regulation of Care) as well as a professional body for registering and regulating social services staff and professional training (The Scottish Social Services Council). The Act led to the creation of Scottish Statutory Instruments (No. 113 and No. 114), which outlined the legal requirements for care homes when registering and providing care services.

The 2001 Act introduced the National Care Standards for Scotland. These outline minimum standards for the quality of care that service users can expect. Care standards are not legally binding but are used by inspectors, as benchmarks, to monitor services (see below). The National Care Standards are designed to be accessible and are written from the point of view of service users. There are 20 minimum standards relating to care homes for older people and are based (as are all National Care Standards) on 6 key principles: dignity; privacy; choice; safety; realising potential; and, equality and diversity.

The Public Services Reform (Scotland) Act 2010 was introduced in order to reform and simplify the landscape of public bodies in Scotland. The Act led to the creation of two new bodies: Social Care and Social Work Improvement Scotland (SCSWIS) and Healthcare Improvement Scotland (HIS). These replaced the Scottish Commission for the Regulation of Care (established under the 2001 Act) as well as NHS Quality Improvement Scotland.

The protection of vulnerable adults

Three key pieces of legislation currently outline the principles and procedures for safeguarding vulnerable adults in Scotland: The Adults with Incapacity (Scotland) Act 2000; The Mental Health (Care and Treatment) (Scotland) Act 2003; and, The Adult Support and Protection (Scotland) Act 2007.

The Adults with Incapacity (Scotland) Act 2000 established a set of general principles upon which decisions made on behalf of an adult with impaired capacity must adhere. Specifically, the Act states that all such decisions must: benefit the adult; take account of the adult's past and present wishes; restrict the adult's freedom as little as possible while still achieving the desired benefit; encourage the adult to use existing skills or develop new skills; and, take account of the views of others with an interest in the adult's welfare. The Act makes provisions for a variety of interventions made on behalf of adults with impaired capacity, such as: continuing and welfare power of attorneys; intervention and guardianship orders; and, the management of residents' finances. The Act provides the Office of the Public Guardian (Scotland) and the Mental Welfare Commission with powers to oversee and investigate potential infringements of the rights of vulnerable adults, as outlined under the Act.

The Mental Health (Care & Treatment) (Scotland) Act 2003 outlines how individuals with a 'mental disorder' should be treated both in the community as well as inpatient settings. The Act is based on the principle that any intervention made under the Act should: be non-discriminatory; promote equality; respect diversity; be based on reciprocity; encourage informal care; facilitate participation; respect the role of carers; follow the least restrictive alternative; be of direct benefit to the service user; and (where applicable) treat as paramount the welfare of children of those individuals who are affected by a 'mental disorder'. The Act outlines the various ways in which individuals with 'mental disorders' may be assessed and treated, as well as the processes of formal appeal against compulsory intervention (e.g. via mental health tribunal). The Act also provides the Mental Welfare Commission with powers to investigate cases where individuals with a 'mental disorder' are/may not be being treated in accordance with the Act.

The Adult Support and Protection (Scotland) Act 2007 places a legal duty on local councils to investigate allegations of abuse in relation to vulnerable adults, and to determine whether further action is needed. The Act outlines a range of adult protection orders (assessment orders, removal orders, and banning orders). The Act established multi-disciplinary Adult Protection Committees (responsible for overseeing local adult protection policies) and places a legal duty on statutory bodies to co-operate in cases where the risk of harm to vulnerable adults is known or suspected.

Q: How are care homes in Scotland regulated and inspected?

Several organisations play a role in regulating care services in Scotland, and in investigating allegations of mistreatment. In accordance with the Public Services Reform (Scotland) Act 2010, the regulation of care service providers is the responsibility of Social Care and Social Work Improvement Scotland (SCSWIS), which became operational in April 2011. Care services previously registered with the Care Commission automatically transferred to SCSWIS on 1st April 2011. Providers of independent healthcare services are regulated by Healthcare Improvement Scotland (HIS), which also became operational in April 2011. Centres which provide care services *and* independent healthcare services are regulated by both agencies (SCSWIS 2011a). SCSWIS regulate care services according to: the regulations laid out in the 2010 Act; the National Care Standards; and, 'other agreed benchmarks' (SCSWIS 2011a: 3).

The Scottish Social Services Council (SSSC) continues to register and regulate the social services workforce in Scotland. According to the National Care Standards, 50% of staff working directly with residents within the care home should have obtained a minimum of

SVQ level 2 or equivalent, or be working towards achieving the relevant qualification required for registration with the SSSC. In addition to regulating professional education and training, the SSSC is responsible for developing codes of practice and can investigate/take disciplinary action against registered workers whose conduct is suspected or known to fall short of the codes. In addition to the above bodies, The Mental Welfare Commission and the Office of the Public Guardian (Scotland) have statutory powers to investigate allegations of mistreatment in relation to *individual* residents.

Since 2008, registered care services in Scotland have been inspected using a framework of quality themes and statements, informed by National Care Standards (SCSWIS 2011b). Care services are graded on a six-point scale according to four quality themes. Themes are: the quality of care and support; the quality of the environment; the quality of staffing; and, the quality of management and leadership (SCSWIS 2011b). Each quality theme is comprised of a series of quality statements. Providers are required to assess their service against all the quality statements and themes, providing evidence of their performance. Inspectors then assess the performance of the service against a selection of the quality statements contained within a select number of quality themes. A grade for each quality theme is calculated based on the inspected quality statements; grades range from 6 (Excellent) to 1 (Unsatisfactory). According to SCSWIS, Grade 3 represents a 'tolerable level of performance for the purposes of regulation' (SCSWIS 2001b: 14). Grades 1-2 therefore result in the service receiving improvement orders, and the imposition of enforcement action if improvement is not evidenced. Key evidence used by inspectors to assess performance include: upheld complaints; incidents; feedback from service users; evidence that previous action plans have been implemented; and, information in the annual return (SCSWIS 2011b). Inspection reports are published and are available on-line.

The inspection of care services has been highlighted as a key priority for SCSWIS for the period 2011-2012 (SCSWIS 2011a). In contrast to provisions made under the 2001 Act, however, the Public Services Reform (Scotland) Act 2010 does not stipulate how often care services must be inspected (SCSWIS 2011c). Following the introduction of the 2010 Act (and the transfer of regulatory powers from the Care Commission to SCSWIS) the grading system will continue to be used to monitor and inspect care services. However, it is anticipated that key changes to the existing system of inspections will include: the use of unannounced/ random inspections; greater maximum periods between inspections for better performing /low risk services; greater frequency of inspections for poor performers/high risk services; and, more emphasis on self-evaluation using validated methods (SCSWIS 2011a; 2011b).

The National Care Home Contract [NCHC] was developed by Convention of Scottish Local Authorities (COSLA) and has been in use by local authorities since April 2007. The aims of the contract are to standardise arrangements, across local authorities, for procuring care home places for older people and to govern/evidence additional investment in the sector provided by the Scottish Government. As such, the NCHC applies principally to services procured from the private and voluntary sectors. The National Care Home Contract includes a series of quality payments. These are intended to provide care home providers with financial incentives to raise standards of care. Until recently, the NCHC has operated these payments on a deficit model, where the poorest performing homes are denied additional payments should they fail to meet grades 3 or above in the relevant area of the Quality Assurance Framework (see above). Recent versions of the NCHC offer additional payments (Enhanced

Quality Award) to care homes which perform at the top of quality framework. The terms of NCHC are currently under review (report expected October 2011).

Q: What has been done to improve care services for adults living with dementia in Scotland?

Over the last four years, a number of policies and frameworks have been developed, designed to improve care services for adults living with dementia in Scotland. Taken together, these place a strong emphasis on promoting universal human rights, improving care standards and promoting excellence.

The Charter of Rights for People with Dementia and their Carers in Scotland (2009) was developed by a Cross-Party Group within the Scottish Parliament. The charter seeks to ensure that universal human rights are recognized and respected in relation to people living with dementia and their carers (as outlined in the Human Rights Act 1998; The Scotland Act 1998; the European Convention of Human Rights; the Universal Declaration of Human Rights; the International Covenants on Economic, Social and Cultural Rights and Civil and Political Rights; and, the Convention on the Rights of Persons with Disabilities). Key principles contained within the Charter are: respect for inherent dignity; non-discrimination; full and effective participation and inclusion in society; respect for difference and acceptance of persons with disabilities as part of human diversity/humanity; equality of opportunity; accessibility; and, equality between men and women.

Scotland's National Dementia Strategy (2010) sets out the Scottish Governments' strategic approach to dementia care services. The Strategy reflects a rights-based approach to dementia care, as outlined in the 2009 Charter. The Strategy outlines eight key action priorities for improving dementia care services. These are: common standards of care; a skills and knowledge framework for dementia; integrated support for change; improved management and outcome information; continued work on diagnosis; better response to behaviours that staff and carers find challenging; accelerated implementation of the dementia integrated care pathway; and, continued action to support dementia research.

Standards of Care for Dementia in Scotland (2011) were led by the Mental Welfare Commission for Scotland and developed in order *'to help people with dementia and their carers understand their rights, and how these rights can help make sure that they receive the support they need to stay well, safe and listened to'* (PP: 1). The Standards of Care were informed by the 2009 Rights Charter and address action priority one of the Dementia Strategy (pertaining to common standards of care). The Standards of Care are intended to be used in conjunction with the Promoting Excellence framework (see below) and are intended to form part of the regulation and inspection of care services in Scotland. Standards of Care are organized around a series of rights-based statements, written in the first person, and grouped under the following six headings: I have the right to a diagnosis; I have the right to be regarded as a unique individual and to be treated with dignity and respect; I have the right to access a range of treatments, care and support; I have the right to be as independent as possible and be included in my community; I have the right to have carers who are well supported and educated about dementia; I have a right to end of life care that respects my wishes.

Promoting Excellence (2011) was developed by NHS Education for Scotland (NES) and the Scottish Social Services Council (SSSC). It outlines *'the knowledge and skills all health and social services staff should aspire to achieve in relation to the role they play in supporting*

people with a diagnosis of dementia, and their families, and carers.’ (PP: 1). The framework is designed to supplement existing frameworks (NHS Knowledge and Skills Framework; the Social Services Continuous Learning Framework; and, the National Occupational Standards for Health and Social Care). The framework is intended to be both rights-based and aspirational. It was developed (and designed to be used) alongside the Standards of Care. Specifically, the framework identifies a range of quality indicators that can be used to measure performance against the Standards of Care. The framework establishes four levels of knowledge/skills competencies that are specific to the worker’s role in relation to the person with dementia (as opposed to their level of seniority within the organization). The levels are: Dementia Informed Practice Level; Dementia Skilled Practice Level; Enhanced Dementia Practice Level; and, Expertise in Dementia Practice Level. Each requirement laid out under the four levels relate to one or more stage in the ‘dementia journey’ (keeping well; prevention and finding out it’s dementia; living well; living well with increasing help and support; and, end of life and dying well).

Q: What are the key future developments in Scotland?

Reshaping Care for Older People was launched in 2010 and is an ongoing programme led by the Ministerial Strategic Group for Health and Community Care and chaired by the Minister for Public Health. The aim of the programme is to inform the re-designing of services for older people in light of increasing demands on limited financial resources; the result of Scotland’s ageing population. It is anticipated/intended that (amongst other things)the re-designing of services will provide a greater focus on anticipatory and preventative approaches to care, on older people being supported to remain in their own homes for longer, and on a greater reliance on self-care and self-directed and voluntary forms of support. Initial work focused around eight work streams, which has subsequently been rationalised to five key areas (Care Settings, Complex Care, Community Capacity, Workforce & Funding and Demographics). For 2011/12, a £70 million Change Fund was established to enable NHS Boards and local authorities (together with the voluntary sector) to apply for ‘bridge funding’ for the re-designing of services. Change Plans were submitted by all 32 partnerships in February 2011 and are now available online via the Joint Improvement Team (JIT) website.

Further information

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Public Services Reform (Scotland) Act 2010

URL: <http://www.scottish.parliament.uk/s3/bills/26-PubSerRef/index.htm>

Adults with Incapacity (Scotland) Act 2000

URL: <http://www.legislation.gov.uk/asp/2000/4/contents>

Mental Health (Care and Treatment) (Scotland) Act 2003

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Adult Support and Protection (Scotland) Act 2007

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Promoting Excellence

URL: <http://www.scotland.gov.uk/Publications/2011/05/31085332/0>

Reshaping Care for Older People

Change Fund Plans

URL: <http://www.jitscotland.org.uk/action-areas/reshaping-care-for-older-people/change-fund-plans>

Care Homes in England:

An overview of legislation, regulation and guidance

The Composition of the Care Home Sector

The Care Quality Commission (2010a) provides the following breakdown of the adult care home market for 2009/10. Earlier reports produced by the Commission for Social Care inspection (CSCI) sometimes provide more specific information in relation to older people's care homes, and so this data is included where relevant.

Type of Provider

	Private	Third Sector (not for profit)	Council	Other
Residential Homes	69%	22%	7%	2%
Nursing Homes	88%	10%	1%	1%

- In 2008, 52% of the independent sector market was occupied by corporate and larger owners defined as providers with three or more facilities. (CSCI, 2008a)
- There is a trend towards higher quality in third sector care homes than those run for profit. 91% of care homes provided by third sector were assessed as 'good' or 'excellent' compared with 81% of services in private ownership. Excellent ratings were achieved by 29% of third sector providers compared with 18% of private sector providers.
- There is a tendency for smaller homes to provide better quality care and for the third sector to have smaller homes than the private sector.
- 87% of small (1-10 places) homes were rated good or excellent, 84% of medium-sized homes (11-40 places) and 82% of larger homes (40+ places). 70% of smaller homes are not for older people, however, within older persons care homes there is still a tendency for better performing care homes for older people to be of smaller size. Of care homes (all adults) rated poor or adequate, 15% were large, 14% medium and 10 % small.
- The average size of nursing homes (all adults) is 46 beds, with private providers averaging 48 beds and third sector providers 36 beds. The average

size of residential homes (all adults) is 19 beds, with private providers averaging 19 beds and voluntary providers 14 beds.

Location of Care Home

- CQC does not publish current data on urban/rural location of care homes, instead detailing care home provision by region.
- The North East has the highest proportion of places in care homes for older people, at 55 places per 1,000 population (aged 65+). London has the lowest at 34 places. The West Midlands and Eastern region are lower than average with 41 and 42 places respectively.
- One in seven older people placed by their councils is in a home out of their area of origin. This is particularly marked in London. In all regions other than East Mids, North East and Yorkshire & Humberside, more than one council places more than 25% of its residents in homes outside of the local area, (CQC, 2010b).

Resident Population

- Councils purchased only 48% of places in care homes for older people (43% nursing home places and 52% residential home places). All other placements are privately funded, (CQC, 2010b)
- In 2008, two thirds of people in care homes had dementia, but only 28% of care homes were registered for specialist dementia care, (CSCI, 2008b)
- There is great regional variation as to the number of dementia registered care home places available per 100 population predicted to have dementia (and aged over 65). The highest is 55 places available per 100 in the North East , with the lowest being 30 in the South West. West Midlands stands at 38 and Eastern region at 42.

Key Legislation

The **Mental Capacity Act, 2005** (MCA) covers both England and Wales. The MCA and its Code of Practice (Department for Constitutional Affairs, 2008) provides a statutory framework for engagement with people who may lack capacity. It provides for protection from liability for acts in connection with care and treatment carried out by health and social care staff in accordance with the Act, and it introduced two new criminal offences: ill-treatment and wilful neglect of a person who lacks capacity. Professionals and paid carers are under a statutory duty to comply with the Code of Practice. CQC regulations reference the MCA throughout and demand evidence of outcomes in accordance with the Act, (CQC, 2010c; CQC 2010d; CQC 2010e; CQC 2010f).

The **Deprivation of Liberty Safeguards, 2009** (DoLS) are an amendment to the MCA and clarify the boundaries of lawful restriction and restraint under the MCA. Restriction and restraint is lawful under the MCA providing a person lacks capacity, it is in their best interests and is carried out in the way least restrictive of the person's rights and freedoms. If such an act is severe enough to constitute a deprivation of a person's liberty (under the meaning of Article 5 of the European Convention on Human Rights) it is not lawful unless a DoLS authorisation is sought and granted from the Supervisory Body, (the local authority of the resident concerned). Managing Authorities (care homes) are legally responsible for requesting and complying with DoLS authorisations for all residents in their care for whom they may be required.

The practicalities of Supervisory Bodies, (whether they sit within the local authority or PCT; their staffing; the use of dedicated assessors; and their screening of DoLS referrals prior to assessment) vary across locality. Therefore the experience of care homes of the process, and any potential impact on care quality impact may differ as well.

The **Safeguarding Vulnerable Groups Act, 2006** (SVGA) outlines the pre-employment checks required of people employed or volunteering in positions with vulnerable adults. For care homes, it requires that all staff in 'regulated' and 'controlled' activity (as defined by the type of contact and frequency/intensity of contact with vulnerable adults) have an enhanced Criminal Records Bureau (CRB) check prior to starting work. The Independent Safeguarding Authority (ISA) holds the list of people banned from work with vulnerable adults (previously known as the POVA list) and this is checked through the CRB process. In practice, this means the vast majority of staff in care homes must have an enhanced check. In urgent situations, staff can begin work under supervision prior to receiving a satisfactory CRB check, if the provider seeks an ISA Adult First check. Employers also have a duty to refer a member of staff to ISA if they have reason to believe they are unsuitable to work with vulnerable adults. This would include situations where

someone is dismissed (or would have been dismissed but they resigned) on grounds of abuse.

Aspects of the SVGA were put on hold by the incoming Coalition government. Likely changes for care home practice include: The removal of controlled activity from the check requirements, (meaning domestic and administration staff and volunteers may be exempt from requirements); the portability of CRBs so they transfer with the individual; and the removal of requirements for staff to be registered with the ISA Vetting and Barring Scheme (in practice, this system was never fully implemented).

The **Health and Social Care Act, 2008** created the Care Quality Commission (CQC) as the responsible body for the registration, regulation and inspection of all health and social care providers in England. This new regime replaces the national minimum standards and associated regulator (Commission for Social Care Inspection, CSCI) of The **Care Standards Act, 2000 & Health and Social Care Act (*community health and standards*) 2003** from October 2010. This means that much of the regulatory system outlined below is only beginning to be experienced by care homes.

Regulation and Inspection

Pre-Oct 2010: CSCI & National Minimum Standards. This regulatory system used the benchmark of 'national minimum standards' and CSCI employed an input and systems-based approach to monitoring compliance. Inspections produced a system of quality star ratings, (CQC, 2010e)

Post-Oct 2010: CQC & Essential Standards of Quality and Safety. This system abolishes quality star ratings and uses 28 regulations governing the standards of quality and safety in a care provider. When CQC monitor compliance they focus on the outcomes for people using services in relation to each of the regulations. The standards are grouped under 6 headings: Involvement & information; Personalised care, treatment & support; Safeguarding & safety; Suitability of staffing; Quality and management; Suitability of management. (CQC, 2010d). CQC monitors both providers (who may operate across many different locations and operate different types of service), and specific service locations. They do this in the following ways, (CQC, 2010e & 2010f):

- 1) A **QUALITY & RISK PROFILE** for each provider based on information from users of services, other agencies and the provider themselves through the registration process (these are so far done for NHS Trusts only. CQC is in the process of developing QRPs for adult social care). Quality and Risk Profiles of Providers are not available to the public, although the reviews of each location run by a provider are available and listed under each provider.
- 2) **PLANNED REVIEWS** of each location. These are carried out at least once every two years, but not at set intervals. Locations/Providers are not informed in advance. They focus on all standards and begin by reviewing the quality and risk profile. If this does not demonstrate compliance other measures may be used such as contact with service users and partner agencies, location visits, or completion of a quality audit by the location.
- 3) **RESPONSIVE REVIEWS** of locations, in response to specific information received by CQC or to follow-up on previous enforcement actions. They can take the same format as planned reviews, but focus on specific standards of concern. It is not specified what type or source of information would provide sufficient enough concern to prompt a responsive review, or when actions would take the form of a location visit rather than other action.
- 4) Issue **COMPLIANCE REPORTS and ACTIONS**. In response to reviews, a location (and provider) can be judged as compliant with standard/s or as noncompliant with minor, moderate or major concerns. It can issue improvement actions, (if it judges a location as being compliant, but unlikely to remain that way), compliance actions (if it judges a location to be

noncompliant) and enforcement actions (if it judges a location to be noncompliant and high risk). Compliance Reports are publically available for specific locations if a review has been conducted since 2010.

Key Guidance

Guidance is not enforceable, but CQC does require providers to evidence their regard to relevant guidance and expert advice, and incorporates it into outcome evidence prompts.

Safeguarding Vulnerable Adults from Abuse

There is no legislation directly addressing adult abuse or safeguarding arrangements in England. No Secrets (DoH, 2000) is guidance only, and places adult social services as the lead in developing and maintaining effective safeguarding arrangements through cooperation with other organisations in each local area. The Association of Directors of Social Services (ADASS) has produced two key reports outlining best practice frameworks for safeguarding adults (ADASS, 2005 & ADASS, 2010), and CSCI assessed the effectiveness of safeguarding arrangements across England, (CSCI, 2008c). The Coalition Government's pronouncements on adult safeguarding suggest there will no update to No Secrets and no framework legislation. However, adult safeguarding boards may be placed on a statutory footing (making safeguarding arrangements more accountable and coherent) and the Law Commission's review of adult social care review may lead to further changes.

This means that the practicalities of safeguarding work vary substantially across localities. Thresholds for what constitutes abuse, who is determined 'vulnerable', what determines that an incident should become part of inter-agency safeguarding processes, and how involved a provider service is in investigating and responding to such abuse are locally determined. Therefore, the experiences of safeguarding by care homes and residents, and any potential impact on their quality varies across each locality. CSCI (2008c) identified that there was a correlation between the quality of safeguarding arrangements in a locality and the quality of care services, and that the best safeguarding arrangements appeared to be those with a broad definition of abuse and then a range of actions to be taken in response to specific circumstances.

No Secrets and the ADASS reports have determined some benchmarks for policy and practice in safeguarding function and governance in a locality. These are as follows:

- Currently, No Secrets defines a **vulnerable adult** as: *“Any person aged over the age of 18, who is or may be in need of community care services by reason*

of mental or other disability, age or illness, and is or may be unable to take care of themselves or able to protect themselves from harm or exploitation". Initially, this was interpreted in some local areas to exclude people who funded their own care. ADASS guidance broadened the definition to prevent this exclusion, defining a vulnerable adult as any adult who: *"is or may be eligible for community care services to retain independence, well-being and choice and to access their human right to live a life that is free from abuse and neglect"*. (ADASS, 2005) However, the requirement for social services to respond in some situations remains unclear.

- No Secrets defines the following **categories of abuse**: physical, sexual, neglect, financial, psychological, discrimination and institutional abuse. Few adaptations have been suggested, although the inclusion of self-neglect and harm is suggested in the Law Commission review.
- No Secrets does not define specific **thresholds of harm or intervention**. It asserts that harm does not only include ill-treatment but also *"impairment of or avoidable deterioration in a person's physical, intellectual, emotional, social and behavioural development"* and determines that intervention is a judgement based on vulnerability, nature, extent and time frame of the abuse, and its impact. ADASS affirmed that good practice is evidenced by transparent, consistent decision-making by local authorities in this regard and that poor understandings or experiences of thresholds and intervention by care services increase vulnerability of service users, (ADASS, 2005).
- No Secrets recommended that **commissioners of care services**, enforce safeguarding by ensuring contractual arrangements and service specifications require compliance with safeguarding policy. This has been enhanced by ADASS guidance specifying the following areas: zero tolerance to all forms and degrees of abuse; embedding of choice and human rights in service design and delivery; recruitment practices and training of staff; and quality assurance of services, (ADASS, 2010)

CSCI Report (2008b): See me, not just the dementia

This report examined the quality of care for people with dementia in care homes and provided guidance for good practice. It noted that the quality of care planning, the size of home (Better performing homes tended to be smaller in size.), and the training of staff were all positively related to resident well-being. It also established that the registration of a service to provide specialist dementia care was not a guarantee of good practice. Training alone is not enough and good leadership, staff support and a culture within

a care home of respecting and treating people as individuals have been shown to be essential components of good quality care.

CSCI Report (2007): Rights, Risks, Restraints

This report examine the use of restraint in care homes for older people and identified that, despite a regulatory requirement to ensure that no service user is subject to restraint unless it is lawful and the only means to secure the welfare of a service user or other, restraint was still widespread and misunderstood. Whilst this report examined care prior to the enforcement date of the MCA (2007) and the introduction of DoLS (2009), it still identified key issues in the use of restraint in older people's care:

- It defined restraint broadly to include: physical restraint and intervention, chemical restraint, environmental restraint, electronic surveillance and medical restraint, forced care, refusal of support and the use of threats and coercion. It found that there was a general lack of recognition of what constituted restraint.
- There was a dilemma for staff in balancing the need for protection (such as preventing falls) with resident freedom.
- There is a perception that restraint is used to manage staffing/organisational pressures.
- The older people most likely to experience restraint were those whose behaviour was perceived as threatening or difficult, who could not be persuaded in other ways to do what others wanted and those who were less physically or mentally able.
- There is an acknowledgement that understanding and interpreting behaviour of people with dementia was central to avoiding restraint but that this was evidenced unevenly in practice.

DoH (2009) National Dementia Strategy

This best practice guidance outlined 16 objectives to improve dementia services in England. 3 objectives directly impact care homes for older people: *Objective 11 - Living well with dementia in care homes*, *Objective 13 – An informed and effective workforce* and, *Objective 15 – Improved assessment and regulation of care services*. Whilst the document is only guidance, it was aimed particularly at commissioners of services and therefore could potentially impact through the care home marketplace. It also identified steps to be taken to achieve objectives, and therefore evidence of those steps could be expected to indicate good quality care.

Possible Future Changes to Legislation, Regulation and Guidance

The Dilnot Commission's report (2011) into funding of adult social care and support identifies the following problems with the current system of funding relevant to care home provision for older people:

- The system is 'not fit for purpose' and requires urgent and lasting reform
- The system is confusing, unfair and unsustainable, evidencing substantial local variations in what is available and what is funded by the state or by the individual. This leads to variations in quality of care and the poor experience of care by many.

The following recommendations could impact on future provision of residential care for older people:

- A cap on the lifetime contribution an individual should make to care costs set at £35,000.
- The asset threshold for those in residential care beyond which no means tested help is given to be raised from the present £23,250 to £100,000
- A standard individual contribution from those in residential care to cover food and living costs (set at max of £10,000)
- National eligibility criteria and portability of assessments, so that local variations in costs, and state support are not evident.
- The need for government to secure sufficient and sustainable funding for local authorities to meet adult social care need.

Caring for our future: progress report on funding reform (2012) sets out the government's response to the Dilnot Commission, accepting the principles of capped costs for individuals and deferred payment for care. However, the government says it is unable to commit to funding a new system in the current constrained financial environment.

Caring for our future: reforming care and support (2012) is the government white paper setting out the coalition government's plans for reform of adult social care, with the draft Care and Support Bill providing the necessary legislative changes. The white paper sets out principles of promoting independence to postpone need for care

and of promoting personal control over care provision. There is a plan to create outcome measures of well-being that are shared by both public health and adult social care. A national minimum eligibility threshold for care and support is proposed, as is a minimum training standard for care workers. There is a plan to introduce rights for carers to support. Connection between care homes and communities are emphasised with collaboration proposed between large national providers and also community, voluntary groups. The white paper says that protection from abuse and neglect will be put on a statutory footing.

The Law Commission's review of Adult Social Care (2011)

This report reviews the law relating to the provision of adult social care in England and Wales and proposes to establish a primary well-being principle in legislation. This will clearly state in law that the overriding purpose of adult social care is to promote or contribute to the well-being of the individual. Individual well-being must be the basis for all decisions made and actions carried out under the statute.

The following recommendations could impact on the future provision of residential care for older people:

- Direct payments should be extended to cover residential accommodation
- A duty is placed on local social service authorities to investigate adult protection cases, or cause an investigation to be made by other agencies, in individual cases
- LA should be required to protect property when person is admitted into hospital or residential care
- LA should have a duty to provide residential accommodation where a person is not ordinarily resident but is in urgent need of accommodation
- LA should have a duty to carry out an assessment of needs, irrespective of ordinary residence

References

Composition

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- CQC, (2010a) *The Adult Social Care Market and the Quality of Services* (London: CQC)
- CQC, (2010b) *Market Profile: Quality of provision and commissioning of adult social care services* (London: CQC)

Legislation

- The Care Standards Act, 2000
- The Health and Social Care (community care and standards) Act, 2003
- The Mental Capacity Act, 2005
- The Safeguarding Vulnerable Groups Act, 2006
- The Health and Social Care Act, 2008
- CQC, (2010c) *Mental Capacity Act: Guidance for Providers* (London: CQC)
- CQC, (2010g) *Criminal Records Bureau Guidance for Providers* (London: CQC)
- Department of Constitutional Affairs, (2007) *Mental Capacity Act Code of Practice* (London: The Stationery Office)
- Ministry of Justice, (2008) *Deprivation of Liberty Safeguards Code of Practice* (London: The Stationery Office)

Regulation

- CQC, (2010d) *Essential Standards of Quality and Safety* (London: CQC)
- CQC, (2010e) *Guide to Monitoring Compliance* (London: CQC)
- CQC, (2010f) *Using Evidence of Outcomes to Demonstrate Compliance* (London: CQC)

Guidance

- ADASS, (2005) *A National Framework of Standards and Good Practice in Adult Protection Work*
- ADASS, (2010) *Quality Assurance Framework for Safeguarding Vulnerable Adults*
- CSCI, (2007) *Rights, Risks, Restraints* (London: CSCI)
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- CSCI, (2008c) *Effectiveness of Arrangements into Safeguarding of Vulnerable Adults* (Newcastle: CSCI)
- Dilnot Commission, (2011) *Fairer Care Funding* (London: Dilnot Commission)
- DoH, (2009) *Living Well With Dementia: A National Dementia Strategy* (DoH, London)
- DoH, (2000) *No Secrets* (London: The Stationery Office)
- The Law Commission, (2011) *Adult Social Care* (London: The Stationery Office)

The Care Home Environment in Wales

Out of the three devolved nations Wales shares many similarities with policy and legislation that is applicable in England, for example the Mental Capacity Act, 2005 and the Deprivation of Liberty Safeguards, 2009. However, there are specifics for the Welsh environment in relation to workforce, demographics and policy that should be considered in any analysis of elderly care provision in Wales.

In Wales, with a population of nearly three million residents, since devolution in 1999 there has been a transfer of a range of policy responsibilities, such as that for the National Health Service (NHS), to what has recently been rechristened the Welsh Government (WG). Since the advent of devolution and the move of greater political powers to all of the nations of the United Kingdom has resulted in a divergence in health policies in the UK's constituent nations. In Wales the WG has sought to improve the cohesion between health and social care by developing policies that seek to encourage different organisations that contribute to service delivery to work more closely together. Wales has been particularly innovative in developing policies in relation to the provision of services to older people that puts "clear red water" between the approach in Wales and the approach in England and Scotland. One key example of this is the implementation of the ten year NSF for Older People whilst another example would be introducing a Commission for Older People.

Under this devolved administration the two main regulatory agencies working in the field of eldercare provision are:

- Care Council for Wales CCW <http://www.ccwales.org.uk/home> This is the main regulatory body that regulates the social care workforce
- Care and Social Services Inspectorate Wales CSSIW <http://wales.gov.uk/cssiwsite/newcssiw/?lang=en> which is the main regulatory body in relation to social care provision.

Welsh Ageing Demographic

CCW have identified that meeting the needs of an ageing population is probably the biggest challenge for social care services in Wales. In certain areas of the country this will be compounded by various other factors such as certain areas of Wales being very popular retirement destinations for people from elsewhere in the UK and also in the more poorer areas of Wales such as the South Wales valleys there are above average levels of limiting long term illness. These factors will impact on the level of care needs in those areas.

The changing demographic of the ageing population as outlined by below:

- In 2006, the proportion of people aged 65 or over was 16%. By 2031, it will have risen to 22%
- In 2006, there were 3.3 people of working age for every person of state pensionable age. By 2031, it is likely that there will be less than 3 people of working age for every person of state pensionable age

- There are around 9,000 people aged 100 or over in England and Wales today. This is a 90-fold increase since 1911 and a 7% plus increase since 2005
- 1 in 3 older people end their lives with a form of dementia. 1 in 5 people over 80 has dementia and two thirds of people with dementia live in the community.
- At the current rate of expansion, UK's centenarian population could reach over 40,000 by 2031
- People over 90 are the fastest growing segment of the population in the UK.

In addition within the Welsh context;

- In Wales, the number of 65 to 84-year-olds will increase by 24% by 2018
- People aged 85 or over in Wales will increase by 29% by 2018. Of these, 33% are likely to need 24-hour care
- It is estimated that, by 2025, Wales will need around 50,000 more social care workers than it has now
- This would mean that, between now and 2025, around a third of all school leavers in Wales every year would need to become social care workers to meet the projected demand
- The total value of the social care sector to the economy in Wales is almost £1bn. If you add to that the effect of workers spending their earnings in local communities, the overall contribution by social care to the economy of Wales is £1.4bn

The Welsh Care Home Work Force:

Around 87% of the workforce are women, 30% are aged 50 or over and only 10% are under the age of 25 while 55% are part-time. Most of the social care workforce is employed by the independent sector: 86% for care homes and 16% of the overall workforce speak Welsh. (Figures correct as of 31 March 2010)

Issues identified in relation to staff training as in need of attention by CCW are:

- support and training for staff;
- staffing levels;
- supervision of staff;
- The appropriate management of medication in care homes.

Welsh Language Provision

Since the Welsh language act of 1993 legislation is in place that supports the notion that Welsh and English should be held in equal status particularly within the provision of public services. Language issues have also been identified by a number of stake holders as a significant factor in quality provision of elderly care in Wales. In certain areas of West Wales, known as 'Cymry Cymraeg' levels of native Welsh speaking can be over 70% and therefore provision of elderly care through the medium of Welsh can sometimes be a

significant challenge for providers, particularly in relation to attracting and retaining qualified staff.

The Care Home Sector in Wales

The distribution of the market between the independent and local authority sectors has changed with a small increase in the proportion of independent sector providers. The independent sector accounting for 87 per cent and local authorities for 13 per cent (a fall of one per cent from the previous year).

Total number of care homes		Number registered to provide nursing care		Number registered to provide personal care only	
Homes	Places	Homes	Places	Homes	Places
1187	26665	300	12235	887	14430

In the past few years there has been an 11 per cent decrease in the number of small care homes (care homes with three or fewer places) across Wales with there now only being 14 left. There has been a small (two per cent) decrease in the number of small care homes across Wales between 2009 - 2010

Policy Documents

The following policy documents specifically relate to the Welsh environment.

- [The Care Homes \(Wales\) Regulations 2002](#)
- [The Care Homes \(Amendment\) \(Wales\) Regulations 2003](#)
- [The Care Homes \(Wales\) \(Amendment No 2\) Regulations 2003](#)
- [The Care Homes \(Wales\) \(Miscellaneous Amendments\) Regulations 2011](#)

Division Between Care and Nursing Homes in Wales

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Additionally the Care Council for Wales (Conduct) Rules 2011 has been implemented as from 1 July 2011.

Policy Development and Implementation:

Two key examples of this clear red water that separates English and Welsh policy in elderly care are illustrated by The Elderly Peoples' Commissioner for Wales and the National Service Framework for Older People.

Elderly Peoples' Commissioner

The role of the Commissioner is to ensure that the interests of people aged 60 and over in Wales are safeguarded and promoted.

The Commissioner, as an ambassador and authority on older people's issues, will speak up on behalf of older people. Perhaps most importantly, the Commissioner works to ensure that older people themselves can influence the way in which important public services are managed and delivered in Wales.

The Commissioner is a source of information, advocacy and support for older people in Wales and their representatives. As well as looking at the interests of older people as a whole, she can also look at:

- the cases of individual older people in certain circumstances, such as where the case raises issues that may have a wider impact on older people;
- the effect that public bodies, such as the Welsh Government, Local Government and the NHS, have on older people. She may publish reports, making recommendations for change;
- the providers of regulated services across Wales, issuing guidance on best practice to ensure that they safeguard and promote the interests of older people. She may also help individuals to make a complaint about the services provided;
- the way in which a local authority or health body implements the policies and procedures that it has put in place for dealing with elder abuse. If these are not being carried out effectively, she can hold authorities to account.

Since 2006 a key example of the unique policy environment in Wales has been the National Service Framework (NSF) for Older People this is an evidenced based standard for the health and social care of individuals aged over fifty years. It is a ten year programme organised over a framework of six policy factors. This overview is discussed within an understanding that policy initiatives appear to be in a constant state of flux and under constant review within Wales.

NSF Structure and Delivery

The NSF for Older People in Wales is delivered by twenty-three partnerships, constituted on twenty-two local authority areas and one all-Wales service which delivers national programmes, such as cancer screening. The twenty-two local partnerships include health and social care services, both statutory and non-statutory. The partnerships vary in their size, constitution, frequency of meetings, reporting arrangements and internal cohesion. All of these factors may influence the NSF implementation and a small number of partnerships have been compromised by inter-organisational and inter-personal tensions. Establishing multi-disciplinary teams *per se* therefore appears insufficient for proper policy implementation and robust professional relationships are also required. Such relationships take time to develop and appear to be compromised by factors such as staff turnover and organisational

re-structuring. In Wales, the NHS since devolution has been undergoing an ongoing major reform programme that has led to greater regional working and an abolishing of the internal market.

The Dignity in Care Programme

A key part of the NSF is the Dignity in Care Programme. This was launched in October 2007 and is aimed at having a care system in Wales where there is zero tolerance of abuse of and disrespect for older people.

The programme includes the following elements:

- A national awareness raising campaign on issues relating to Dignity in Care
- Promotion of partnership working to secure improvements in service
- Identification of key areas for action through focused inspection and regulation
- Development of communities of practice against health and social care to promote improvements and eliminate poor practice
- Integration of Dignity in Care considerations in key national and local strategies

Particularly since 2010 work has started under this programme to integrate Welsh language provision into elderly care.

The Continuing Development of the NSF

From the outset of its implementation in March 2006 the NSF has been subject to continual review in order to monitor its effectiveness in improving services for older people. The first review reported in Autumn 2009 and sought to answer the question:

‘What impact is the NSF having on the quality of life of older people in Wales?’

In order to address this the report was organised around three central themes:

- Nutrition,
- Dignity and Respect
- Integrated services

This review and a follow up conducted by Health Inspectorate Wales (HIW) and Care & Social Services Inspectorate Wales (CSSIW). The review, the first one undertaken jointly by the inspectorate will inform the policy direction of the NSF between 2011 and 2016. This review has been conducted by consulting with key groups and agencies that work throughout Wales such as: Age Alliance Wales (which consists of voluntary organisations) and Care Forum Wales (who represent the independent care home sector).

Flexibility Within the Delivery of NSF

In Wales, there is variation in the population sizes of local authority areas, from about 50,000 to 250,000. Variation also exists in terms of population demography, health profiles and service availability. For example, the valley communities in South

Wales, former sites of heavy industry such as coal mining, are characterised by a high prevalence of long term chronic conditions and a life expectancy less than the Welsh average. The aim of the NSF is to offer flexibility so that implementation in these areas can differ from a large local authority in mid Wales, which borders the English midlands, in which there are challenges of a mainly rural population.

Development of for Partnership Working NSF

As well as the independent review, there is a close working relationship between the WG and the twenty-three partnerships across Wales. This includes quarterly meetings held on a regional basis, namely Mid and South West, South East and North Wales. These meetings provide a forum for all aspects of the NSF to be discussed and debated by a group of professional stakeholders who are implementing the standards. In addition, an Implementation Advisory Board convened by the Welsh Assembly Government oversees the implementation of the NSF. This Board consist of Government civil servants, representatives of older people from groups such as the National Partnership Forum for Older People in Wales, academic institutions, local authority umbrella groups, health organisations and other partners such as voluntary sector providers. Whilst acknowledging the debates and differences of opinion that occur, the engagement with all pertinent stakeholders offers a platform for the progression of the NSF.

Relationship of NSF to Welsh Government

In Wales, the Deputy Minister for Health and Social Service, takes the lead for issues relating to older people. This minister takes direct briefings on all aspects of the NSF and deals with inquiries in relation to the policy. In addition, since 2007, there is a National Dignity in Care programme in Wales, which is managed as part of the NSF.. As part of the programme the WG has put aside resources to fund a dignity in care training initiative across Wales. This training may be considered to be an integral part of workforce development strategy in Wales.

Outline of the Welsh National Service Framework for Older People

Standard 1 Rooting out age discrimination

Standard 2 Person centred care

Standard 3 Promotion of health and wellbeing

Standard 4 Challenging dependency

Standard 5 Intermediate care

Standard 6 Hospital care

Standard 7 Stroke

Standard 8 Falls and fractures

Standard 9 Mental health

Standard 10 Medicines in older people

Standard 11 Workforce development

The Self Assessment Audit Tool (SAAT) is an internet based reporting system which is used as one of the systems to monitor the NSF implementation. The SAAT, which has strengths and weaknesses, offers evidence that implementation against the phase one targets and milestones for the standards have been largely achieved across Wales. There is, however, variation across Wales within this overall picture and there is further work to do in a number of areas.

For example, the implementation of the mental health standard appears wide ranging across Wales. The developing Dementia Action Plan in Wales will be helpful to progress this standard further forward. There are also issues of information sharing that have challenged the NSF implementation. Different organisational boundaries and information technology systems between health and social care services have resulted in difficulties in capturing all pertinent evidence. This experience perhaps illustrates a wider issue of collaborative working in the provision of integrated services; although in Wales this is mitigated to some extent by an increasing drive toward joint commissioning within Wales (Morgan 2009)

Useful Supporting Documentation

National Assembly for Wales performance indicator SCA/002b available at <http://dissemination.dataunitwales.gov.uk/webview/index.jsp>

[Care and Social Services Inspectorate Wales Chief Inspector's Annual Report 2009-2010](#)

Chief Inspector's Annual Report 2009-10,

From Vision to Action: The Report of the Independent Commission on Social Services in Wales, November 2010

Fulfilled Lives, Supportive Communities: A Strategy for Social Services in Wales Over the Next Decade, February 2007

Improving Care and Social Services in Wales: Chief Inspector's Annual Report 2009-10, page 11

Improving Care and Social Services in Wales: Chief Inspector's Annual Report 2009-10,

Strategy for Older People in Wales 2008-2013: Living Longer, Living Better, March 2008

www.ssiacymru.org.uk

WAG Sustainable Social Services for Wales: A Framework for Action

Appendix 2: Schedule for Contextual Interviews



UNIVERSITY OF STIRLING



Date of Interview:

Identifier:

Care Home Organisations Implementing Cultures for Excellence:

Key Informant Interview Summary

Roles & Responsibilities
Differences between types of care home provision -
Key issues with types of care home provision -
Key challenges facing the care home sector now -
Key challenges facing the care home sector now
What helps/hinders – Commissioning
What helps/hinders – Regulation -
What helps/hinders – Policy development/implementation N/A
What helps/hinders – safeguarding process -
What helps/hinders – care workers to do good practice

-
What helps/hinders – managers in the management of care homes
Other (if appropriate) N/A
Policies/papers/documentation

Appendix 3: Table 4: Data collected at each case study site

Case study	Staff	Residents	Relative	PIECE-dem Number of residents observed	Hours of ethnographic observation - approximate	Research process – contextual information
Mantle View	7 (4 persons in one interview)	1 (in the interview with a relative)	1 (in the interview with a relative)	2	56	Case study focussed on one unit
Chamomile Place	8	1	1	4	48	Case study of whole home
Sage Court	1 (plus 4 people visiting home in professional role)			2	48	Case study of whole home
Lovage View	4 (limited by change of manager)	1		4	20	Delays in negotiating access limited the case study
Marjoram Place	5		2	4	32	Case study of whole home
Chives Court	3			4 (of which 2 partial)	15	Case study limited by increasing other pressures for care home
Tansy View	7	2	3	4	65	Case study of whole home
Bergamot Place	9		2	2	48	Case study of whole home
Thyme View	7	4 (2 persons in one interview)	3	4	30	Case study of whole home
Hyssop Place	6 (2 persons in one interview)	None able to participate in interview	3 (2 persons in one interview)	3	40	Case study focussed on one unit
Angelica Court	4	None able to participate in interview		4	30	Case study focussed on one unit
Total	61	9	15	37	432	

Appendix 4: Propositions presented to the panel group

This shows the phrasing of the propositions presented to the panel group, gives an indication of the discussion that took place about the propositions, and below are the final themes, for comparison.

1. The way in which the environment is used impacts on the quality of care experiences. Conscious reflection on the environment by the home is required to positively impact care experiences.

AK said they had seen excellent purpose built homes, although some were 'purpose built' 35 years ago, and since then the aims for residential care provision have changed, some places were constrained which dictated activities. Panel member commented newly opened dementia care in the local NHS Trust, has purpose built rooms which has created a good environment, good care.

2. The sense of connectedness within the home impacts on care quality. An active facilitation of this connectedness is required to positively impact care experiences.

Panel member commented that these statements need to be 'spoken in their language', they all commented 'this is University speak'. AK advised the definition of connectedness i.e. something staff and resident were doing together in that moment despite what might be going on around them. All commented that perhaps instead of connectedness the words interaction, one-to-one or person-to-person may be used.

3. The understanding of a home's purpose impacts on quality of care. Unity of vision, purpose and practice across management and staff is required to positively impact care experiences.

Again, what the statement was trying to convey, and how this could be more clearly expressed, was discussed, with suggestions: 'Purpose is for residents'. 'Purpose impacts on quality of care' is shared understanding. Panel member asked how often is it like this, with everyone sharing the same understanding? AK said possibly total shared purpose one fifth of time, partial, shared half of the time. Panel member said you sign a contract to establish what you/relation is being cared for are getting in their care, 'to put it bluntly be sure of what people are getting for their money'. It was asked might purpose be stated in the contract. Panel member commented it was a good idea but not in practice. Panel member said that where they are funding care for a resident the NHS and the county council carry out reviews, referring to this contract, and so this would be one way of looking at shared purpose. Panel member asked 'what if the purpose of the home is to make money?'. An alternative way of wording the statement was proposed: 'The understanding of a home's purpose for residents impacts on quality of care. Unity of vision, purpose and practice across management and staff improves quality of care.'

4. Factors external to the home itself impact on care quality. An active mediation and translation of these into day to day care practice is required to positively impact care experiences.

AK described examples of 'factors external to the home' as how much will LA pay or priorities from CQC. AK advises that some managers take responsibility along with outside forces however some managers hand it out to care staff. Some actively go out to seek more engagement with community. AK describes how some managers will pass things on i.e. completing care plans and this has an impact. Panel member commented it comes to down to inspirational managers. Re wording, this statement was seen to be about management responsibility.

- 5. The extent to which activity and engagement are viewed as care work impacts on care quality. Activity and engagement must be actively enabled to be integral to care work to positively impact care experiences.**

- 6. The extent to which staff are able to be effective individuals impacts on care quality. Empowering and present leadership (achieved in a variety of ways) creates effective staff and positively impacts care quality.**
Panel member advises this depends on hands-on leadership. Panel member comments that you need an excellent manager, succession planning, good carers and carers need to be loving and patient. Panel member advised these could be gained through experience and training but JG advised 'not necessarily'.

- 7. The way in which a home views and pursues change impacts on care quality. Change pursued in a gradual and ongoing way, towards a resident-oriented (rather than organisation-oriented) goal, will positively impact care experiences.**

Final presentation of themes:

Theme One: Shared purpose in providing the best person-centred care

Findings show that having a shared purpose in a care home can have a bearing on the quality of care. Shared vision and understandings of the purpose of the home and the aims of care among management and staff that put the needs of residents as paramount were associated with positive care experiences.

Theme Two: A sense of community between all involved in the care home

The sense of connectedness within a care home impacts on care quality. An active facilitation of this connectedness is required to create a sense of community and positively impact care experiences.

Theme 3: Managers ensure external pressures do not have a negative impact on care delivery

The forces and factors from outside of a care home such as those from the regulator, from owner organisations and from families can impact on the care experience in a negative way even when they are meant with good intention. Managers can mediate these pressures so that they do not have a negative impact either by taking on the responsibility for them or by interpreting them into meaningful types of activity.

Theme Four: Staff are empowered to take responsibility for resident well-being by active management processes

The findings show that the extent to which care staff were empowered to be effective in their practice had an impact on care experiences for residents. Supportive management; responsive management; present leadership; leading by example; defining boundaries and expectations; united leadership; and strong management all served to increase staff taking responsibility in their work with residents and families.

Theme Five: Openness to Change for the benefit of residents

Findings suggest that way in which a home views and pursues change impacts on care quality. Change pursued in a gradual and on-going way, towards a resident-oriented (rather than organisation-oriented) goal, appeared to be associated with positive care experiences.

Theme Six Using the care home environment to the benefit of residents

The findings suggest that the ways in which the environment is used in care homes is shown to have an impact on the quality of care experiences. Where conscious reflection on the environment and its use is evident in a home, it can contribute to positive care experiences.

Theme Seven: Person centred activity and engagement is integral to care work

The extent to which activity and engagement are viewed as care work impacts on care quality. When activity and engagement are embedded and integral to care work then the impact on care experiences of residents is positive.

Appendix 5: Example of coding frame

Refined Coding Framework for CHOICE Project

1. Ethos of organisation/care [including the ethos of person-centred care uttered by participants]
 - 1.1. Purpose of organisation/drivers
 - 1.2. Role of finance
 - 1.3. Promotion of ethos within/outside community
2. Values [including organizational values; values held by individual staff members, relatives or residents]
 - 2.1. Aspirational
 - 2.2. Spiritual/religious
 - 2.3. Communal/individual
3. Norms of practice
 - 3.1. What is accepted/not accepted
 - 3.2. Way things are around here
4. Power/empowerment/disempowerment [including where power and control lie in terms of family carers access and involvement to knowledge, defining their relatives care needs or influencing care provided to their relative]
 - 4.1. Delegation
 - 4.2. control
5. Positive care experiences [in practice observed and/or uttered in interviews]
 - 5.1. Person-centredness
6. Roles [individual peoples jobs and how they identify with their jobs; how jobs may have changed; how what they may do for their job differs to another person's job e.g. the difference between the manager's and carer's job and what people think of this. 'Protector' is a particular example of how senior staff thought of their job – as protecting older people residents from ageist attitudes and discrimination. There could be other examples]
 - 6.1. Managers/carers
 - 6.2. protectors
7. What is "care work" [including how care work is organized and staff, resident, relative involvement in defining what this is and expectations etc]
 - 7.1. Work expectations [and responsibility]
 - 7.2. Autonomy
 - 7.3. Task orientation
 - 7.4. Seen to be physically working
 - 7.5. Paperwork
 - 7.6. How communicated/enacted
 - 7.7. How understood/resisted
8. Activity and engagement

- 8.1. How is it valued
- 8.2. How is it understood/enacted
- 8.3. Staff structures [includes the separation and/or integration of care and activities work]
- 8.4. Uniting/isolating
- 8.5. Equity/tailoring
9. Leadership [including self leadership. Including creating vision, influencing, motivating, empowering others – so people focused]. [Management is making things happen, driving things forward by controlling resource to reach predefined objectives].
 - 9.1. Managing team/balance
 - 9.2. Mediating external pressures [wider organisations; CQC/CSSIW/CSWIS; LA; Families]
 - 9.3. Present/diffuse/united/strong [types of leadership with org]
10. Team working
 - 10.1. Interaction
 - 10.2. Membership
 - 10.3. Strengths/weaknesses (skill mix per shift)
 - 10.4. Person-centred relationships between staff
 - 10.5. Creating norms
 - 10.6. Challenging each other
11. Organisational factors [including training; staffing levels; staff skill mix; structures/hierarchies]
 - 11.1. How relate to wider organisation
 - 11.2. Role of finances
 - 11.3. Commissioning
12. Poor care experiences [including examples expressed by relatives, residents and/or staff]
 - 12.1. Mistreatment/neglect
 - 12.2. Less than optimal care
 - 12.3. Choice v best interests
13. Change
 - 13.1. How is it viewed
 - 13.2. Where is it? (stability, moving forward?)
 - 13.3. Challenge/opportunity
 - 13.4. Who
14. Emotional labour [includes the expectation on staff members to control their emotions as part of their work role either in showing their emotions or in hiding/suppressing them; whether emotional labour is embraced, exploited, expected in the org; support for staff in feeling/expressing emotions in the workplace including negative emotions such as frustrations, irritation etc]
 - 14.1. Control of emotions
 - 14.2. Acceptance of emotions
15. Boundaries
 - 15.1. Categorisation/labelling
 - 15.2. Monitoring/managing fit between care needs and provision
 - 15.3. Inside/outside [including between staffing groups, relatives within the home]
 - 15.4. To what extent does organisation have control?
 - 15.5. Negotiating responsibility for resident

- 16. Openness/inclusion of culture [involvement of staff, relatives and other stakeholders in the whole life of the home]
 - 16.1. Community
- 17. Language
 - 17.1. English/non-English
 - 17.2. Descriptive language used (e.g. "behaviour")
- 18. Physical environment
 - 18.1. How is it used
 - 18.2. Location