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'Freedom from and Freedom to': An ethnography of life in care homes in Iraqi Kurdistan

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Abstract

Background: Little is known about the lives of older people who live in Kurdish care homes and very little also about the staff who work within such settings. In addition, there is limited literature exploring any aspects of life in care homes in Iraq in general and Iraqi-Kurdistan care homes in particular. Much of what is known about care home is derived from Western experiences and is based on notions of care in the developed world.

Aims: The study aimed to explore daily life for older people and staff within two care homes in Kurdistan. This included the nature of activities, relationships and the degree to which people engaged in decision making. Furthermore, older peoples' experiences of admission into care was also explored.

Design and Methods: A qualitative design was adopted using an ethnographic approach. The study sought to undertake data collection with both residents and staff using in-depth interviews with 28 participants (15 residents and 13 staff members). In both homes, approximately 140 hours of participant observation were undertaken. These approaches were augmented by using observations, fieldnotes and documentary analysis.

Findings: The ethnographic study identified that the two care homes in the study each had very different cultures. Of these one was termed 'relational' and the other 'organisational'. These two cultures were characterised on the basis of values, policies, level of shared decision making and engagement with the older people and staff within them. Furthermore, admission for all residents were broadly similar as most participants had a very limited role in the choice made about their admission. Residents' perception of admission influenced their initial reaction to the home, with some 'engaging' with

the home quickly whilst others remained somewhat ‘distant’ from it. The subsequent analysis suggested a ‘typology’ of residents who held differing perspectives of life in the care home and these were termed as ‘Embracers’, ‘Tolerators’ and ‘Isolates’. There were differences in the ways the two homes operated, attributable to the differing leadership styles within each of the homes. Daily life was characterised by the degree to which residents and staff felt that they had ‘Freedom From’ unhelpful aspects of their lives and ‘Freedom To’ express choice, continuity and build relationships. The culture of the homes largely determined these experiences.

Conclusions: The study makes an important contribution to knowledge in that it is the first ever of its type conducted in a Kurdish context. The differing cultures identified within each of the care homes determined the experiences of both older residents and staff. Furthermore, leadership and management styles played an important role in contributing to such cultures. Despite a decision not to impose Western notions of care when carrying out this research it is apparent that Kurdish care homes have a lot in common with those already noted within the literature. One of the key implications of the study is the notions of ‘Freedom From’ and ‘Freedom To’ which may have the potential to become a useful heuristic device which may be used to help innovate and evaluate care home practices, not just in the Kurdish region but also elsewhere.

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Dedication

This thesis is dedicated to the one person who always was (and will be) there for me, stood right behind me and encouraged me to achieve my goals but unfortunately he has not been able to see what I have achieved so far. This is dedicated to a truly inspirational man, my Dad.

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List of abbreviations used

Abbreviation	Meaning
CIA	Central Intelligence Agency
HMU	Hawler Medical University
KRG	Kurdistan Regional Government
KRSO	Kurdistan Region Statistics Office
MHL	<i>MyHomeLife</i>
NCHRDF	National Care Homes Research and Development Forum
R	Resident
WHO	World Health Organization
WW II	World War II

Chapter One: Introduction to the Thesis

1.1 Introduction

This chapter provides the reader with an overview of the thesis. It begins by describing my personal and professional motivation for conducting the study in order to provide a context for the work. This is followed by a broader rationale for undertaking the study upon which this thesis is based. Lastly, this chapter closes with an overview of the content of the subsequent chapters that comprise this thesis.

1.2 Personal context, motivation and rationale for the research

This study provides what is believed to be the first systematic attempt to explore the experiences of older people and staff living and working in care homes in Iraqi Kurdistan. As the research was undertaken in a culture that many readers will be unfamiliar with it is important to set the study into both a personal and cultural context. The former is important so that the reader can get a sense of my interest in the subject matter and why I considered it important. The reader would be denied any appreciation of my potential influence on the study if I did not situate myself in relation to it. That is the purpose of this section.

I have a background in nursing and for the seven years prior to undertaking the study I worked as a lecturer in the nursing school at Hawler Medical University in Iraqi Kurdistan, where I focussed on providing undergraduates with an introduction to the care of older people. As part of my role I visited care homes and met residents and staff living and working in these settings, which stimulated an interest in their experiences of living and working in such environments. I was aware that there was an acute shortage of research/discussion about older people in Iraq generally, and particularly in

Kurdistan, with even less being known about what it was like to live and work in a care home, with the perspectives of older people and staff member being largely invisible. At one level this was not surprising as there are currently only two care homes operating in Iraqi Kurdistan (see later) but as the population of older people rises so too will the number of such facilities. Given that care homes are at a very early stage in their development it seemed important to gain a better understanding of how they currently operate in order to potentially influence their future development.

I was particularly interested to explore how the culture operating within the homes influenced the lives of those individuals living and working there. For example, how do older people experience their lives in the home, how do they interact with each other and with staff? In order to appreciate this, I felt it was important to have a picture of how staff experienced their work in such environment. This thesis provides an account of the research journey that I undertook and the insights that have emerged. It is organised in several chapters that are outlined below.

1.3 Structure of the thesis

1.3.1 Chapter Two: Background and Context

This chapter provides a brief history of the Iraqi Kurdistan region and the services that are provided for older people by the Kurdistan Regional Government (KRG). It goes on to give an overview of Kurdish cultural beliefs and values about older people and their attitude towards care homes. This information provides the reader with important insights about the political and cultural context within which the study took place.

1.3.2 Chapter Three: Literature Review

This chapter presents an overview of the role that the literature played in the study and the strategies that were adopted to explore the literature in the field before the study

properly commenced. In particular, it provides a rationale for my decision to focus primarily on early seminal literature arising from Western countries together with more recent developments, particularly the *MyHomeLife* initiative arising from the UK. As will be explained there was no literature emerging from Kurdistan itself and very little from related cultures. Whilst I did not wish to impose western cultural concepts on to a quite different context it nevertheless felt important to understand what might be significant factors influencing life in care homes. Given the very early stage of development of care homes in Kurdistan it seemed appropriate to explore influences on the early development of care homes in other settings. How this was undertaken will be described in this chapter, which concludes by providing the broad research questions and aims that initially drove the study.

1.3.3 Chapter Four: Methodology and Methods

The methodological and philosophical assumptions that underpin the current study are highlighted in this chapter. It also discusses the methods used to collect and analyse the data and the ethical considerations in some detail. In particular, the decision to adopt an ethnographic orientation is considered and how this was adapted to the care home context will be outlined.

1.3.4 Chapter Five: An Overview of the Care Homes

In order to help better understand the main findings, this chapter provides a detailed description of the care homes themselves including the physical layout and environment of the homes studied, staffing roles, and the organisational structure, policies and overall philosophy that the homes adopted. Finally, it provides a brief description of the main actors involved in the form of profiles of the residents and staff who participated in this study in each care home.

1.3.5 Chapters Six, Seven and Eight: The Findings

The findings comprise three main chapters. Chapter six begins with an analysis of the trajectory of admission into the care homes and considers the factors that led older people to enter the care homes. It argues that largely dependent on the extent to which older people felt they played an active role in the decision and whether they could see the admission as of benefit to them or not shaped their initial reactions. Two main groups are identified, the early engagers with life in the home and those who were initially distant from home life. Case studies illustrating these differences are presented.

Chapter seven focusses of how residents and staff, especially the former group, perceive life in the homes on a day to day basis. Building on the ideas of early engagers and remaining distant it is argued that perceptions in the longer term are influenced by two major factors, termed 'Freedom From' and 'Freedom To'. It is suggested that moving into the home provided all residents with a number of 'freedoms from' their previously difficult life situation, such as family conflict, loneliness, accommodation problems and threats to personal safety. It is then further suggested that for certain residents, especially those who actively engaged with life in the home, that moving into the home also provided a number of 'Freedoms To' better their life by, for example, exercising choices, being active and engaged and contributing to life in the home. Based on this a typology of three groups of residents is identified: The 'Embracers', who fully engage with life in the home; the 'Tolerators', who appreciate the 'Freedoms From' that the home provides but see living there as a temporary measure until some better comes along. They therefore 'tolerate' rather than engage with life in the home. The last group, the 'isolates' keep themselves distant from life in the home and rarely engage at all. It is suggested that whilst these groupings are in part determined by residents' perceptions of their lives that the culture of the homes also play a large part. Two broad cultures are identified, the 'relational' and the organisational.

Chapter eight explores these two cultures in greater detail, describing how they are largely shaped by the leadership styles of the two managers and the degree of ‘Freedom From’ unnecessary rules and regulations that staff enjoy and the ‘Freedom To’ take part in decisions, act on their initiative and receive positive feedback about their work.

1.3.6 Chapter Nine: Discussion and Conclusions

Chapter nine concludes the thesis with a consideration of

- The relative quality of the work, together with its strengths and weaknesses
- The extent to which the original study aims have been what new insights the results provide, both for care home sin Kurdistan and further afield
- The implications and recommendations of the study for policy, practice, education and further research.

Chapter Two: Background and Context

2.1 Introduction

This chapter begins with a brief history, geography and culture of Kurdistan as a whole and in particular Iraqi Kurdistan where this study was carried out. In order to set the thesis into context it also considers the demographic ageing of the global population and how this relates to the situation in Iraqi Kurdistan, with particular reference to the role of care homes in supporting older people. An understanding of this is necessary so that the reader can start to appreciate the differences that exist when compared to western culture and the influence that these may exert on interpreting the findings of the research.

2.2 History, geography and culture of Kurdistan

The earliest roots of the Kurdish culture can be traced back 8,000 years to prehistoric Mesopotamia, when the Kurdish people were part of Sassanid Empire which played a significant role in shaping the emergence of Islam and its future history. Since then however the Kurdish people and their culture has had a very mixed evolution, resulting in a fractured population lacking a 'country' to call their own. The turbulent events in the Middle East and West Asia following the demise of the Ottoman Empire and Persian monarchy during the 20th century means that there is now a large Kurdish Diaspora population around the world, totalling 30-35 million people (Mutlu, 1996; Mojab, 1997). The majority live in four countries: 43% in Turkey, 31% in Iran, 18% in Iraq, and 6% in Syria. The Kurdish community is considered to be the fourth largest ethnic group in the Middle East and also the largest ethnic minority without a homeland in the world (Meho and Maglaughlin, 2001).



Figure 1.1 Map of Iraqi Kurdistan

(Maps of world, 2016)

This study is focussed on Iraqi Kurdistan (see map above) and it is to here that attention is now turned. Iraqi Kurdistan comprises parts of the four governorates of Erbil: the capital city (Hawler), Sulaimaniyah, Duhok and Halabja (Kurdistan Region Statistics Office, KRSO, 2015). The Kurdish regional area is located in the northern part of Iraq, along the borders of western Syria, Iran and Turkey in the east and north, lying on the fertile plains that meet the Zagros Mountains (Dahlman, 2002). The Kurdish population in northern Iraq has established its own autonomous government known as the Kurdistan Regional Government (KRG), although Kurdish leaders remain involved with the Iraqi government in Baghdad.

The two official languages in Iraq are Arabic and Kurdish. Kurdish (*Kurmanji*) is widely regarded as being an Indo-European language in origin, bearing similarities to Persian, and it differs sharply from Arabic and Turkish (Broadaway et al., 2006);

however, all three of the latter have influenced the Kurdish language (Dahlman, 2002). Kurds who speak Kurmanji are divided into northern (*Bahdinani*) and southern (*Sorani*) groups (Broadaway et al., 2006; Dahlman, 2002). The majority of Kurds in the Iraqi Kurdistan are Muslim and Sunni, as in neighbouring areas (Mutlu, 1996). Izady (2015) stated that about 60% of Kurds are Sunni, they generally follow the Shafi school of jurisprudence. There are a small number of Shia Muslims, with Christian Kurds and a small minority of Yazidis co-habiting in Kurdistan region.

The total population of the Kurdistan region is 5,472,436 (KRSO, 2015) and whilst the urban population is increasing the rural population still comprises a significant part of the region. The area of Iraqi Kurdistan under the KRG administrated territory is 40,643 square kilometres (KRG, 2016). There are two major types of employment in the region, the governmental and non-governmental employment (i.e., private sector) but there is no official data to quantify them.

2.2.1 Local community attitudes toward older people and care home residents

How societies view older people varies greatly from culture to culture. Kurdish people traditionally value family-centeredness and family members usually have close relationships. Maintaining a tight connection with relatives and keeping in contact with them are central to the beliefs of Kurdish people (Saarinen, 1998; Robson, 1996)

Respecting older people is a key value amongst Kurdish families and supporting and valuing ageing family members, especially parents is a deep-rooted tradition. The duty of children or younger members of the family (brothers and sisters) is to care for their older family members. Even outside the family circle older people generally are valued and their wisdom is held in high regard. Whilst such values may be weakening in the

face of modernization and the adoption of western values they still predominate. Within such a culture the idea of placing an older relative in a care home, evokes ambivalent, usually negative reactions.

However, there is increasing recognition that such homes are required as the number of older people increase (see later) and family conflict in the face of a changing society is now more common. As will become clear later the existing number of homes is very small (two) and they differ markedly in terms of their population from what a western care home would look like. However, despite the perceived stigma of placing a relative in a care home, the homes themselves are seen as important parts of the community rather than being isolated from it. The religious and cultural milieu of Kurdish communities highlights the importance of visiting those who are ill or alone, and care homes may benefit from this (Sharif, 2011). The few anecdotal accounts available suggest that staff work to foster relationships with the local community so that residents can feel a part of it (Abdull-Karim, 2005).

Having provided a brief overview of Iraqi Kurdistan, its people and culture attention is now turned to the older population and the role of care homes. To place this into context the situation in the western world is considered alongside.

2.3 Older people and care homes

Most developed countries have accepted the chronological age of 65 years as a definition of an older person, even though this definition is to some extent arbitrary. However, the United Nations definition of an older person is one aged 60 years or above (WHO, 2016) and this is the one in use in Iraqi Kurdistan. It has therefore been adopted for this study. However, as many discussions refer to people aged over 65 this will be used when adopted by the original reference.

One of the biggest challenges facing the world over the next century is the global ageing of the population (WHO, 2004). The population of people aged 65 and over began to rise rapidly during the latter part of 20th century, both in absolute numbers and as a percentage compared to the younger population (Geirsdottir et al., 2012). Ageing is affecting every country in every part of the world but in differing ways depending upon how long ageing has been occurring and the resources that the country has. According to a report released by the World Health Organization (WHO), it is anticipated that the number of older people aged over 60 will double by 2050 (WHO, 2015) with notable geographical variations in the proportion of older people throughout the world. Generally improving living standards in developing countries in the last century precipitated significant changes in the pattern of health and disease so that people have been living far longer but with increasing numbers of ‘long term’ conditions. Consequently recent decades has seen the emergence of Gerontology where specialists in developed countries began studying all aspects of life amongst the older people population, including physical and psychological changes related to old age and societies responses to these (Park, 2000).

It is generally accepted that most older people would like to live in their own homes for as long as possible and this has become a policy aim in most Western countries. However, as the population continues to age and many people become increasingly frail care homes have a significant role to play in the care of older people, and this role will continue to grow as the population ages each year (Froggatt, 2004). Indeed, it is argued that care homes will continue to provide an essential service for the foreseeable future (Vinsnes et al., 2012). But, as will be explored in the next chapter, care homes occupy an ambiguous position and whilst remaining central to a mixed economy of care they are generally held in low esteem by society as a whole and most older people in particular. This attitude, and the rapidly changing nature of the population of care

homes, exerts a considerable influence on their status, perceived desirability and the way they operate, the impact of which will become clear later.

The above demographic trends have more recently been experienced in Iraq, including the Kurdistan region, which has seen improving medical and social services over the past two decades, in addition to improved standards of living (Alwan, 2004).

As in the majority of developing countries, the population of Iraq is increasing sharply, and the number of older people is also growing. The population of Iraq has grown from 33,765,000 in 2012 (WHO, 2012), to 37,056,169 in 2015 (CIA, 2016). Persons aged over 60 years old and older in Iraq account for 5% of the entire population, which equates to more than 1.5 million people and the percentage of older people aged 60 years and over in Kurdistan is documented as 4 % (Kurdistan Board of Investment, 2015; WHO, 2012), with this figure set to increase rapidly (Alwan, 2004). Whilst for Iraqi Kurdistan the percentage of older people to total population is low compared to more developed countries, the absolute size of the aged population is still considerable and there is only limited provision for them.

One of the main challenges that I encountered during my research was the very limited amount of the information about state provision for older people. No data were found about general services provided for older people in the Kurdistan region. However, based on my own knowledge, the KRG provide no wide range of community or general support services for older people (i.e., social and health services). The Iraqi Kurdistan healthcare system, social services and policy makers have not considered the needs of older people as a subgroup of society potentially in need of dedicated services. But despite this limited attention a very small number of care homes have been developed in Iraqi Kurdistan. Their evolution is considered briefly below.

2.4 Iraqi Kurdistan care homes

As I have already described the official data on services for older people in Iraqi Kurdistan is very limited and what follows below is therefore based on a small number of reports and also articles in the local media (Abdull-Karim, 2005; Sally, 2012).

As part of their humanitarian mandate, the KRG established a limited number of care homes in order to provide support, help and assistance to older people (men and women) in need of care. The first care home was established in Iraqi Kurdistan in 1979, and the second was opened in 1996 under the provisions of the Ministry of Labour and Social Welfare, inaugurating the system of care homes in the Iraqi Kurdistan.

As defined in the care home guidance (No. 2) issued by the Council of Ministers on 25th February 2013, care homes for older people in Kurdistan context are places allocated for the provision of accommodation. On the face of it this appears to be a limited definition of Kurdish care homes, with little mention of health and social care provision. However, the guidance states that the main aims of care homes should include the provision of health, social and psychological care as well as cultural and recreational services. The guidance, therefore, helps in providing us with an extended and more appropriate definition. Working towards protecting older people's identity and enabling those who could not live independently to live a dignified life and to ensure their psychological comfort were other aims of these care homes (Abdull-Karim, 2005). The privacy of older people has become recognised as a vital aspect of quality of care (Helleso et al., 2004) and efforts have been made to ensure that care homes have also become more home-like environments (Hauge and Kristin, 2008). Their primary aim is to meet all the needs of older people, for example, the provision of food, clothing, warmth, environmental support and help with personal care in terms of bathing, washing, dressing and getting in or out of bed, as well as their psychological needs.

How far they are able to do so and what it is like to live and work in such an environment remains unknown. Exploring such issues is the main aim of this study.

Whilst the above is hopefully of use in helping the reader to understand something of the context in which the study was undertaken it is very likely that a reader from a Western, developed country will carry with them an image of a ‘typical’ care home as meeting the needs of very frail older people. The situation as it currently stands is, as far as it is possible to tell, very different in the care homes in this study, where people are generally far younger and more independent. In order to highlight this, I have produced a table below describing the Kurdish care homes in different aspects such as age, gender and physical status of residents. This should be interpreted with caution given the lack of ‘official’ data but nevertheless I believe that it does provide a broadly ‘accurate’ depiction.

Table 2.1 Care homes in Iraqi Kurdistan

Items	Kurdish care homes
Age of residents	Older people aged over 60 or 50 (for men and women respectively), with some flexibility in admission criteria.
Gender	Male and female residents are accepted but the numbers of male residents are higher compared to female residents. Staff of both genders work in care homes, with the majority of them being male.
Health/physical status	Most of the residents are independent in terms of daily living activities in which they can eat, wash, dress, and do their shopping independently.
Number of care homes	There are only two care homes across the Iraqi Kurdistan region. Two main cities in Iraqi Kurdistan
Cost of care	Free. All the services provided by the Kurdistan regional government are free. For example, accommodation, food and health services. Besides that the residents are receiving monthly stipend from government.
Provider	Government provision only. Receiving support from some charities.

In order to better understand the conceptualisation of Kurdish care homes within the international provision of service integrated housing for older people, it is important to refer to the work of Howe et al. (2013) in which they analysed over 90 approaches to the care of older people identified in literature from the UK, the US, Canada, Australia and New Zealand. Howe et al (2013) grouped terms into three major types: ‘services focusing on life style and recreation, services providing support and service providing care as well as support (see Table below comparing terms for different types of service integrated housing offering different levels of support and care). Kurdish care homes could be located within the third of these types, in which both care and support are provided for older people. Kurdish care homes could be parallel to ‘assisted living facilities’ in which four distinguishing characteristics of this type of service were mentioned by Howe et al (2013) and these are:

- *“A residential rather than a medical or institutional physical form and operational culture;*
- *Provision of a wide range of services including meals, personal care, medical assistance, housekeeping, social activities, transportation and security;*
- *Residents who are characterised as ‘semi-independent’ in the sense that ‘with assistance, they can complete daily routines in a residential environment without requiring skilled [nursing] care’; and*
- *Making neither an explicit or implied commitment to provide continuing care to meet increasing care needs, nor having the capacity to provide such care”*
(Howe et al., 2013, p.24).

Table 2.2 Comparisons of terms

Same/similar terms applied to same/similar forms	Different terms applied to similar forms
1. Terms for service integrated housing offering lifestyle and recreation	
Retirement community Retirement village	US: Retirement resort; Active adult retirement community; Leisure oriented retirement community; Retirement town/new town; Retirement housing for special affinity groups Australia: Lifestyle villages Canada: 55 plus retirement community
2. Terms for service integrated housing offering support services	
2a. Independent living in private dwellings	
Independent living facility (ILF), Independent living unit (ILU) Self care unit in a retirement village	Retirement village; Vertical village/retirement condominium; Affordable rental villages UK: Sheltered housing, warden supervised US: Mobile home/trailer park UK: Park-homes Australia: Residential park; Manufactured home estate
2b. Shared housing	
Agency assisted shared housing	Board and care home; Boarding house/rooming house US - Single Room Occupancy (SRO) Hotel
3. Terms for service integrated housing offering support and care services	
3a. Housing with support and care	
Assisted living facility (ALF) Services/assisted living apartment	US: Congregate seniors' housing; Service coordinators; Supported housing Community residential care, incl. adult family homes and adult residential care; Housing-care UK: Very sheltered/ extra care housing; Service-enriched housing; Close care/ flexi-care/integrated care; Supported housing; Flexi-apartment Canada: Supportive seniors' housing NZ: Supported independent accommodation European countries: Service housing; Service flats (Denmark); Heavy service housing (Finland); Small group housing (Sweden)
3b. Housing with continuing care	
	US: Continuing care retirement community; Life care community UK: Retirement community/ village; All age community Australia: 3 tier complex; Continuum of care; Ongoing care

Adapted from Howe et al. (2013)

The aim of this introductory chapter has been to provide a background and context for the study. In doing so it has presented a brief history of Kurdistan, the cultural value accorded older people in Kurdish society and the emergence of care homes. Broad comparisons have been made between the situation in Iraqi Kurdistan and the 'West',

especially the UK. The next chapter presents an overview of the literature on care homes, primarily from an historical perspective based on seminal literature arising mainly from the UK and the USA.

Chapter Three: An Overview of the Literature

3.1 Introduction

As will be described later given the lack of prior research into care homes in Iraqi Kurdistan this study adopted a qualitative approach, informed by the principles of ethnography. The role of the literature in qualitative research has been, and remains, contested. Some authors, such as Glaser and Strauss (1965) argue that no literature should be consulted until data collection and analysis are completed. This position is linked to strongly held philosophical and methodological beliefs. Others, such as Morse (1994), contend that an understanding of the literature is required before any study starts, not only to justify the need for the study and to secure funding and ethical approval for it, but also to avoid ‘reinventing the wheel’ by replicating what is already known. The role that the literature should play in my study was even more complex because the existing literature on care homes in Iraq/Kurdistan in particular and Arabic cultures in general was virtually non-existent.

An initial search using electronic databases (CINAHL, MEDLINE and PsycInfo) was undertaken in order to identify relevant articles regarding experiences of residents and staff living and working in care homes from the national and international literature (see Appendix F for the flowchart of literature searching). Different key words and synonyms were used in the search. In addition, other search techniques were used to identify any related information concerning older people and care homes, such as local newspapers and reports published in Kurdish and Arabic languages and Google scholar. The search of both the academic and popular literatures, in Arabic and English, concerning older people and staff in care homes in Middle Eastern countries failed to reveal any studies, nor were there any real insights to be gained from sources such local newspapers. Consequently, no literature could be found exploring any aspects of life in

care homes in Iraq in general and Iraqi Kurdistan care homes particularly. The vast majority of the available literature focused on care homes for older people in the UK, North America and other European countries. As a result, the literature is heavily dependent upon both Western cultural notions of care and systems of care provision which might be of questionable relevance to my study but also potentially bias it by imposing Western cultural concepts.

In addition, there is limited international literature exploring residents' perspectives of living in care homes including nursing and residential care home settings, with the exception of the following studies being identified during the search. For example, in Lebanon, a study explored residents' perspectives of quality of life in two care homes (Adra et al., 2015). A study conducted in Iran focused on the living conditions of nursing home residents in Tehran and found that most of the participants had no relationships with outside the nursing homes and were least visited by their relatives (Sheykhi, 2004). Another study conducted in China to explore Hong Kong Chinese older people adjustment to nursing home life by Lee et al. (2002). The key finding was that after admitting to nursing homes, older people adjusted through different stages of "orienting", "normalizing", "rationalizing", and "stabilizing" and struggled to "gain normality" with their pre-admission life (Lee et al., 2002, p.667). In Taiwan, Chao and Roth (2005) conducted a qualitative study exploring Taiwanese residents' perception of care in a long-term care facility. Residents considered attitudes of care providers as the most important aspect of quality care in long-term care facilities.

As noted in the last chapter there are currently only two care homes for older people in Iraqi Kurdistan and these are significantly different from such homes in Western countries on several fronts. As illustrated in the previous chapter the resident population is significantly younger than the UK and less frail, both physically and cognitively and

there is a far greater proportion of male residents and staff. Such differences perhaps reinforced an argument for me not to consider the Western literature. On the other hand, despite the very limited provision in Kurdistan there has been a shift in the ethos of, and rationale, the care home in recent years towards promoting the social, psychological, physical and cultural well-being of care home residents in Kurdistan and ensuring that their privacy and dignity are met. Such values and aspirations accord with those espoused in the Western literature, perhaps suggesting that valuable insights to guide the study might be provided from a consideration of this body of work.

A decision was therefore made to consult this literature, not to dictate the direction of the study but rather to enable me, as Morse (1994) suggests, 'To recognise leads but not be led'. In reaching this decision, and in discussion with my supervisors, it was considered appropriate to focus primarily on early studies from the Western literature on care homes emanating from the late 1950's to the mid 1990's. Such literature, it was felt, would capture the early evolution of care homes in these countries at a time when they probably more closely reflected the stage of development in Kurdistan at the moment. After a consideration of this early literature, for reasons that will be discussed later, focus was turned to the major review carried out during the initial stage of the *MyHomeLife* project (Help the Aged, 2007).

Following this rationale attention is first turned to a consideration of what might be termed the 'early literature' on care homes in Western countries.

3.2 The 'Early' literature on care homes: A western perspective

A consideration and analysis of the early care home literature provided a number of important methodological and conceptual insights that helped to shape both the

approach taken to conducting the study and the broad questions that it sought to explore. These are outlined below, starting with methodological considerations.

As Peace et al. (1997) note it was only during the late 1940's and early 1950's that the provision of 'institutional' care for older people became a suitable subject for political, and later intellectual, debate. Policy developments in the UK following the more widespread state provision of health and social care for older people after WW II witnessed a great increase in the numbers of care homes for this population. Concerns over the quality, cost and quantity of such provision led to one of the earliest, and indeed seminal studies, of such care, at least in the UK, carried out by a team led by Peter Townsend. This resulted in the publication of his book 'The Last Refuge' (Townsend, 1962) which has been described as "*The most influential empirical study of residential care for older people in a century of debate*" (Peace et al., 1997 p.9). Its intellectual contribution will be considered shortly. Although primarily a large scale survey of care home provision in England and Wales it was important methodologically in that it also comprised a qualitative element from which many of its most telling insights arose. The central importance of qualitative research to a full understanding of life in care homes arose largely from this study and has manifest itself in studies in the UK, North America and further afield ever since.

In the US the adoption of qualitative methods was heralded by the emergence of 'Nursing Home Ethnography' in the 1970's (Hendrick, 1980), a movement which generated studies of 'evocative power and critical significance' (Henderson and Vesperi, 1995). Studies such as 'Living and Dying in Murray Manor' (Gubrium, 1975) and 'Making Gray Gold' (Diamond, 1992) applied principles of what became known as the 'new ethnography' (Gubrium, 1975) that focussed not on the views of expert researchers but rather sought to capture 'participants' own versions of their worlds'

(Gubrium, 1975). Such participants included not just older people but also staff at all levels who worked in such homes. The intent, as Diamond (1992) notes, was to ‘Open windows (into life in care homes) from the inside’. Such developments were mirrored in the UK during the 1970’s to the mid 1990’s with the goal being to ‘Open up’ care homes (Stanley and Reed, 1999) and in so doing to explore the complexity of life within them and the factors that shape it. Within such a paradigm the care home becomes a living and working environment the culture of which is ‘created’ by multiple actors (Willcocks et al., 1987) and their interactions. Consequently, subjective meanings take on considerable importance as “*A single nursing home might, from the point of view of its participants, be several quite different organisations*” (Gubrium, 1993, p.26). From such a perspective the care home is “*.....storied, transacted, layered with ambiguity... and ultimately given life through perspectives of interpretation*” (Maines, 1993, p.35). It is such potential complexity and richness that I sought to explore and, as will be argued more fully later, my study was therefore influenced methodologically by these early studies from the UK and North America.

In addition to providing methodological direction such studies gave me several conceptual insights that provided a number of broad roads to potentially follow.

3.3 Conceptual insights from the early literature

As noted above the first large scale exploration of residential provision for older people took place between 1958 to 1959, when Peter Townsend and colleagues completed a major study of so called, ‘institutional’ care, for older people in England and Wales.

Townsend examined whether long stay institutions for the older people were needed and, if so, whether improvements could be made to the nature of such provision. The research was markedly innovative in both its scale and its use of qualitative research

methods including face-to-face interviews and observations. Photographs and field notes regarding the situation of the buildings and the facilities were also included in the data collected.

In his findings Townsend (1962) pointed out that several elements play a part in shaping the lives of older people in institutional care, beginning with the admission process and how peoples' applications for care are handled. Generally, he found that the older people entering care had no choice of homes and usually priority was given to the homeless and those frail persons who were living alone. The main reasons older people entered homes at the time were identified as follows: lack of close relatives and friends, loss of supporting relatives, separation from family and community, difficulties of living with family members, consequences of isolation, and financial insecurity which could result in homelessness or inappropriate housing conditions without adequate facilities.

After admission life in the homes varied according to the nature of the physical environment and the characteristics of the residents and the staff but generally the residents enjoyed certain benefits that they might not have had before such as a regular diet, warmth and a degree of physical comfort and security. However, Townsend (1962) argued that this came at a price in terms of: lack of privacy; loss of identity; lack of self-determination; instability of relationships, and loss of occupation. In his conclusion to the book in a section entitled 'Developing Future Policy' Townsend (1962) suggested some fundamental principles that should underpin all policy for the 'aged' in order to avoid, or at least reduce, the above negative effects, irrespective of whether people lived in their homes or a care home, these were:

(1) "Enlarge, or at least preserve, the individual's degree of freedom and powers of self-determination;

- (2) Help him to retain his personal identity and respect his need for privacy;*
- (3) Safeguard or, if necessary, restore his health and his capacity to undertake personal and household activities;*
- (4) Help him to live as independently as possible in a home of his own;*
- (5) Ensure that he has adequate means of occupation;*
- (6) Make it possible for him to maintain his relationships with his family and friends and with the community with which he is familiar;*
- (7) Make it possible for him to establish new social relationships;*
- (8) Protect him from a serious divergence in income from levels enjoyed by those at work; and*
- (9) Equalize the facilities and resources available to different categories of the handicapped, the poor and the sick, irrespective of race, origin of class”*
(p.192).

It might be argued by some that such aspirations have still to be met. At the time of his study the title of Townsend's book 'The Last Refuge' mirrored the overall largely negative tone of his report and its publication was followed in the UK by studies such as 'Sans Everything' (Robb, 1967) which reinforced such sentiments. Such a negative image was not confined to the UK with studies of such care in the US emerging which also used highly emotive titles such as 'Hell's Vestibule' (Henry, 1963). Townsend's work set the tone for much of what was to follow for the next decade or so. But also, as already noted, it highlighted the importance of qualitative methods as well as pointing out that the factors shaping how people lived in care homes began before admission and were influenced by a number of things subsequently, central to which were the

interactions between residents and residents and staff. The idea that differing homes created very different experiences for older people and staff depending on the 'culture' in operation, which had emerged in the late 1950's from seminal studies such as Goffman's (1968) 'Asylums', was reinforced.

The 'New Ethnography' which emerged in the US in the 1970's was intended to challenge the largely negative image of care homes for older people prevalent at that time (Henderson and Vesperi, 1995) by exploring in depth the subjective worlds of residents and staff in order to unpack the complexity of life in such places and to seek to understand how even within one home life could be good for one person yet the opposite for another. A number of studies in the US (Gubrium, 1975; Hendrick, 1980; Diamond, 1992), together with distillations of this work (Henderson and Vesperi, 1995) and programmes of work in the UK carried out by CESSA (Willcocks et al., 1987) and later by the 'Caring in Homes' initiative (Youll and McCourt-Perring, 1993) and a synthesis of such work to date (Peace et al., 1997) reached broadly similar conclusions that built on and expanded the early conclusions of Townsend (1962).

As with Townsend's work the above studies stressed that a full understanding of how older people live in care homes can only be reached by including a consideration of 'their prior lives' (Gubrium, 1993). As Willcocks et al. (1987) assert older peoples' lives prior to admission are of 'central importance' because:

'In order to understand what residential care means to older people it is important not just to consider the characteristics of the residents themselves but also to examine the process of becoming a resident' (Willcocks et al. 1987, p.31)

Just as Townsend had noted Willcocks et al. (1987) reasserted that many older people enter care because they are frail or fearful and they hope to exchange this for a better life. Their prior life often shapes their expectations of life in the home as they 'usually

compare their situation with their previous living arrangements' (Youll and McCourt-Perring, 1993). How this operates at an individual level, and the impact that expectations of life in a home exert, was captured eloquently by Gubrium (1993):

“...to be a ‘nursing home resident’ means something personally positive for Martha Gilbert who never had a home to speak of ...and something quite the opposite for Rebecca Bourdeau who left a loving home.” (p.179)

The importance of capturing the way in which the older person entered care was one of the key conceptual points that I took away from this early literature.

Subsequently life in the home is, again as Townsend noted, influenced by the nature of the physical environment, a point reinforced by subsequent studies and synthesis of existing work (Willcocks et al., 1987; Peace et al., 1997) and this was something of which I needed to take account. Over time the trend was clearly to move away from larger communal living, and especially sleeping, spaces, towards more personal areas that allowed greater privacy and individuality. The challenges this poses was succinctly captured in the title of Willcocks et al., (1987) work ‘Private lives in Public Places’. Such a desire for greater privacy has recently become apparent in care homes in Kurdistan and has influenced their physical environment as described in the previous chapter.

Notwithstanding the role of the physical environment Townsend (1962) highlighted the central role played by personal relationships in creating life in a care home and most of the work since has reinforced this. Studies on both sides of the Atlantic have stressed the need to understand the perspectives of multiple actors and their interactions (Gubrium, 1975, 1993; Diamond 1992; Willcocks et al., 1987; Youll and McCourt-Perring, 1993; Peace et al., 1997). In ‘opening up’ life in a care home Stanley and Reed (1999) stressed the need to understand the interpersonal processes that operate between

residents themselves, staff and residents, and between staff. This was described as the ‘narrative of relations’ by Diamond (1992) with all actors, but especially staff, being seen as the ‘creators’ of care (Willcocks et al., 1987). Moreover, authors suggest that staff should not be seen as a homogenous group with Gubrium (1975) arguing that there are both ‘top staff’ and ‘floor staff’ and as Youll and McCourt-Perring (1993) assert it is staff ‘at the bottom of the ladder’ (or floor staff for Gubrium) who deliver most of the care and who ‘really’ understand what is going on. Therefore, obtaining their perspectives, as well as those of staff in managerial or higher roles, is essential to a full understanding of life in a care home (Willcocks et al., 1987; Diamond, 1992; Youll and Mc Court-Perring, 1993; Peace et al., 1997). It is suggested that the culture in the best care homes will create an *“explicit balance so that no one groups’ interests are denied, subverted or suppressed”* (Peace et al., 1997, p.121). What emerged clearly from a consideration of this early literature was the potential existence of different ‘worlds of interpretation’ between, and even within, care homes (Gubrium, 1993) and that care is ‘created’ by the interactions of the main actors. Such interactions largely determine the ‘culture’, or cultures, operating in different homes (Gubrium, 1993). As will be noted later this idea of a ‘culture’ of care has become increasingly important.

A consideration of this early literature therefore highlighted a number of key methodological and conceptual points that played an important role in shaping my study. These can be summarised as follows:

- That important insights can be gained from using a qualitative approach informed by the techniques of the ‘new ethnography’;
- The need to understand the route by which older people enter a care home;
- The need to consider the role played by the physical environment;

- The central importance of capturing the perspectives of multiple actors and their interactions in order to understand the ‘culture’ of care operating within a given care home setting.

Another important source of insights informing the study came from the ‘MyHomeLife’ project (Help the Aged, 2007).

3.4 The influence of the *MyHomeLife* Review

Despite the extensive work undertaken in both the UK and North America described above the care home continued to occupy an ambiguous position in peoples’ minds and, due largely to the promotion of a policy of community care, was seen as an option of last resort by most older people and their families (Nolan et al., 1996). Few entered a care home as the result of a ‘positive choice’ and for the majority it was a ‘fait accompli’ (Nolan et al., 1996). However, despite a policy of community care the increasing age and frailty of the older population meant that care homes remained an essential element in a balanced provision of care.

Concerns about quality of life in care homes remained and indeed increased in the 21st century and consequently, as a key part of their policy work, ‘Help the Aged’, a major charity in the UK, launched the *MyHomeLife* project (Help the Aged, 2007). The overall aim of the project was to build on the knowledge and experiences of older people, staff, families and researchers about what it is like to live, work in and visit care homes and to use this knowledge to make a difference for the better. One of the first tasks of the project was to undertake a comprehensive review of knowledge in the field and this was completed by the newly formed National Care Homes Research and Development Forum (NCHRDF). In undertaking this review 57 ‘experts’ in the field shared their knowledge. A synthesis of this knowledge was then completed by a core

group of individuals on behalf of the project and a major report was published (Help the Aged, 2007). This represents probably the most comprehensive review and synthesis of its kind ever undertaken and it was felt that this would provide me with a ‘state of the art’ understanding of recent thinking that might provide several insights to guide my project.

In bringing together the review the core team identified a number of themes that helped to capture the key findings, these were:

- Quality of life and quality of care
- Transitions into a care home
- Working to help residents maintain their identity
- Creating community within care homes
- Shared decision-making in care homes
- Making the workforce fit for purpose
- Health and healthcare services
- End-of-life care
- Promoting positive culture in care homes

As will be appreciated these themes mirror some of the insights gained from the earlier literature, for example the importance of the transition into the home, the idea of residents and staff shaping the ‘culture’ within the home (for example decision making) and the need to create a positive culture. Some of these themes, for example ‘end of life care’, were not the focus of my work due to the younger and fitter population of care homes in my study. Others, such as health and healthcare services, were based largely on Western systems of provision and were therefore of little relevance to the situation in Iraq. However, the other themes were thought to be of potential use and were

considered carefully to see what additional insights they might provide. The main points are outlined below.

Upon closer inspection of the review it was apparent that the themes of *MyHomeLife* (MHL) review potentially provided a very useful framework to guide the development and direction for my study, especially as they related quite clearly to the nature of care environments from the perspectives of older people and staff. I found that the MHL review was the best available analysis of the literature and it provided me with several important insights. Within the MHL review, the experience of older people moving into and living in a care home and staff working in a care home was considered in several circumstances. In addition, an underpinning theme throughout the MHL review was the importance of relationships between residents and staff in improving the care home environment. This was again consistent with much of the earlier work. The following broad themes were therefore used to help inform my study:

- Transitions into a care home
- Working to help residents maintain their identity
- Creating community within care homes
- Shared decision-making
- Promoting positive culture within care home

The following sections presents these themes in more detail.

3.5 Transitions into a care home

The MHL review authors highlighted the importance of the older person planning their decision-making prior to the transition into care homes together with significant others including: relatives or carers; social and health care professionals; and staff members in care homes. However, this is often not achieved in reality and consequently older

people usually do not have adequate knowledge to make an informed choice about entering the home. Moreover, admission is often rushed, having taken place at a time of crisis with older people often not feeling well supported when making their move. The review recommended that much more attention should be given to the transition into care and that a culture of partnership and sharing be created. The importance of creating a culture of mutual collaboration was to appear repeatedly throughout the review.

Therefore, one of the key messages for best practice from the MHL report was the impact of the transition into a care home. The move should be acknowledged as a major transition in the life of older people and one that may involve considerable losses. However, the authors argued that with proper planning and support the transition can be considerably improved so that entry to care becomes a positive option bringing with it new opportunities. This should help to establish an older person's identity from the outset, maintenance of which is another key goal of care.

3.6 Working to help residents maintain their identity

Another aspect central to shaping residents' lives in care homes is maintaining their identity. The MHL review concluded that moving into care homes can affect an older person's identity in different ways. The culture of the care home including its settings and environment may bring about discontinuity and alter an older person's existing relationships with families and friends. For example, the physical characteristics of care homes and/or the nature of organisational routines may be important and the degree physical and cognitive frailty can provide challenges to the older person's identity.

The MHL review concluded that an essential element of maintaining identity in a care home context is the adoption of suitable models of care, such as person-centred or relationship-centred care that enable residents to be themselves and provide them with

the opportunity to link their past experiences with their present life. Such models of care value older people and treat them as individuals. A person centred or relationship centred approach relies on good communication between care home residents and staff and the MHL review promoted biographical approaches to care where residents, family members and staff are involved in discussing how care is to be delivered and how to maintain continuity between the past and the present.

However, it was also recognised that such models of care have an impact on staff as they are emotionally demanding. This needs to be recognised and staff members have to be adequately supported in meeting the multifaceted challenges they face. Person and relationship centred models therefore have to lie at the heart of the culture within the care home.

On the basis of the research reviewed important characteristics of a person/relationship centred culture within care homes emerged including: choice, rights, independence, identity recognition, autonomy and expression of beliefs. These issues need to be tackled by adopting an appropriate approach culture of care, one that the MHL report equated with creating a ‘community’.

3.7 Creating community within care homes

The idea of making care homes feel like ‘home’ for residents has been advocated for many years, but the MHL review argued that this might not be an appropriate goal as there are clear differences between home as a private space and living within a communal setting. As an alternative the review suggested that a more relevant goal would be to move towards “*creating care homes as ‘communities’*” (p.65). In order to create community in care homes it was argued that six broad processes need to be

adopted by residents, their relatives and staff, who can all make a contribution to creating community.

These processes were described as follows:

- *“understanding and respecting the significance of relationships within care homes*
- *recognising roles, rights and responsibilities*
- *creating opportunities for giving and receiving*
- *creating opportunities for meaningful activity*
- *building an environment that supports community*
- *having a commitment to shared decision-making” (p.66).*

Central to creating a sense of community is the quality of the relationships between residents, their families/relatives and staff, highlighting the interdependence of staff, residents and families as an important value in creating a positive culture. Therefore, this interdependence needs to be nurtured. In order to do this the MHL review advocated the use of the model of relationship centred care developed by Nolan and colleagues (Nolan et al., 2001). Central to this model is the ‘Senses Framework’ intended to promote positive experiences for residents, staff and families. There are six ‘senses’ which capture the perceptual and subjective nature of creating an ‘enriched environment’ of care, not only for older people but also for their families and staff members working there. The six senses described as follows:

- a sense of **security** (to feel safe);
- a sense of **belonging** (to feel part of things);
- a sense of **continuity** (to experience links and connections between past, present and future);

- a sense of **purpose** (to have a goal(s) to aspire to);
- a sense of **achievement** (to make progress towards goal(s)); and
- a sense of **significance** (to feel that you matter as a person).

The ‘enriched environment’ fostered by these senses ensures that the needs of all stakeholders are acknowledged and addressed. This is seen as essential to creating a ‘community’ within the care home, especially one in which there are opportunities for shared decision-making between residents, staff and families. Consistent with a relationship centred model the MHL review asserts the importance of involving all the stakeholders (families, residents, and staff) in decision making and recognising and valuing everyone’s contribution so that care homes can function as communities. However, it also recognised that ‘community’ is a complex concept and building on earlier work by Davies (2001) the review team promoted the development of a ‘complete community’, one of three community types in care homes identified by Davies (2001). These were described as the: controlled community; the cosmetic community; and the complete community. These are briefly outlined below.

3.7.1 Controlled community

Based on her detailed study of three care homes Davies (2001) described the primary objective of the controlled community model as promoting safety and control, often at the expense of personal autonomy. Work is organised in order to achieve a series of tasks, most of which have to do with meeting the basic physical necessities of life rather than addressing the social and emotional needs of residents. The culture of care is therefore largely a ‘controlling’ one, with power vested in staff in a top down fashion. The home also largely operates in isolation, not engaging with the local community outside its bounds (Davies, 2001). In terms of the ‘senses’ there is little feeling of belonging and security is weak as staff and others feel open to criticism. There is

continuity of care but only because physical routines dominate and the sense of purpose and achievement for staff is determined by whether things get ‘done on time’. Little attention is given to creating such senses for residents or families. Such a community would be seen as primarily ‘impoverished’ (Nolan et al., 2004).

3.7.2 Cosmetic community

This approach to care adopts the principles of the modern service industry, such as hotels and travel services. It focuses on individual need rather than those of the wider community and according to Davies (2001) is a reflection of the business culture that has developed in the care home industry, emphasizing service specifications and the need to demonstrate concrete, measurable services and outcomes. However, the cosmetic community is likely to appeal to some older people and their families, especially since it is premised on the illusion of the ‘customer’ retaining control (Davies, 2001). Despite this real control remains vested with staff and the culture of care revolves around creating a neat and orderly environment. Once again the creation of the ‘senses’ is limited.

3.7.3 Complete community

In contrast to the above the complete community is quite different as it is relationship-based and community focused. The culture of care is aimed at enabling and nurturing residents to achieve their best quality of life whilst also recognising the needs of staff and families. The main approach to care is based on: enablement and partnership; effective teamwork with mutual appreciation and blurring of roles; relatives are seen as essential team members; interdependence is an important value; and there are close links to the local community. Relationships between residents, staff, relatives and local community dwellers are fostered and encouraged. As a consequence a community is

created in which each member is equal and seen to make a significant and valued contribution (Davies, 2001). Within such a community all groups are far more likely to experience the ‘senses’ and an enriched environment is created. The figure below provides a visual representation of these three types of community.

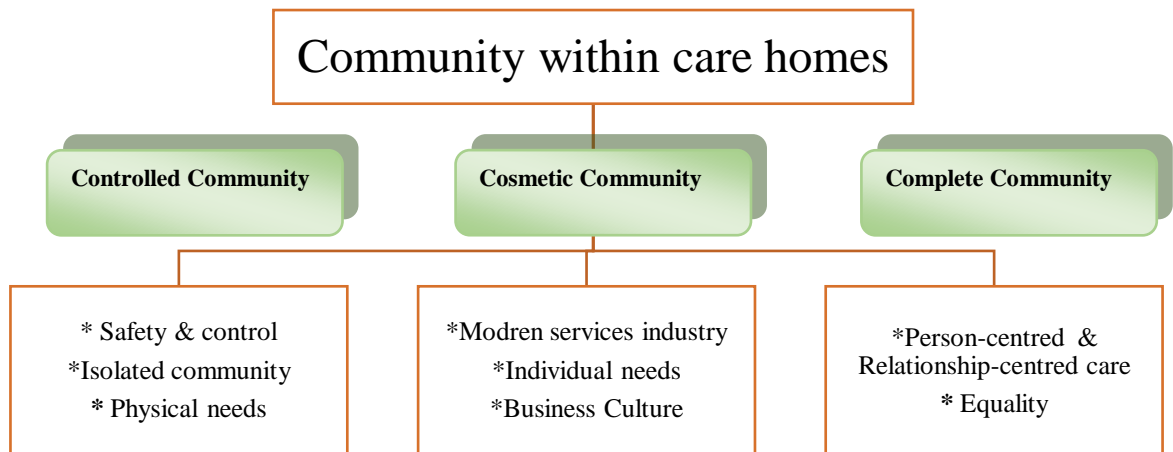


Figure 3.1 Types of community in care homes

3.8 Promoting a positive culture

As will be apparent by now the concept of ‘culture’ is one that has appeared regularly in the care home literature. From the early seminal works to the above review it is clear that how life is experienced within a care home is shaped by several complex factors. Whilst the nature of the physical environment is important it is the interactions and relationships between residents and staff, and to a lesser extent families, that largely shape the culture of care. Over time, at least in principle, the philosophy of the care home has also shifted away from a semi custodial one with an emphasis of physical

needs to one in which quality of life for residents and quality of working lives for staff have become pre-eminent. However, achieving these goals has proved very difficult in reality, largely due to the poor image of the care home and its relative undesirability as a place to live and work. The primary aim of the MHL report was to promote a vision of the care home as a positive place to live, work and visit and to connect care homes to the wider community. Central to this was the need to create a 'positive' culture' within care homes. The concept of culture is a complex one and an agreed definition remains elusive (Patterson et al., 2011). Rather than attempting a definition the chapter on culture within the MHL review instead elaborates upon the characteristics of a positive culture which are seen to be:

- Person and relationship centred
- Fostering a 'complete' community
- Recognising the complex and multidimensional nature of life in a care home
- Has interdependence as a core value. (Dewar, 2007)

The MHL movement is aligned with the culture change movement in the USA (Meyer and Owen, 2008) which asserts that the degree to which personal expectations are met in care homes is determined largely by the distinctive culture that develops in each setting. Too often, in both the US and the UK, the dominant culture usually reflects a set of criteria determined by quality inspection regimes that focus on physical characteristics of the home and the 'basics' of care. MHL sought to promote a much more multidimensional approach based on the dimensions of a positive culture outlined above.

The MHL review reinforced the key insights emerging from the early literature but expanded upon these by recommending specific models by which to achieve its goals, such as relationship-centred care and the promotion of a complete community. The key

concept was the notion of culture and how this is created and sustained by the interactions of all those involved in the life of the care home.

The paucity of research or wider literature on care homes in Iraq/Kurdistan has already been highlighted, as has my decision to look to the early Western literature and the more recent MHL review to see if there were pointers that might inform my own study. Given that my study would be relatively unique I was conscious of the importance of not imposing Western cultural ideals of the situation in Kurdistan but at the same time did not want to miss any potentially useful 'leads'. Given the important insights that are gained by qualitative methods and the importance of exploring 'culture; to understanding life in care homes a decision was made to adopt a qualitative approach informed by the principles of the 'new ethnography'. It was clearly important to try and capture the perspectives of the key players and to locate older peoples' lives in care home in the context of their earlier lives and how/why they entered the home. On the basis of this the following broad set of questions/aims were decided upon:

3.9 Research questions

- How do residents and staff perceive their life within Kurdish care homes?
- How does the 'culture' in Kurdish care homes influence the experiences of residents and staff members?

3.10 Aims of the study

To explore:

- The trajectory of older peoples' admission into a care home.
- Life in the care home from the perspectives of older people and staff.
- How residents and staff relate to and interact with each another.

- How these interactions shape the culture in Kurdish care homes and how this culture influences the lives of those living and working there.

The next chapter describes the methodology and methods used to explore these issues.

Chapter Four: Methodology and Methods

4.1 Introduction

This chapter starts by restating the aims of the study prior to outlining the methodological and philosophical assumptions underpinning it. In particular, it provides a rationale for the selection of a qualitative approach, informed by the principles of the ‘new ethnography’ (Gubrium, 1975). Subsequently attention is turned to the nature of the research process, the recruitment of participants, the collection and analysis of data, ethical considerations and the finally, the quality criteria that will be applied to the current study are briefly discussed.

Aims of the study

As noted in the previous chapter the overall aims of the study and the questions that it sought to address were shaped following a consideration of the ‘early’ literature on care homes, mainly from the UK and the US and the more recent MHL review. The aim was not to impose the findings of this largely ‘western’ literature on the present study but rather, in the absence of literature from an Arabic perspective, to identify potential leads that might inform the study but without being led by the extant literature (Morse, 1994). As a result of this process the following were decided upon as a starting point for the study:

Overall questions

- How do residents and staff perceive their life within Kurdish care homes?
- How does the ‘culture’ in Kurdish care homes influence the experiences of residents and staff members?

Broad aims of the study

To explore:

- The trajectory of older peoples' admission into a care home.
- Life in the care home from the perspectives of older people and staff.
- How residents and staff relate to and interact with each another.
- How these interactions shape the culture the Kurdish care homes and how this culture influences the lives of those living and working there.

4.2 Methodology

Given the above aspirations the best approach to achieving the study goals had to be decided upon. This required a consideration of the methodological approach to be adopted. Methodology is the framework of theories and principles on which methods and techniques are based (Holloway, 2009). There are several methodological frameworks that can be applied. One of a variety of approaches that can be used to answer research questions is the conventional scientific method (i.e. the quantitative paradigm), which depends primarily on precisely stated hypotheses and their testing, largely using numerical measurement. Whilst this has long been held as the 'gold standard' in 'traditional science' its appropriateness for questions concerning 'social life' has been questioned for many years.

Building on earlier sociological writings nursing researchers since the 1970's have increasingly acknowledged that many of the questions and issues that they sought to address could not be answered by using quantitative methods. This concern led researchers to explore methodologies that enabled them to provide a more in-depth understanding of individual experience and behaviour. Falling under the broad heading

of ‘qualitative’ methodology such approaches adopted more inductive, holistic and interactive principles. The qualitative ‘paradigm’, as it became known, uses several flexible methods of data collection and analysis and itself comprises several varying positions (Parahoo, 2006; Creswell, 2007).

Ritchie and colleagues (2013) report that qualitative research is a very “*broad church*” that involves a variety of methods and approaches adopted by diverse research disciplines. They also point out that qualitative research generally is described as an interpretative and naturalistic approach that explores and examines the phenomena of interest from the ‘inside’, taking the perspectives of study participants “*as a starting point*” (Ritchie et al., 2013).

In addition, Denzin and Lincoln (2011, p.3) suggest that despite the inherent diversity in qualitative research, many approaches share some common precepts which they describe as:

“A set of interpretive, material practices that make the world visible. These practices transform the world. They turn the world into a series of representations, including fieldnotes, interviews, conversations, photographs, recordings and memos to self ... qualitative researchers study things in their natural settings, attempting to make sense of or interpret phenomena in terms of the meanings people bring to them”.

In seeking to bring together the variety of methodological approaches available Lincoln and Guba (2000) summarised the main paradigms as ‘positivism’, ‘post positivism’, ‘critical theory’ and ‘constructivism’.

The choice of a specific research paradigm, or world view, depends on specific assumptions concerning three philosophical questions: first, the ontological question

(what is the nature of reality?), second, the epistemological question (what is the relationship between the researcher and participants?), and finally, the methodological question (what are the methods used to obtain knowledge?).

Given the nature of the questions that I wished to address the qualitative paradigm seemed the most appropriate and of the above broad divisions constructivism appealed the most. Snape and Spencer (2003, p.12) define constructivism in the following way, considering it as “*displaying multiple constructed realities through the shared investigation by the researchers and participants of meaning and explanations*”. Guba and Lincoln (1989) consider that this paradigm has (i) a relativist ontology where the world comprises multiple realities constructed by individuals in a particular place and time, rather than being absolute; (ii) a subjectivist epistemology where knowledge is created conjointly through the interaction between the researcher and participants in a study and that this interaction shapes what emerges from the investigation; (iii) a hermeneutic methodology where understanding can be explored by the researcher and shared with others through an iterative dialectic process between the researcher and participants.

From the literature reviewed in the previous chapter the application of a qualitative approach to the study of the care home can be traced back to the seminal work of Townsend (1962). Building on this work qualitative approaches evolved, and the use of the ‘new ethnography’ (Gubrium, 1975) became a prominent feature in care home research. Ethnography is one of a number of qualitative approaches that can be considered to be broadly ‘constructivist’ in their orientation as captured in the table below.

Table 4.1 Qualitative research approaches

Approach	Research purpose	Research question	Data collection method	Disciplinary origin
Ethnography	To explore the cultural characteristics of a group of people.	Descriptive questions	Participant observation plus interviews with informants and fieldnotes	Anthropology
Phenomenology	To describe the human experiences of a phenomenon.	Meaning questions	In-depth conversation	Philosophy
Grounded Theory	To inductively generate a grounded theory describing a phenomenon.	Interaction, action, and meaning, and focus on process questions	Interviews and observations	Sociology
Narrative Research	To describe individual's stories about their experiences.	Questions concerning verbal interaction	Narrative interviews or oral stories and diaries	Multi-disciplinary

Adopted from (Morse and Field, 1995; Parahoo, 2006)

As this table demonstrates there are different qualitative methods researchers might adopt and it is important that the most appropriate approach is selected. Whilst there is no definitive answer to which is the best approach some are more suited than others to addressing specific types of questions and generating varying research products as a result. For example, in grounded theory, the aim is to generate an explanatory theory and hypotheses that describe social processes, while in phenomenology, researchers seek to provide an in-depth description of individual experience of a specific phenomenon (Parahoo, 2006). Ethnography, on the other hand, provides narrative description and stories that help to explain what is going on in a specific cultural context. Roper and Shapira, (2000) explain that ethnographic study enables researchers to incorporate numerous methods such as observation and interviews to understand and describe study participants in their cultural setting. Given the prominence that 'culture' achieved in the literature on care homes and the widespread adoption of ethnographic principles in care home research, ethnography was felt to merit serious consideration.

4.3 Ethnography

Ethnography is considered the best method to adopt if the aim is to understand and fully grasp the lives and experiences of individuals connected through group membership (Speziale et al., 2011). Parahoo (2006) states that “*ethnographers are interested in how the behaviours of individuals is influenced or mediated by the culture in which they live*” (p.67). Culture is considered to play an important role in formatting, reflecting and influencing individual beliefs and behaviour (Trafimow et al., 2010). Ethnographers believe that human behaviour can be best understood if it is studied in the same setting in which people naturally interact. Therefore, ethnographers tend to search for meanings that participants construct to interpret their lives. Ethnography allows the researcher to study how and why particular people behave the way they do and to do so ethnographers classically spend time with people as they go about their daily lives (Parahoo, 2006). By doing so they are better able to understand and interpret the influences that shape peoples’ behaviours. This means that ethnographers have to enter the ‘field’ with an ‘open mind’ devoid of preconceived ideas. However as Roper and Shapira (2000) note an open mind does not mean that ethnographers should have an “empty head” and that they can be informed by insights gained from prior study, just as in my case.

Classic ethnography, which emerged from the anthropological tradition, typically involved researchers spending extended periods, frequently several years, in the field, in order to discover “*what they (people) do, what they say, how they relate to one another, what their customs and beliefs are, and how they derive meaning from their experiences*” (Speziale and Carpenter, 2003, p.159). Such an approach not only raises several practical questions about the length of time it is realistic to spend on a study but has also been the subject of considerable debate about the ethics of ‘interfering’ in peoples’ lives in this way.

Parahoo (2014) states that one of the challenges that now faces researchers in ethnographic studies is the time that it is realistic to spend in undertaking an ethnographic study in order to build trusting relationships with participants. In addressing this dilemma Savage (2006) argues that most studies in healthcare settings now undertake what has become known as a ‘focused ethnography’, or sometimes mini or micro ethnography (Roper and Shapira, 2000). As the name suggests this involves a far more circumscribed consideration in which the researcher aims to study a small culture or group within a particular setting. Such a focused ethnography can be accomplished within less time than that required for traditional ethnography since it examines a smaller context or culture (Roper and Shapira, 2000; Savage, 2006). But despite this focused ethnographers still study activities within a naturalistic setting, and aim to provide a holistic perspective in order reveal the cultural beliefs operating within that setting (Roper and Shapira, 2000; Gerrish and Lacey, 2010). Therefore, a focused ethnographic approach was adopted for the current study as it provides the researcher with an appropriate approach to collect the data on the phenomena of interest.

Furthermore, such a focussed ethnography has clear resonance with the ‘new ethnography’ described by Gubrium (1975), where the main aim is to go beyond the researcher’s perspective and to understand life within the care home from the viewpoints of the multiple actors involved in order to capture ‘participants’ own versions of their worlds’ (Gubrium, 1993) and thus understand the ‘subjective complexities’ that shape the care home culture. This seemed ideally suited to my goals and so a decision was made to adopt an ethnographic approach for my study. However, it was felt important to do so with a full understanding of some of the criticisms of using ethnography.

4.3.1 Critique and challenges of ethnography

As with all qualitative research there are a number of issues and criticisms associated with ethnography. In addition to the broad ethical concerns outlined above one of the criticisms levelled by many authors is that the results of ethnographic studies have the potential to be determined largely by the personal experiences and views of the researcher (Savage, 2006). This aspect of ethnographic research has been highlighted as deeply problematic, mainly by the positivistic research community and would also clearly be antithetical to the approach advocated by proponents of the new ethnography. Hammersley and Atkinson (2007) propose that in order to acknowledge and account for personal beliefs that ethnographers should be reflexive in describing the role that their beliefs might have played in the analysis of the data and the subsequent findings. Seale (1999) describes reflexivity as “*showing the audience of research studies as much as is possible of the procedures that have led to a particular set of conclusions. In more elaborate conceptions of reflexivity, this is taken to involve an account of the researcher’s personal story during the life of the project, exposing assumptions, values and theoretical perspectives for the benefit of the reader, again in the interests of enabling a critical evaluation of conclusions*” (p.158). Lietz et al. (2006) assert the importance of researchers prioritising the thoughts, feelings and experiences of participants over their own. To complement this, researchers must ensure transparency and be explicit in describing the context in which the data were collected.

In addition, it is important for the researcher to immerse him/herself into the setting of the study for a period of time. This facilitates building trust-relationships between the researcher and these within the study setting (Flick, 2014), which is more likely if researchers spend time in the research setting (Parahoo, 2006; Bowling, 2002). Mason (2002, p.149) explains that subsequently the consequent interpretation of data collected must be made transparent through “*a careful retracing and reconstruction of the route*

by which you think you reached them". How this was achieved in the present study will be considered later. Having decided that an ethnographically informed approach would inform the study it was necessary to consider how the data would be collected.

4.4 Methods of data collection

In qualitative studies, a variety of methods can be used in order to collect data. These include:

- Observations, whether participant observation or non-participant observation.
- Interviews, whether face-to-face interviews or focus groups, or more informal conversations.
- Field notes/data sources, whether it is documents, policies, reports, videos, photographs, paintings and drawing.

Each of these approaches were used in the present study and are described in more detail below.

As mentioned earlier that ethnographers should be reflexive during the course of their study, throughout the subsequent sections I endeavoured to make my own characteristics such as gender and social position explicit and thus helping the reader of the thesis to decide whether or not my position might have influenced the study. I also described the context in which the data were collected, and tried to present detailed account of how I made sense of data and how I reached a particular conclusion.

4.4.1 Observation

Adler and Adler (1994, p.34) state that *'for as long as people have been interested in studying the social and natural world around them, observation has served as the bedrock source of human knowledge'*. The feature that differentiates ethnography from

other methodologies of data collection is its use of observation as the principle way of obtaining knowledge about social phenomena (Gobo, 2008). In general, the main aim of observation is to gain an insider's view of the group under study (Treacy and Hyde, 1999). The key advantage of observation as a method of data collection is to offer the researcher the opportunity to obtain detailed information and understanding the subject of the study in order to provide a picture of the daily lives of study participants (Green and Thorogood, 2004; Schensul et al., 1999). In ethnographic studies, observation is considered as one of the central elements whereby 'hidden' behaviours, practices, interactions and relationships may be made more apparent (Allen, 2010).

The researcher in ethnographic studies observes the setting primarily in terms of the ways people act and interact, and the ways in which they use space and spend time. According to Gerrish and Lacey (2010), observations are initially relatively unstructured, although they become progressively more focused when significant features emerge from the data that might be of importance for the study. Unstructured observations enhance the researcher's flexibility in the early stages of the research process as there are no restrictions on what should be observed, within ethical bounds. However, a clearer focus is needed as phenomena of interest emerge. Moreover insights gained from observation can be augmented and enhanced by being combined with other sources of information such as interviewing or document analysis (Parahoo, 2006) with each approach informing the other. For example, the questions to be asked during interviews can be informed by observations or the meaning of certain observations can be enhanced by asking participants their purpose (Gerrish and Lacey, 2010). Classically observations in ethnographic research are associated with participant observation.

4.4.2 Participant observation

According to Gold (1958), there are four types of participant observer roles. These roles are described as complete participant, participant-as-observer, observer-as-participant and complete observer. In the complete participant and complete observer, observations are conducted covertly. The complete participant attempts to act as one of the group being observed (undisclosed researcher) and actively participates in activities in the field of study. In order to gain information observations are conducted covertly (i.e. those being observed are unaware of the research). In the complete observer role, the researcher observes participants' behaviour without any interaction and participation within the social field of study. Such observations can be made either with or without using technology such as video and audio recordings (Gerrish and Lacey, 2010). Both of these types of observation raise ethical concerns regarding consent and the potential for deception and were not deemed appropriate for the present study.

In participant-as-observer and observer-as-participant roles observations are usually conducted overtly, the role of the researcher is known and consent is obtained from the study participants. The difference between these two roles is the amount time the researcher actively participates in the setting other than by observing. In the participant-as-observer role, the researcher plays an active part in the setting other than as a researcher. Conversely, when in the observer-as-participant role, the researcher participates briefly in the activities of the setting and spends most of the time observing participants (Gerrish and Lacey, 2010).

The role of the observer-as-participant was adopted in the current study. By using this approach, I focused my attention on observing day-to-day life within the care home. Maintaining a presence in the home, I sought to observe the activities of both staff and residents. For example, this meant observing mealtimes, shared activities or prayer.

There were occasions when a more active role was needed as not to take part would have been culturally unacceptable. For instance, during certain events such as picnics and social activities in both homes I was asked to contribute and be involved in the event, but for the majority of the time I primarily observed what was occurring whilst trying to play as little part as possible.

Over the course of the study I spent extensive periods of time undertaking observations during the day (morning and evening), at weekends and holidays in different areas of the care homes in order to make sure that I had as full a picture as possible. Observations were mostly undertaken in the morning and during weekdays as compared to evenings and weekends. In this study, in both homes, approximately 140 hours of participant observations were undertaken, the majority being during the day. The process of participant observation in both care homes in terms of time, hours, place, and activities is illustrated in the Table 4.2.

Table 4.2 Information about participant observation

Time (Sat-Fri)	Hrs.	Length of Observation/ hour	Place	Activities	Note
Star Care Home					
Morning	8:00-11:59	1 – 4 hrs	*Communal area *Corridors *Garden *Kitchen *Meetings *Events outside the care home.	* Getting up * Starting day *Taking breakfast *Taking medicine *Interaction between residents, and interaction with staff.	*The observation timetable was flexible and depended on activities such as activities in weekends or in special events. *At some point in the care homes, I was there every day and also in different times.
Afternoon	12:00-16:59		*Communal area *Kitchen *Resident’s room.	*Taking lunch *Taking medicine *Worships *Communication *Other activities.	
Evening	17:00-20:00		*Communal area *Corridors, *Kitchen *Resident’s room.	*Taking dinner *Taking medicine *Interaction between residents, and interaction with staff *Communication *Other activities.	
Moon Care Home					
Morning	8:00-11:59	1 – 4 hrs	*Communal area *Corridors *Garden *Kitchen *Meetings *Events inside and outside the care home.	*Getting up *Starting day *Taking breakfast *Taking medicine *Interaction between residents, and interaction with staff.	*The observation timetable was flexible and depended on activities such as activities in weekends or in special events. *At some point in the care homes, I was there every day and also in different times.
Afternoon	12:00-16:59		*Communal area *Kitchen *Resident’s room.	*Taking lunch *Taking medicine *Worships *Communication *Other activities.	
Evening	17:00-20:00		*Communal area *Corridors, *Kitchen *Resident’s room.	*Taking dinner *Taking medicine *Interaction between residents, and interaction with staff *Communication *Other activities.	

In the beginning of the current study, I used mainly unstructured observations to collect detailed information on different aspects of the homes. This enhanced my flexibility in the early stages of the study to observe life in the care homes without restrictions on

what should be observed. For example, I observed patterns of daily life, the way participants spent their time, the interactions between residents and staff and between staff themselves, and events and activities as they occurred in daily life. However, as the study progressed, the observation became more structured. Event sampling was used as the data progressed as I focused my observations on those aspects that I considered central to addressing the research questions. Event sampling occurred in response to discussions within interviews with participants. This led me to attend to and observe those activities or events that were substantial in achieving the research aims.

The participants were informed of my intentions and what I would be doing. In addition, I used the observations to help inform later interviews with participants. As Chang and Horrocks (2006) note participants should be given the opportunity to narrate their stories in whichever way they wish. Therefore, potential interviewees were approached during the observation time and after indicating their willingness to participate, a convenient time for an interview was agreed. The flow chart below shows the relationships between the observations and the interviews during the period of data collection in both care homes.

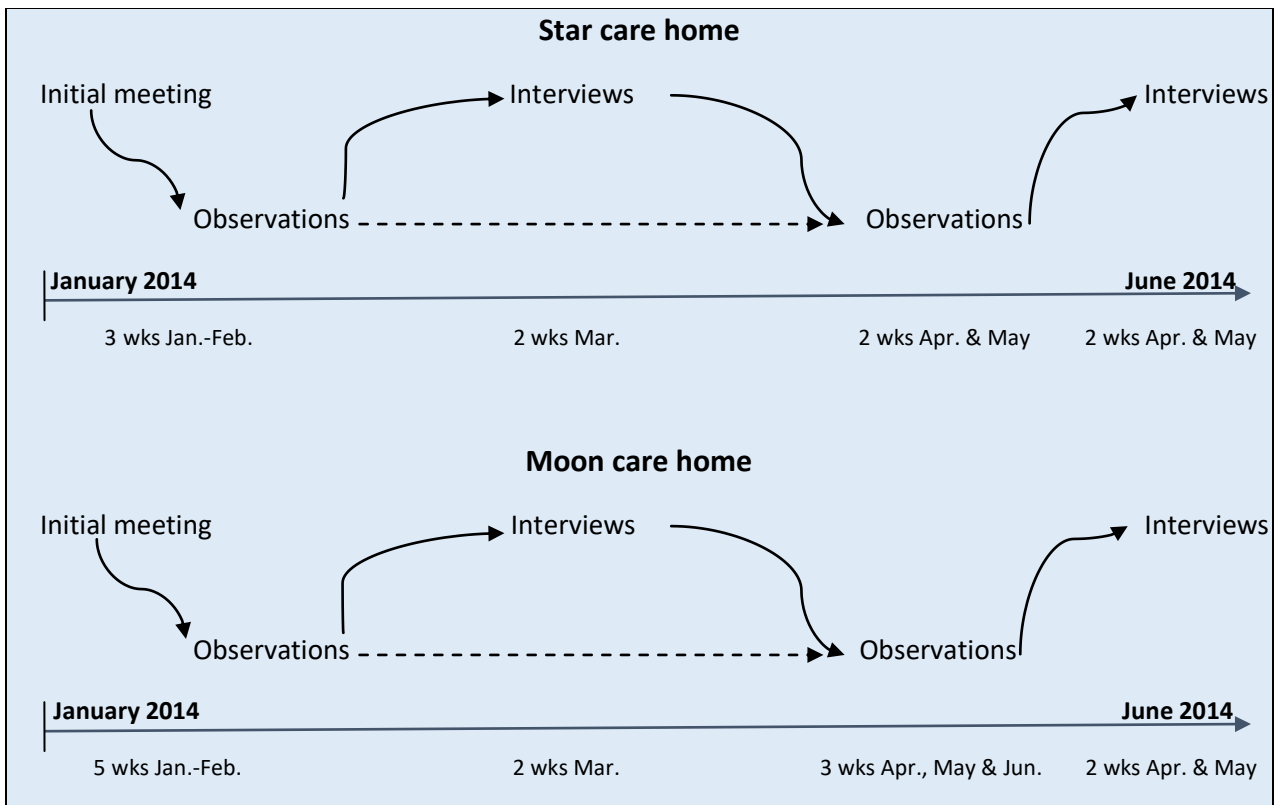


Figure 4.1 Process of data collection (observations and interviews)

With regard to participant observation, a number of factors have an bearing on whether the role of researchers as observers is accepted in the community life under study. These factors were documented as researcher’s ethnicity, gender, age, his/her appearance and social class (Schensul et al., 1999). Lack of a trust relationship between observer and participants and the latter’s discomfort of being observed by an outsider were reported to be the reasons for not accepting the researcher and not including him/her in the community activities.

For that reason, I sought to immerse myself in the culture of the homes under study by spending time with residents and staff in both homes and eventually being able to build a trusting relationship with the study participants (both residents and staff). I took particular ‘cues’ on the ways in which others were acting and relating with me as an indication of my acceptance. For example, if participants change their topic when the researcher arrives there or if they move away from the researcher in order to avoid

talking to him/her. Another example is that when participants do not invite the researcher to participate in events and activities such as social gathering. Here, I have to acknowledge that the participants in both homes were equally welcoming and I did not encounter any sort of the above mentioned examples with them. Both staff and residents in both homes were enthusiastic to talk and share their experience and personal life with me. They frequently invited me to drink tea, play games with them such as dominos and participate in their gatherings. Both homes invited me to their activities both inside and outside the homes such as during national holidays and picnics. In addition, in both homes both the staff and the managers invited me to attend their meetings with residents and exclusive staff meetings. In both homes, I have been asked to contribute in modifying a menu for the homes' meals in a staff's meeting.

4.4.3 Qualitative interviews

Qualitative interviews are one of the most commonly used methods as they provide participants with the opportunity to explore issues that they see as important (Gerrish and Lacey, 2010), primarily using their own words (Creswell, 2007). Mason (2002, p.62) describes qualitative interviews as “*conversations with a purpose*” and in qualitative studies interviews play a central role in data collection.

Semi-structured interviews are the main type adopted as they enable participants' cultural values, beliefs and norms to be explored by the researcher (Gerrish and Lacey, 2010). At the start of the interview the researcher usually uses a few set of questions to facilitate the interviews and also to encourage the respondents to provide information about the phenomenon of interest. However rather than following a set sequence of questions a flexible ‘interview guide’ is used to explore the topics of interest. This guide is not followed in any particular order but the flow of the interview is dictated by the participant's responses. In semi-structured interviews participants can formulate

responses in their own words, rather than having multiple choice-answers to choose from (Parahoo, 2006). The topics on the interview guide evolve over the course of the study as data analysis proceeds. It is the researcher's responsibility to clarify meanings and to ensure that participants understand the questions completely. In addition to such interviews, informal and casual conversations between the researcher and the participants provide important data in exploring the life in the care homes and addressing the research question.

In the current study, in addition to observations, semi-structured face-to-face interviews were conducted with participants (residents and staff) to explore their understanding of and perspectives regarding life in the care home. A total of 28 interviews with residents and staff members were conducted (15 and 13 respectively) in the Star and the Moon care homes at which point sufficient data were considered to have been collected. This was based on the fact that I began to see the same information being given by multiple participants, with no new insights being gained. The duration of each interview varied between 20 to 60 minutes with the average lasting 30 minutes. The researcher conducted interviews with participants in the Kurdish language, which is the main language in Iraqi Kurdistan.

Prior to conducting the interviews, interview guides (resident and staff) was produced and whether the questions were understandable and unambiguous was considered. In order to check whether the questions were understandable by participants, the interview guides were pre-tested by discussing this with my supervisors, amongst friends, colleagues and some non-resident older people. Some broad and open-ended questions about life experiences in the care home were developed based on the literature regarding care home culture and from my personal experiences in the field. Moreover, the

interview guides were further informed by the observations made and the nature of the individual responses. The initial interview guide is attached in Appendix-A.

The literature on interviewing participants was considered prior to conducting the interviews in order to develop an understanding of how best to manage the process. Speziale et al. (2011) acknowledge that *“interviews should not be conducted without adequate preparation and understanding of the process, its intent, and the desired outcome”* (p. 35). The interviews with the participants were conducted in a quiet and comfortable place either in the resident’s bedroom, private room, communal hall or resident’s hall. Privacy was ensured throughout the interviews for those residents who had roommates by conducting the interview when their roommates were not in the room at the time; otherwise an alternative place was organised. The importance of finding a suitable place and allowing sufficient time was highlighted by Speziale et al. (2011, p. 36) as *‘the more comfortable each participant is, the more likely he or she will share important information’*.

The participants’ interviews were audio-recorded to ensure that the data were not lost (Wright and Schmelzer, 1997). Moreover, digital recording allowed me to focus on my interaction with the participant and reduce note-taking during the interview. Too, (1996) points out that the advantages of audio-recording interviews are that they allow the interviewer to interact with the participants rather than having to concentrate on note taking.

It is worth mentioning that the informal conversations were also documented (written) such as direct quotations and included in the data analysis process as these information provided the researcher to gain a deeper insight into the data interpretation. It is more likely that casual conversations (*i.e.*, informal interviews) occur during observation where audio-recording is impossible. Therefore, I made notes or jottings of the

conversation as soon as possible. Soon following the informal interviews, I wrote (manually) detailed fieldnotes. The observations and interviews were complemented by fieldnotes.

4.4.4 Field notes

Field notes are also one of the key approaches used in ethnographic studies (Gerrish and Lacey 2010; Speziale and Carpenter, 2003). Such notes allow the researcher to capture insights as they arise such as displays of emotion, for example expressions of anger, sadness or happiness (Wright and Schmelzer, 1997). The researcher's own experiences, feelings and reflective comments are also included in the notes made. Importantly field notes allow the researcher to capture new insights as they emerge and form on important addition to on-going analysis.

For Patton (2002) "*field notes, including brief jottings, direct quotations, and episodes of dialogue help to capture the 'native language of the setting'*" (p.289) and as Gerrish and Lacey (2010) suggest these notes can also be used at a later stage of study in order to help the researcher to distil significant issues and further questions that need to be asked. Such notes can be recorded during observations and interviews to aid the researcher in later interpretation.

Parahoo (2006) and Silverman (2006) offer principles that researchers should consider as they document their field notes. These principles are shown in Fig. 4.2. These principles were adopted by me during the fieldwork.

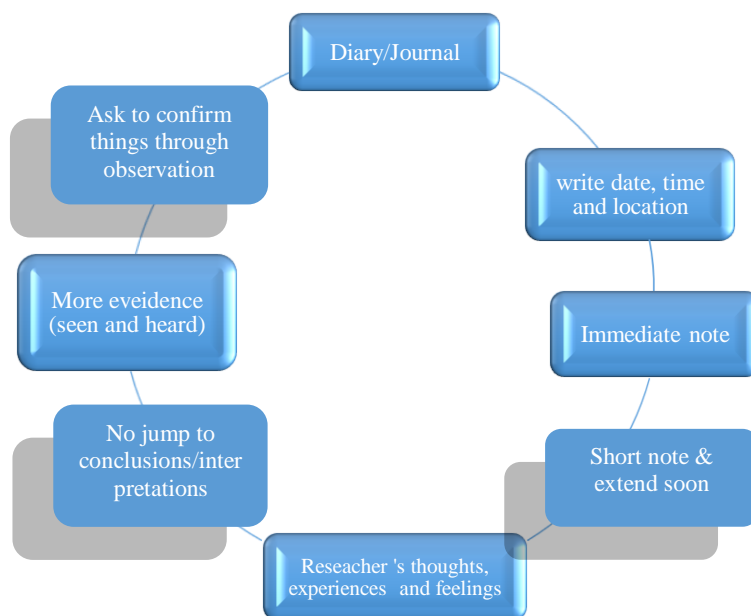


Figure 4.2 Principles of fieldnotes

For the purpose of recording field notes a special notebook was allocated for each care home and used as a research diary. In this I noted the date, time and location for each observation based on what I had seen and heard. The style of note taking was initially brief comprising mainly bullet points and these were extended on a daily basis soon afterwards.

My thoughts and feelings were also recorded constantly to aid my interpretation in the later stages of the research (analysis process) and to aid reflexivity. While I was carrying out observations within the care homes, I sought to write down certain interactions, activities and events (while they occurred) as a series of short notes, so as to later make more precise and bring accuracy and expand upon to record more detailed information. It helped my memory to recall the details of the observations I have made for talks, actions, activities and events in order to be documented thoroughly afterwards. For example, during conversations between study participants, I documented the actual words, phrases, quotations or verbatim dialogues along with the emotional and sensual details, for instance, facial expressions and gestures (Emerson et al., 2011).

Considering the circumstances in which the research was conducted especially how the observations and fieldnotes are recorded is also an important aspect when judging the quality of an ethnographic study. It is common that the fieldnotes are not written on the spot and the effect of memory distortion is possible. Therefore, measures were taken to minimise this as much as possible. As stated, special handwritten notebook was dedicated for each home. This notebook became my close friend during the data collection as I wrote short notes after each observation I made and during the interviews in order to capture what my participants talked about or to what/whom they referred to. After each visit, a detailed description of the people, interactions, events were documented as they were still fresh in mind and I could recall them efficiently. Careful attention was given to where and when notes were written. For example, I endeavoured to observe events and interactions fully to understand the context and gain a complete picture of what I have been observing and then immediately recorded these notes. This was helpful in reducing any distraction that may have caused by taking notes during the ongoing interactions, events or activities.

4.4.5 Documents

One of the characteristics of ethnographic study is collecting data from various sources, using a variety of methods (Gerrish and Lacey, 2010). Thus, alongside the observations, interviews and fieldnotes, I examined some documents including national and local policies, reports and residents' files. Such sources often say a great deal about the factors that can shape the broad cultural factors operating within a setting that can otherwise remain latent or hidden.

Therefore, I examined the care home policy documents produced by the Ministry of Labour and Social Affairs which shaped the overall aims and goals of the homes. It was also important to collect relevant information and documents about daily processes

operating within the homes that shaped of the lives of residents and staff as these were likely to be central to understanding how wider policies were interpreted and enacted on a daily basis. More detail about the policy documents will be provided in the first findings chapter.

Having described the primary methods of data collection attention is now turned to the details of the care homes where the study was undertaken.

4.5 Putting the Study into practice

4.5.1 Study setting

The ethnographic study was carried out in two governmental care homes in Iraqi Kurdistan between January 2014 and June 2014 after obtaining approval from the University of Sheffield Ethics committee and the General Directorate of Social Care / Ministry of Labour and Social Affairs / Kurdistan region (see Appendix 'B'). The Star and Moon care homes (pseudonyms) were selected as they represented the only two care homes across the region for older people. In the next chapter, more detailed information on both settings is provided.

4.5.2 Sampling

In qualitative research, sampling strategies give researchers the opportunity to gain access to people whom they can observe and interview in-depth, and from whom they can obtain rich data. The whole process is guided by the principles of ethics (see section 4.8).

Non-probability sampling schemes are often used in qualitative research, particularly in nursing research (Gerrish and Lacey, 2010) because the purpose is to explore and understand the phenomenon of interest in depth with selected individuals rather than at

random (Parahoo, 2014). These methods include snowball sampling, purposive sampling, theoretical and convenience sampling, each of which uses certain criteria so that the researcher can achieve selected objectives (Polit and Beck, 2006). In snowball sampling, the researcher approaches one or a number of participants and then through them recruits other participants. Parahoo (2006) asserts that this type of method is most useful when the researcher needs to recruit participants from a specific group. Purposive sampling describes a process whereby the researcher deliberately selects participants who can provide the necessary information. Theoretical sampling is used mainly in grounded theory where the researcher selects participants on the basis of their developing theory. Finally, convenience sampling is an approach in which the researcher “*select(s) an accessible population or place that the researcher believes to be typical rather than a representative sample.*” (Gerrish and Lacey, 2010, p.151).

Purposive sampling was used in the present study in which individuals were selected on the basis that they were likely to have an informed opinion on the phenomenon of interest. (Speziale, 2011; Mason, 2004; (Green and Thorogood, 2004). Ethnographic researchers often use purposive sampling and adopt particular criteria to select their participants, which should be made explicit (Hammersley and Atkinson, 2007).

However, ethnographers do not normally choose the participants for their study in advance and many authors advocate the use of ‘key informants’ in ethnographic studies, Parahoo (2014, p. 252) states that “*the term ‘key informant’ is used in ethnographic studies to describe the main person or persons who can provide insights into the group’s behaviour and can help the researcher to gain access to others, events or activities. An ethnographic site can have more than one key informant*”. As the notion of the ‘key’ informant is central to ethnographic research (Marshall, 1996), I sought to include those residents or staff who thought to be likely ‘key informants’. The key

informants were selected during the observation period, based on their personal skills, experiences, willingness to participate, availability and their position in the care homes, they were able to provide deeper insights and more information regarding what is going on in the care homes.

In the present study the sampling frame potentially comprised everybody who lived and who worked in the two care homes. In order to provide some basis for inclusion the following criteria were applied:

Table 4.3 Inclusion and Exclusion Criteria- Residents

Subject	Inclusion Criteria	Exclusion Criteria
Length of stay	Residents were selected to ensure that there was a good balance between those newly admitted as well as those who have lived in the care home for some time.	*Unable to speak and understand Kurdish language.
Age of resident	A blend of older and relatively younger residents was approached (residents aged over 60 or 50 (for men and women respectively).	*Residents with medical problems which prevent participation (e.g. dementia) as they might not be able to recall their experience on the care home or they might not be able to give their consent.
Gender	I ensured that both men and women took part in the study	
Level of impairment	I included those residents who do not require physical assistance as well as those who do require assistance in daily living.	
Nationality	Iraqi.	
Care home registration	Registered formally as a resident in either of the care homes.	
Communication	Able to communicate in Kurdish language. Willing to participate with informed consent.	

Table 4.4 Inclusion and Exclusion Criteria- Staff

Subject	Inclusion Criteria	Exclusion Criteria
Length of employment in the care home	All staff were eligible to be included in the study regardless of the length of time they have worked in the settings. For example, I included those staff who have just started working in care homes as well as those who had been working there for many years.	* Non-Iraqi
Age	An attempt been made to achieve a good balance between younger and older care staff.	
Gender	I ensured that both male and female staff are approached.	
Seniority	I included staff with both management and more junior roles in the care homes.	
Staffing pattern	Both professional (social and health care personnel) and non-professional care staff who provided or influenced the physical and/or psychosocial care of residents.	
Nationality	Iraqi and willing to participate with informed consent.	

Whilst this approach went some way to ensuring the involvement of a range of participants, others were included on the basis of the observational data (*i.e.*, key informants).

Here, it is important to comment on the number of female residents participated in the interviews. As mentioned earlier, in both care homes, I used a purposive sampling as well as identifying key informants based on the observations. Although there were female residents in both homes the number of female residents consenting to take part in interviews was considerably lower than male residents. Just one female resident (Sharmin, Moon care home) participated in an interview as part of the study. Women in the care home did say that they were too shy to talk. I concluded that this might be due to the values and traditions inherited in Kurdish culture, in which the older female generation are reserved especially when communicating with men. This was not the case for younger generation. Sharmin was the only woman who participated in the study and was in her fifties.

It is important to note that the current study did not include relative's views, due to the fact that the majority of cases entered the care homes were because of loneliness or family breakdown/conflict, and this influenced their relationship with their relatives. As a result, relatives were rarely seen to visit their older people and they had limited or no contribution into the older people's lives in the homes. During my data collection period, I have only seen a few residents been visited by their relatives (one case in the Moon care home and two cases in the Star care home). This might be again due to the social stigma that faces those family members who bring in their older members into the care homes.

It is also important to acknowledge the way the sampling of observations was undertaken. The observations were sampled on events rather than people. By this, I

mean that I was able to identify activities that provided me with a thorough understanding of the culture of the home. For example, I sought to observe the different aspects of each of the homes such as the activities and events which were held either inside or outside the homes (i.e., picnics, meetings and activities), the structure and environmental setting of the homes (the residents' rooms, communal areas, administrative units). Patterns of daily life were also of interest to me, for instance, when the residents were getting out from their bed and in the evening when they were going to bed, the way participants spent their time; and what type of routine or procedures were practised by staff. How residents interacted with each other and with staff and how staff responded to residents' queries were also of particular interest to me. How staff interacted with each other and with managers also became an important aspect of the care home culture that I sought to explore. Once the data collection progressed, I obtained clearer understanding of how each care home worked, how residents spent their time, what types of interaction and relationship staff and residents adopted. At this stage I shifted my focus on those aspects/events that were raised during interviews and were considered important in exploring the culture of the home. For example, I observed to identify the reasons for adopting a particular behaviour by some staff or residents such as some being sociable and others being isolated. These all helped me to obtain the data necessary to address the research questions.

4.5.3 Gaining access and recruitment

Brink et al. (2006) stress that it is unethical to commence studies involving humans without obtaining ethical approval. Prior to conducting data collection, ethical approval was obtained from the Ethics Committee at the University of Sheffield and Hawler Medical University/the General Directorate of Social Care. In research process, gaining access and immersing oneself in fieldwork and gaining the participants' trust is time-

consuming since researchers normally have to gain permission to access a particular setting from managers (Parahoo, 2014). After this, I obtained permission from the manager of each homes and I was warmly welcomed by both managers and had a short meeting with them in which we discussed the study proposal. A separate meeting was held with the residents and staff, the purpose of the study, the process of collecting data, and their possible participation in the observation was discussed. Residents and staff were reassured that they did not have to take part in the study or could withdraw at any point without any consequences. The information sheets were distributed and read out for those residents who could not read and write and interested to participate in the study.

Most of the residents were seen to be interested and asked to know why I was conducting this research and the reasons behind coming from United Kingdom and selecting this setting. The majority of residents and staff asked about the care homes in western countries in particular the United Kingdom. For instance, questions about how residents live their daily life were raised. Some of them were curious to know what I would do with the data and what was the expected outcome. The residents and staff were assured that the intention of the study was to explore their perspectives, perceptions and difficulties that they face in their daily life in the care home. This was helpful to me in that it minimised any suspicions that they had about the researcher's role. Some of them immediately showed their personal intention to participate in the study by stating:

“Many researchers visited the care home and interviewed us; no one like you came from abroad and travelled thousands of miles to see us. We thank you and appreciate your efforts. Sometimes it is difficult to know people's intentions, we know you have good intentions”

Raza-Moon-R

My research diary helped me to organise and record reflections about how participants met me for the first time whilst in the homes and their reaction towards my research. Recruiting residents and staff members was not a complicated process in both settings. This was due to the way trust was built with the researcher prior to data collection. Another possible explanation for this might be due to that the number of studies conducted in particular qualitative studies on older people and staff in Kurdish care homes was very limited and they were excited to talk about their experiences in the care homes. Therefore, it was not difficult to recruit residents and staff members since all of them (with the exception of some of the female residents) agreed to participate in the observation part of the study. The reason for not participating in the observation for these female residents (four residents) was that they felt uncomfortable to be observed or 'shy' when communicating with men.

Following the observation, those residents and staff who met particular criteria or were identified as key informants were approached in the care home setting. They were given further time to discuss their participation in the interview and time also to consider consent. Following a decision, a time suitable to them was arranged for an interview to take place where appropriate. Prior to conducting each interview, I thanked each participant who had agreed to take part in the study, and a signed consent form (see Appendix D) was obtained after clear information had given.

However, there were some challenges with regard to the interview time table, as some of the staff were busy and did not always have the free time or were not always available in the home. I became familiar with their free-time and was able to conduct the interviews with them at an appropriate time. During the interviews with staff, I sometimes stopped the interview for a while especially when other staff members/residents came in to the interview room, or sometimes they went to undertake

an essential task and I had to wait for their return. Also, during the interviews with residents, I would temporarily halt the interview when their roommate came in. Immediately after concluding the interviews, reflexive notes were made, recording thoughts, feelings and expressions. These consequently shaped an essential part of analysing the data.

4.5.3.1 Preparing for data collection

Before commencing data collection, I visited both care homes to consider the social and cultural context where the data will be collected and to develop my understanding of the care home system (McDougall, 2000). I spent a period of time in each care home in order to get to know the homes, residents and staff members. I spent time chatting to residents and staff members about the study. It should be noted that I did not spend an equal amount of time in both of the care home settings in that I spent more hours in the Moon care home relative to the Star care home and some explanation is required here. In my professional role, and prior to the start of my PhD study, I was responsible for the supervision of undergraduate students for a module as part of my teaching role. During that time, I became familiar with the home's setting, structure and daily routines. As a result, more time was needed to become familiar with the Moon care home and in particular familiarise myself with the home environment.

It is necessary to acknowledge that my presence in the Star care home previously may have an influence on the way the participants may behave during observation. However, it is important to clarify for the reader that I had a professional relationship with the former manager of the Star care home rather than a personal relationship as I have only been in the Star care home in academic term time, only for one semester and once per week (morning shift). It is also essential to note that my relationship with staff in the Star care home at the time was professional and I did not know them personally as we

rarely interacted only to exchange greetings. Familiarising with both homes prior to data collection period was an effective task in which enabled me to get to know the homes, observe and examine events and activities, interact with the managers, staff and residents.

Generally, my relationship with the residents and staff was based on sincerity and respect. I was a good listener and enthusiastic to listen to their views during my interactions with them. However, no formal interviews were conducted, this was an important starting point in familiarising myself with the fieldwork.

It is important to acknowledge that this was an essential stage of the study as it enhanced my understanding of the care homes in many ways. On the one hand, it provided me with the opportunity to initiate relationships with potential participants (both residents and staff), and allowed me to become familiar with each of the settings. On the other hand, it provided preliminary data on how the residents interacted with each other and with staff and how staff reacted and related to each other and with residents. This provided me with basic information and enabled me to recognise any behavioural changes (if any) in the later stages of the study, particularly, during the observation period.

Some researchers emphasise the importance of becoming a “familiar face” before conducting field works (Bailey, 2009). This was a great opportunity to establish relationships with residents and staff members prior conducting the field work. This ultimately led me to establish a trust-relationship with both residents and staff. Speziale et al. (2011, p.35) suggest that the researcher should take the time for establishing a relationship with those from whom he/she will be obtaining information.

4.6 Issues of translation and transcription

Van Nes et al. (2010) state that *“the findings should be communicated in such a way that the reader of the publication understands the meaning as it was expressed in the findings, originating from data in the source language”* (p.314). The process of translation presents some challenges here for the researcher, in particular how it might influence to credibility of the research data and the findings. Consequently, researchers have to make efforts to reduce the potential impact of the translation procedure (Regmi et al., 2010; Brislin, 1970) and are largely dependent upon the ability of researchers to preserve the meaning of data being translated (Denzin, 1989). Loss of meaning of translated data means loss of credibility of the qualitative findings and its interpretations, since understanding meanings is central to the research endeavour (Van Nes et al., 2010). Producing a high quality translation can be achieved and errors can be minimised when it is carried out by a person who is familiar with the culture of the subjects under study and knows both languages (native and the target translation languages) (Regmi et al., 2010; Birbili, 2000).

4.6.1 Data translation and transcription

Translation is the process of translating words or sentences from one language into another language. Conducting research in a language other than English has increased gradually (Regmi et al., 2010) and this is becoming common in health and social care research (Birbili, 2000). This process requires careful consideration, especially in cross-cultural studies where the researcher should provide a clear description of the processes used.

In qualitative research, the process of analysis is concurrent with data collection and therefore, the process of translation is part of the analytic process, which can be a

lengthy undertaking, especially if large volumes of data have been collected (Halai, 2007).

It is appropriate here to explain the strategy that has been used in transcribing and translating interviews. In this study, all interviews were conducted in Kurdish language, translated and transcribed into English. This was all with the exception of one of the interviews which was already conducted in English language and transcribed into English. This was due to that participant (resident) being fluent in both languages and was interested to conduct the interview in English.

The process of transcribing the interviews started directly after they were carried out; this was suggested by Green and Thorogood (2004) in which help the researcher to write comments and remember events.

In order to avoid any issues surrounding the credibility of the research data and findings, I had translated the interviews carefully and shared these with another bilingual Kurdish-English speaker; in order to check the quality of the translation and to ensure that the meanings of the words have not been lost. This process can minimise the translation error. The bilingual person was fluent in Kurdish and English language, has a bachelor degree and obtained a master degree in English language in the UK. Regmi et al. (2010) and Zeilani (2008) suggest that to produce a good quality translation, to minimize errors as much as possible in the translation process, its necessary to involve a bilingual person who knows both languages sufficiently and aware of the cultural backgrounds of them.

Through the translation process extensive efforts were made to maintain the meaning of translated interview closer to the original (Kurdish source) as much as possible. As a consequence, reading each sentence in the Kurdish language carefully and then translating it accurately into the English language was performed aiming to keep the

meaning closer to original sentence. Finally, the transcribed text was revised to ensure whether or not the translation sentence make sense and had similar meaning to the Kurdish source.

4.7 Data analysis

Following transcription and translation the early interviews were sent to my supervisors so that they could provide me with feedback and guidance both on my interview technique and the type of data that was emerging. During the period of data collection, I was in regular Skype contact with my primary supervisor so that on-going support could be provided. Data analysis occurred both whilst I was in Iraq and on my return to the UK.

Qualitative analysis is an on-going and interactive process and in order for concepts to emerge the researcher needs to achieve an intimate familiarity with the data. This usually involves reading their narrative data again and again in order to find a meaning within them (Polit and Beck, 2006).

In ethnography, analysis begins from the moment the researcher enters the field. Ethnographers are continually seeking to understand how informants/participants speak about the environment and the ways in which they act within the setting. Key events such as social gatherings are very important aspects of activity that are analysed by ethnographers as these may provide a lens through which to view any culture (Polit and Beck, 2006)

Roper and Shapira (2000) asserted that qualitative analysis requires rigor, time and energy and they stated that *“analysis of ethnographic information is a long and thoughtful process and requires time for reflection to achieve personal understanding for complex events and people who perform them”* (Roper and Shapira, 2000, p.93).

As ethnography involves various sources of data including observations, fieldnotes and interviews with key informants, ethnographers gather a huge amount of information and subsequently have to make sense of it and as Roper and Shapira (2000, p.92) note there is “*no rule that says*’ how this should be done and it is very important to clearly explain the steps that are carried out in analysing any data.

As a novice researcher I wanted a framework to guide me through the data analysis process, so I read several texts on the subject. The data analysis framework proposed by Holloway and Todres (2010) seemed both an appropriate and straightforward approach as it provided a step-by-step guide. Holloway and Todres, described the main steps in data analysis as follows:

- i. *Bringing order to the data and organizing the material*
- ii. *Reading, re-reading and thinking about the data*
- iii. *Coding the data*
- iv. *Summarising and reducing the codes to larger categories*
- v. *Searching for patterns and regularities in the data, sorting these and recognising themes*
- vi. *Uncovering variations in the data and revealing those cases that do not fit with the rest of the data, and accounting for them*
- vii. *Engaging with, and integrating, the related literature* (Holloway and Todres 2010, p.172-3).

The above analytic procedures provide an overview of how I made sense of my data and in the following sections, I will explain how I used this to assist in the analysis process.

Bringing order to the data and organizing the material

Many authors and researchers put emphasis on organising the data and becoming immersed in the data before breaking it into sections (Gerrish and Lacey, 2010; Green and Thorogood, 2004). Thus, after I have interviewed a participant, and before starting the transcription, I listened to each audio-recorded interview at least one time.

Fieldnotes and information obtained from observations were arranged according to the type of activities, events, topics, interactions, and setting structure. The transcribed interviews were also organised and properly named. I named each of these files (transcripts, fieldnotes and information yielded from observations) with identifiable information such as name or type of activity or event; which then helped me to easily retrieve information on a specific aspect of the data. These were saved in separate files in Microsoft word. The process of preparing, organising and bringing order to data prior data analysis is documented to be an important step in qualitative data analysis (Aurini et al., 2016).

Reading, re-reading and thinking about the data

In qualitative data analysis, one of the important steps to be undertaken is to immerse oneself in the data in order to comprehend and understand its meaning as a whole. This facilitates identifying the connections and links between emerging ideas and thoughts with their context (Bradley et al., 2007).

In order to understand the data fully and deeply, I read the transcripts and fieldnotes/observations repeatedly. All of these were applied while I was still collecting the data. I also collated the transcripts into separate documents. For examples, I created different folders for residents' audio-recordings and staff as well as the observations and fieldnotes.

Alongside the Kurdish transcripts for each participant, I summarised each of the transcripts in English. These summaries included bullet points or simple description about the key information emerging from each particular participant. This was useful especially after the analysis had finished as it enabled me to gain a quick overview of the data from each participant if needed. The information obtained from the observations and fieldnotes related to a particular participant were organised and included in each participant's file, while all other general information obtained from the observations and fieldnotes (*i.e.*, events and activities) were kept separately; as such information regarded as pivotal in the data analysis process.

Coding the data

After having gained a good overview of what each transcript contained I started coding the data in greater detail. Holloway and Todres (2010) state that a process of breaking down the data and giving each significant chunk of data a descriptive label is called coding. Early on in this process I shared the English version of the transcripts with my supervisors who also undertook to produce preliminary codes to see if there was consistency between ideas.

The excerpt below is an example of a paragraph obtained from a participant with the initial codes applied by both myself and my supervisors. Whilst, there were differences between the descriptive labels given to the codes by different individuals, the meanings were very similar.

“My experience is like for example I have my own place here and sometimes sitting with other older people or friends and talking about nice things. And if we have any requirement, the manager will come and ask us about it. For example, if any of us is sick and need treatment, they will treat us”.

Coding

- Significant interaction between residents
- Interaction between residents and staff
- Staff listening to residents requests

Although, there are various software packages (e.g. CAQDAS, ATLAS.ti6 and QSR Nvivo8) available to assist researchers to undertake data analysis (Gerrish and Lacey, 2010), I decided to manually organise and analyse the data. Whilst, I had attended several workshops and taught myself how to use Nvivo, I found it both too time consuming but importantly also felt that it did not allow me to get really close to the data and achieve the sort of immersion that is required (Parahoo 2014; Hammersley and Atkinson, 2007). As codes began to emerge I also started to write memos in the margins of the analysis to describe potential links between codes and suggest larger categories in preparation for the next stage of analysis.

Summarising and reducing the codes to larger categories

In order to reduce the number of codes and begin to identify themes Holloway and Todres (2010, p.173) state that *“thematically similar sets of categories are grouped together, with links and relationships established between them. Broad patterns of thoughts and behaviours emerge at this stage, and major ‘construct’ or themes are developed”*. After the initial coding was complete, I started to group similar or relevant codes together in order to develop a smaller number of categories, for example, after immersing in the data as a whole, I sought to visit and revisit them repeatedly. I also looked across all of my data, including resident and staff interviews to find similarities and differences of accounts. Then, other sources of data such as observations and fieldnotes were examined to be integrated with the whole data analysis process. This involved a great deal of sifting and sorting that went on for a number of months. On a practical level I would use post-it-notes to move codes around, often making decisions about the similarity and differences between them with a view to these being merged to create the aforementioned categories. For example, those codes that covered one cluster of my data were grouped together along with those that were related. This also involved

discussions with my supervisors where I would present my ideas about the categories and we would discuss implications for my analysis. See Table below for a worked example of how I combined codes to form a broader category.

Table 4.5 Codes and categories

No.	Code	Category
1	- no worries of being homeless anymore - it is a place for poor and homeless people - shelter	Being relieved from previous home-life stresses after admission
2	- not being alone anymore - enjoying companionship in the home - feeling safe of not being alone	End of loneliness and isolation
3	- a secure place to be in - feeling safe and not being worried of being a victim - safe from threat - secure region	Free from physical harm and threat
4	- enjoying having pocket money - financial security	Free from financial insecurity

Searching for patterns and regularities in the data, sorting these and recognising themes

Common phrases and patterns emerged after comparing and finding links between codes within the interviews and observation notes and between them. An iterative approach was again undertaken to connect the data from different sources with emerging insights. This process of iteration was reflexive in nature since it enabled me to think about the data, their meanings and identify links and relationships between the emerging broader themes whilst being aware of my own relationship with these data. Through further visiting and revisiting all the data (within and across the data sources), I was also able to verify that the resultant themes or fit with the data. Lines were drawn between categories to help in making links between them. This process continued until no new themes emerged from the data and I had to go back and forth and thus it took a considerable amount of time. Again this process involved extended discussions as a

team, including my supervisors, in order that we found a way to articulate life within the care home for all involved and a means to account for care home culture.

Table 4.6 Categories and themes

Category	Theme
Being relieved from previous home-life stresses after admission	Freedom From
End of loneliness and isolation	
Free from physical harm and threat	
Free from financial insecurity	

Uncovering variations in the data and accounting for them

In this stage, researchers develop a “*classification system*” in which the variations in the data are identified and should be addressed in the findings. For example, a researcher may uncover two different contrasting types of accounts or behaviours of a group under study. These types or variations should be addressed clearly (Gerrish and Lathlean, 2015, p.208).

Holloway and Galvin (2015) provided an example of two types of nurses in a specific ward, those who make solid decisions and those who generally ask for advice from others in order to make a decision. Holloway and Galvin (2015) state that ethnographers might name these types of nurses as “*decision-makers*” and “*advice takers*” (p.208). An example here is the identification of the extent to which residents were allowed the ‘freedom to be active and engaged’. I was able to identify examples where residents were able to participate and collaborate in the life of the home, this was particularly emphasised in a care home culture that valued relational aspects of the lives of older people. I was also, however, able to identify examples where residents did not contribute or participate and to them they did not have the potential or ‘freedom to be active and engaged’. This allowed me understand variation in the data from within one particular major theme and subsequently draw attention to the difference between

cultural characteristics of the two homes. This allows answering the research questions and disclosing the cultural elements being studied. In another example, different typologies of residents (older people) emerged from the data after an extensive critical analysis of the data around life after admission. These types are described as ‘Early Engagers’ and ‘Initial distance’ who had different views and behaviour towards their stay in the care home. As in all typologies, these types are at the end of a continuum and they overlap at some point on the continuum, but nevertheless identify variation.

Engaging with, and integrating, the related literature

The final step as explained by Holloway and Todres (2010) “engaging with, and integrating, the related literature” will be elaborated in the discussion chapter where the findings of the study will be discussed in an analytical and critical way in which inferences can be made. At this stage, the findings of the project (the resultant themes and my observations relating to care home culture) that obtained from the analysis will be linked to previously developed theories which might add to my own analysis or indeed help in the development or further elaboration of existing theories. This is done by comparing one’s own research project with other researchers’ work (Holloway and Galvin, 2015). Through the processes of analysis and interpretations, Holloway and Galvin (2015) argue that “*researchers build a holistic portrait of a culture from a number of building blocks*” (p.208). I will of course return to this in the final chapter of this thesis.

4.8 Ethical considerations

According to Green and Thorogood (2004), all types of research studies on human beings potentially create ethical concerns and it is important to protect the study participants irrespective of the research paradigm applied (Speziale et al., 2011). The

main ethical issues considered in this study were autonomy, confidentiality, beneficence and non-maleficence and justice. How these were addressed is outlined below.

4.8.1 Respect for autonomy

Respect for the decisions, personal choices and rights of study participants are a vital ethical concern. As discussed previously my role and purpose in this study were made clear to the participants, as is consistent with respecting the autonomy of the study participants. Knowledge of the researcher's role and the overall purpose of the study are essential if participants are to give informed consent. As Nnebue (2013) notes study participants should be well informed about the research and must give their consent prior to be involved in any research if their rights are to be respected. As Moore and Savage (2002) caution a signed consent form does not ensure that the study participants have understood the study completely and in order that they do they must be provided with as much detail as is necessary in a format that they can understand (Parahoo, 2014). In addition to giving informed consent participants need to be made aware of right to withdraw from the study at any time (Speziale et al., 2011).

As previously mentioned, prior to data collection, an initial meeting in both homes was conducted in order to ensure that the participants could provide informed consent. This meeting was conducted on different occasions, for instance, a separate meeting with all the residents and staff in both homes. After introducing myself, I explained the purpose of the study and described what would be involved in detail, encouraging attendees to ask any questions that they might have. The process of the research was also explained to all the attendees. For example, I clarified that the research will start with a period of observation, followed by face-to-face interviews. I also described how observation might continue for a considerable length of time. I explained that events, activities and interactions between residents themselves and staff will be observed.

Following this, the copy of the information sheet about the research project, aims, and participants' rights was distributed among all the attendees (see Appendix C). I reinforced that the participation was entirely voluntary and both older people and staff were free to decide to take part in the study or not without any coercion. I also emphasised that even after they agreed to participate, they could withdraw from the study at any time they wish.

In addition, I ensured that all the attendees take a copy of the information sheet to be read or read out for them in a later time and think about it. I also explained that after reading the information sheet, they could ask any questions regarding the project that they might have. In fact, some of the attendees (residents and staff) expressed their immediate interest in taking part in the study. Verbal consent as well as written consent form was obtained from those residents and staff who were willing to participate in the observation. The consent form was signed by those who were interested in participating in the observation immediately in the same meeting. However, for others a signed consent form was obtained afterwards. It is also important to acknowledge that verbal consent for the observations was obtained on an iterative basis, for example, before each period of observation.

For the face-to-face interviews, I also ensured that the participants were also willing to participate in the study and thus, verbal and informed consent was obtained. This consent was obtained after the meeting when I was making decisions about my sample. The consent for the informal interviews was obtained verbally.

4.8.2 Confidentiality

Another principle of ethics is to protect the confidentiality and anonymity of participants in the research study (Speziale et al., 2011). According to Polit and Beck

(2004, p. 150), confidentiality “*is a pledge that any information participants provide will not be publicly reported in a manner that identifies them and will not be made accessible to others.*”

As mentioned before, interviews were audio-recorded and permission obtained in advance from each participant to record his/her voice digitally. A choice of audio-record interview was given to participants, in which participants were free to accept/refuse to record their voice. Only the manager of the Moon care home refused to be audio-recorded, thus, I have taken detailed notes during the interview and then immediately after the completion of the interview expanded them.

The participants’ interviews recorded in the fieldwork were transcribed verbatim by myself to ensure a meaningful data. All the data generated (observations, interviews, and fieldnotes) were anonymised and no participants’ original names were written on them rather fictitious names were given to the participants to protect their anonymity.

I referred some of the names of residents by a nickname, a Kurdish word to give an essence of their role and their primary activity in the life of the home. For instance, Mr. Baxawan took on the role of gardener that is why I called him a ‘gardener’. This was a way of both maintaining confidentiality but also as a means for communicating the ‘essence’ of their role and place within the care home community.

All the participants’ data were kept safe in a locked cabinet and any data stored on a computer were password protected.

4.8.3 Beneficence and non-maleficence

Any type of research is a potential risk for participant identity (Gobo, 2008), while, the level of potential risk is different from a method to another, for instance, the potential for occurring physical harm in ethnographic research is less compared to biomedical

research. Murphy and Dingwall state that “*the study researcher’s responsibility is to anticipate and avoid risks to participant while, at the same time, ensuring greatest possible benefit*” (Murphy and Dingwall, 2003, p. 150).

During the data collection, particularly during the interviews with older people, participants may feel tired. To address such issues, the well-being and safety of participants must have the priority over research project (Parahoo, 2014). Beneficence implies to do good, striving benefits outweigh the risks for the study participants (Holloway and Wheeler, 2010).

To support the principle of non-maleficence, attention was given for avoiding the causation of harm and discomfort resulted of participating in this study. In fact, during the data collection, particularly, the interviews, no serious emotional distress expressed while the study participants talked about their experiences of living/working in the homes. I carefully used an interviewing style that was conversational and sensitive. I showed to participants that I cared and pleased to listen to their stories and experiences. I also showed my interest once they desired to expand on some topics. In addition, if participants felt tired during the interview, I encouraged them to relax and stopped the interview. I arranged to continue interviewing them at a later time. I did not face any particular problems of this nature from the participants during my observations. For example, I did not encounter any behaviour from participants indicating their disapproval of my presence such as negative facial expression, changing their topic, or keeping silent. This might be due to either having a trusting relationship with residents and staff after prolonged presence at the homes or Kurdish people’s attitude towards others (as they are friendly and hospitable). The one exception to this was for many of the female residents. I found it very difficult at times to engage with the women in the home as they did express that they ‘felt shy’ in my presence. I put this down significant

aspects of Kurdish, and indeed Arabic, culture and the relationship between men and women. This is a real challenges for carrying out this type of research in such a culture.

I also ensured the study participants that if they have any concerns towards me with regard to my behaviour, attitude towards them in any time during the data collection period for example, observations or interviews; they can contact the care home manager who could then communicate concern to my supervisor. This information is also included in the participant information sheet.

In addition, the observation of activities which may be viewed as intrusive, such as personal care or those which take place within private spaces were not undertaken. As I was available in the homes for a considerable time, sometimes I had to stop my observations and participate in what was happening around me. For example, I sometimes helped residents to top up their mobile phone or dial up a number for them or if staff asked me to do something or take part in an activity; I had to respond to their requests. On one occasion, during one of the outdoor activities (picnic) in the moon care home, I had to stop my observation and leave my notebook and field noting behind in order to help a resident after falling over.

4.8.4 Justice

The principle of justice refers to being fair and applying equality in including or excluding particular individuals or groups. Prior to data collection, initially through identifying inclusion and exclusion criteria, I applied the principle of justice where all individuals who might potentially be part of the study had equal opportunities to participate without including some individuals and marginalising or excluding others without any reasonable justification. I tried to include an equal and diverse sample by including different individuals from both the residents and staff without considering

their age, gender, or work status in the home. As I have already mentioned, whilst this was my intention I was not able to recruit a large number of women and I shall return to this in the discussion chapter.

In addition, justice also means that the researcher being fair and impartial in treating and interacting with participants even-handedly, ensuring equality among the study participants (Parahoo, 2006). Murphy and Dingwall (2003) state that in the principle of justice, qualitative researchers require treating the study participants equally. In this study, no favouritism was practiced; all participants were treated equally regardless to their gender, ethnicity and age. For example, being nice to someone and not others.

4.9 Quality criteria

As is the case with most qualitative research the question of how best to judge its 'quality' is a contested issue. Unlike quantitative research, where there are widely accepted canons of what makes for a 'good' study, in the form of validity and reliability, there are no universally accepted criteria in qualitative research. This is as true of ethnography as it is of other traditions. Here I draw on the work of Hammersley, one of the UKs foremost ethnographers to consider this issue as it relates to my study.

In reviewing the field Hammersley (1998) contends that there is no one approach to judging the quality of an ethnography that is adopted by everyone. Consequently, some ethnographers contend that the criteria applied to quality should be no different than those used by other qualitative methods, others argue for the need to develop a distinct set of criteria for ethnography and still others question the need for quality criteria at all.

Hammersley (1998) takes the stance that the central question to be addressed when quality is considered is the purpose for which research was conducted. For him the answer is that the study should produce 'knowledge' that is of public relevance. In other

words, the findings should be able to inform public debate and any subsequent action taken on the subject under study. This is a pragmatic approach that some more theoretically oriented researchers would question. However, given that my aim was to inform the development of care homes in Iraqi Kurdistan Hammersley's arguments resonated.

Therefore, in order to consider the quality of an ethnographic study Hammersley (1998) proposes that 3 broad questions need to be asked, these are:

- How 'plausible' it is? Does the explanation provided sound realistic and reasonable?
- How 'credible' is it? How well are the assertions supported by the data provided?
- How 'relevant' is the study and does it address a subject that in some way 'matters'?

Overall answers to the above questions will determine the contribution that the study can be said to make, especially in a field where there is little prior knowledge.

For Hammersley (1998) each of the above questions involve some form of judgement in that there are no hard and fast 'rules' to determine whether the questions have been answered satisfactorily. Moreover, he argues that such judgements should be made by the research community. Whilst I chose to adopt his principles I believe that judgements about quality need to be made by the wider community who is likely to use the research and this is the stance I will adopt when issues of quality are considered in the final chapter.

4.10 Summary

This chapter presented an important information on the methodology of the current study which was qualitative methodology and the rationale for choosing this methodology was underlined. It also discussed the methods of data collection in detail and considered the issues of ethics in the research. The findings of this study including the descriptive and analytic findings will be presented in the subsequent chapters.

Chapter Five: An Overview of the Care Homes

5.1 Introduction

In order to best interpret the findings reported in the subsequent chapters it is important to have a clear understanding of the homes in which the study took place and of the participants whose accounts provided the data upon which the results are based. Therefore, this chapter provides such information. It begins with a brief description of the location and physical layout of each the homes, followed by an overview of their organisational structure, staffing roles, philosophy and related policies, especially that relating to the admission process, together with a description of a ‘typical’ day. These factors shape what might be described as the ‘visible’ aspects of the homes ‘culture’. The chapter concludes with a brief ‘pen portrait’ of the participants in each home to give a flavour of their role in the life of the home, which is captured, where appropriate, by a nickname.

5.2 Structure and context of the care homes

The table below provides an overview of the main characteristics of each of the homes.

Table 5.1 Characteristics of the care homes

Item	Star Care Home	Moon Care Home
Home type	Governmental	Governmental
Location	Biggest city in the region	Second biggest city in the region
Building structure	Composed of one floor, adapted building	Composed of two floors, purpose built care home
Capacity	35 beds	70 beds
Religion	Muslim	Muslim
Fee charges	Free (state funded)	Free (state funded)

5.2.1 Care Home 1: Star Care Home

Location and physical environment

The Star care home was a governmental home with 35 beds, located in the capital of Kurdistan region. It was located in a popular area and surrounded by a variety of shops and restaurants. The city centre could be reached on foot in approximately 30 minutes. Although there was no specific taxi rank in the area, taxis were generally available on the main street where the home was situated. In addition, the area was serviced by buses during the day time.

The home was not purpose built and had been moved from another location in the city so that the former site could be used as an orphanage. The current building was seen as a temporary site for the home, with it being expected to be relocated to a new building in the future. This of course was before the outbreak of war in the region.

The home was situated near to both government and private hospitals which facilitated access to the emergency department, providing immediate help and treatment to residents, if required. The home had a private ambulance to transport residents if required.

The home was a single storey with various rooms and halls organised around a front yard. Immediately through the main entrance on the right there was a reception room followed by administrative offices. The administrative area included several rooms allocated for the manager, assistant manager, administrators, health staff and social and psychological workers.

The residents' halls and rooms were adjacent to the main entrance. After entering the residents' living area, there was a long semi-circle corridor off which were located the residents' sleeping accommodation, termed 'halls (see below)'. On the walls of the corridor there were multiple windows which gave natural light and various pictures

including photographs of the home's trips and activities and individual photos of current residents. In addition, some bouquets of flowers were located in the corridor (see Appendix E for the sketch).

The male residents' living area was composed of four sleeping halls and one bedroom with two single beds with one hall for female residents. There was also one communal area and a dining hall branching off from the corridor. Each resident's hall had a shoe storage area prior to entry for residents or guests to put their shoes in, reflecting the Middle Eastern tradition of barefoot walking indoors for cleanliness. Beside each residents' hall there was an information sheet on the wall displaying the number of residents living in that hall, their names and date of admission.

Each hall accommodated 7-10 beds and each resident had a single bed and two lockable wardrobes to keep their possessions. These wardrobes were situated in different places in each hall based on their designs; some were placed next to the beds, while others were placed opposite to them. Each bed was furnished with one or two pillows and blankets and a bed sheet. There was nothing to separate the residents' beds from each other, such as curtains or partitions.

Air conditioners and fridges were placed in each hall, and various forms of decoration (e.g. flowers and personal pictures) were in place. Toilet and shower facilities were located in each hall and also in the main corridor. However, the residents were free to use either the halls' toilet or the main toilet in the corridor; most of residents used the main toilets and shower rooms located at the main corridor in order to prevent any bad odours in the halls.

The communal facilities such as the dining room, kitchen and laundry room were grouped together at the other end of the corridor. The dining room was furnished with chairs and tables. Usually, the kitchen staff prepared a big pot of tea and placed it on the

cupboard with every meal, so the residents were free to drink their tea either with the meal or afterwards. The tables were set and the food served on the tables before the residents entered the dining hall to take their preferred seats. It was the kitchen staffs' responsibility to serve the food as was stated in the home's policy.

The communal hall was specified for social activities, including meetings, leisure activities such as board games, watching TV and praying. Whilst, praying in the communal areas was not common, some residents chose to pray there and the culture of the home allowed this. A big TV was placed on the wall in one corner with many sofas and small tables around it. As with the other halls, the communal area was decorated with flowers and pictures. Several recreational games were available such as dominoes, chess and backgammon. Residents were free to access this hall at any time (i.e., 24/7) for any reasons.

A small room was located in the corridor next to the dining hall for the observer who walked around the corridors and halls to check residents' needs.

Organisational structure and staffing roles

The care home's organisational structure provides details of how work within the home was organised and who was responsible for what. An organisational framework for care homes in Iraqi Kurdistan was established by the Ministry of Labour and Social Affairs which stipulated the main roles staff working in the home from the top of the organisation down.

This structure is captured in the chart below.

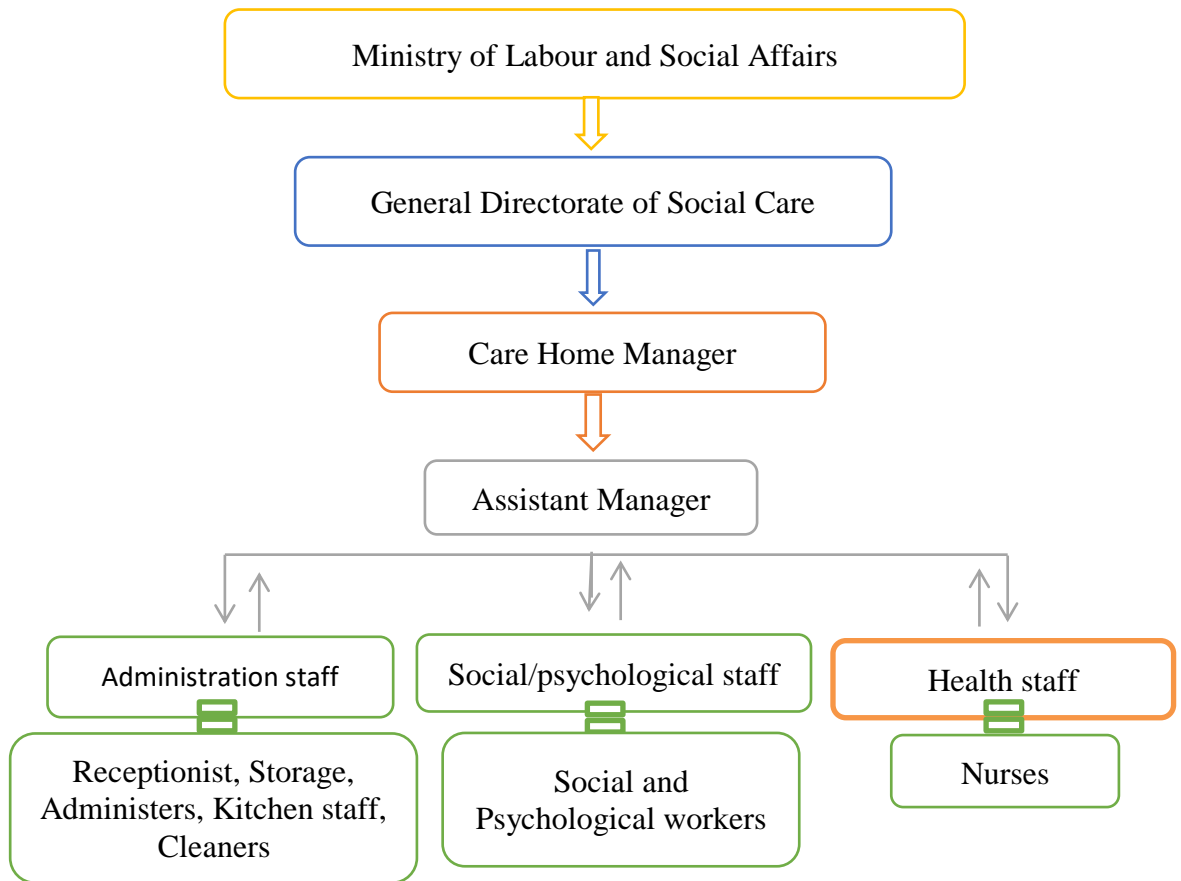


Figure 5.1 Organisational framework of care homes

The organisational structure of care homes was hierarchical with those at the top of the structure having more authority than those beneath them. Nevertheless, within each care home, it was at the managers' discretion who was involved in the decision making process, and what part they would play. In the Star care home, the manager chose to involve other staff members in decision making and also took residents' views into account (see later).

According to the official guidance (Section 15b), the working hours and staffs' shifts followed those laid down by the Ministry of Labour and Social Affairs and comprised three shifts, consistent with other governmental organisations. The morning shift ran from 8:30-13:00, the evening shift from 13:00-17:00 and night shift from 17:00 to 08:30). See the Table below.

Table 5.2 Duty rota of staff in Star care home

Shifts	Time	Kitchen Staff	Social workers	Manger/Assistant manager	Health staff	Housekeepers	Observer
Morning	07:00	3	2	1/1	2	4	
	08:00						
	09:00						
Afternoon	13:00						
	16:00		1				
	17:00				1		
Night	08:30					1	1

The home manager was responsible for directing the home and ensuring that appropriate organisational policies and procedures were in place; everything needed to be submitted to the managers' office and approved by his signature.

The manager was usually available in the morning shift from 8:30am. After his arrival, he usually spent some time in his office doing paperwork and talking to staff, before meeting the residents and greeting them. I observed that the manager spent considerable time with residents by visiting them in the sleeping halls, communal hall and garden and always sought their views and opinions. He was frequently seen in dining hall during meal times and in addition, his office was open to staff and residents anytime they wanted to see him. He often stayed after his shift had officially finished to deal with any outstanding work. The assistant manager followed a similar pattern and also engaged with residents and staff.

Other staff members on the morning shift included a receptionist, a clerical officer, treasurer, social and psychological workers, health staff, a tea maker, housekeepers and kitchen staff. The receptionist was responsible for welcoming any visitors and providing them with any information they required. They were also responsible for distributing daily newspapers to the staff and some residents. There were two clerical staff members

responsible for routine documentation and administrative tasks. One individual was responsible for making and serving tea to the staff and visitors of the home. Most of the 'work' was done in the morning shift. Social and psychological workers¹ played a significant role within the care home. As stated by the Ministry's Guidance (2013), Part 11, Section 1(C), care home managers should hold at least a bachelor's degree in either sociology or psychology. The social and psychological workers' primary responsibilities were to solve the social and mental issues of residents with cooperation with health staff after establishing a firm relationship with the former, and to encourage a social network among residents and maintain their relationships. Two social workers were present in the morning shift and dealt with residents' issues and spent most of their time with them.

The Star care home had a small health unit, three nurses worked there; two of them were in the morning shift and one in the afternoon. In their office they had various equipment such as first aid boxes, sphygmomanometer, thermometer and medicines. The healthcare staff provided the residents with immediate healthcare assistance and treatment, when needed. For example, checking vital signs (blood pressure, pulse, and body temperature), administering medications, cannula insertion, intramuscular or intravenous injections and wound dressing (if any).

The health unit also had a small pharmacy located at the care home; in which some medications such as antibiotics, analgesic and pain killers were provided to residents when required. Additionally, if any residents needed to be treated in hospital, a nurse sometimes accompanied them, a referral form was prepared to be sent with the resident to the hospital as appropriate. The care home had an ambulance for transferring

¹ In Kurdistan region, two different job titles were given to graduates of sociology and psychology: social researcher and psychological researcher, however, in this study I have referred to them as social or psychological workers. In care homes, they were responsible for social and emotional aspects of residents. It was observed that they conducted the same work and the only difference they had was with their work title.

residents when required. After treatment the residents were transported back to the care home where treatment continued as appropriate. Sometimes use was made of community services, such as the local pharmacy.

Moreover, they regularly monitored those residents who had chronic diseases such as hypertension, diabetes or stroke. Usually a nurse was also a member of the Food Supervision Committee whose role it was to observe the quality and quantity of food provided.

A social worker and one nurse were present during the afternoon shift (13:00-17:00). On the night shift (17:00-08:30), an observer with the same nurse were present in the home. The observer (not required to hold a degree) was responsible for observing residents' different aspects such as their lives, determining issues in the halls (if any) and listening to residents' requirements and queries. The night shift observer reported issues within the home (if any) to the staff members or the manager in order to take actions.

Kitchen staff and cleaners had different working hours, from 07:00-16:00 for the former and 08:30-17:00 for the latter (with one exception, mentioned below). There were four cleaners responsible for cleaning the residents living quarters and helping them bathe if required. One of the cleaners lived in the home. Three kitchen staff were responsible for food preparation and providing meals according to a timetable fixed by the home. They were also responsible for cleaning the kitchen area and washing up the dishes.

Despite the apparent distinctions between staff roles there was quite a bit of flexibility in the Star home and staff worked well together as a team. This will be considered in more detail in the following chapter. Attention is now turned to the Moon care home.

5.2.2 Care Home 2: Moon Care Home

Location and physical environment

The Moon care home was also a governmental home but was bigger with 70 beds. It was situated in the second biggest city in the region and was located in a popular area surrounded by a variety of mini supermarkets, restaurants and pharmacies. It was approximately a 40 minute walk from the city centre, with two bus stations close by and taxis were generally available on the main street. Unlike Star, the Moon home was purpose built with modern bedrooms accommodating a maximum of two residents. During conversations both staff and residents were happy with the care home's structure and design.

The Moon care home had its own health department which provided the residents with immediate assistance and treatment, when needed. In contrast to the Star care home, the home did not have a private ambulance and called for one if required.

The home had two storeys comprising a variety of different accommodation for staff and residents organised in three main wings with almost identical interior design. Two of these wings were allocated for male residents while the third wing was designated for female residents and administrative personnel (the manager, assistant manager, social staff, health staff etc.).

The care home was accessed by one main gate and had a large garden to the front. All the three wings had their own entrances to the garden and were joined to each other by a wide corridor at the rear. On the left of this corridor were the kitchen, dining room, activity hall and laundry room. The care home also had a back garden which was accessed from the main corridor (see Appendix E for the sketch).

The residents' wings were composed of several en-suite rooms; each room had either one or two beds. Each wing had its own communal space, with a TV and furnished with

carpet and sofas. Central air conditioners were placed in each room, and numerous decorations such as flowers and personal pictures were in place. Toilet facilities were also located on the corridor in each wing. The residents were free to use either the bathrooms located in their rooms or the main one in the wings' corridor. It was noticed that the residents mainly used the toilet located in the corridor.

There were multiple windows on the wall of the main corridor which overlooked the back garden. Various decorations and pictures were hung on the walls such as photographs of the home's events and activities.

The communal facility (i.e., the dining room and kitchen) was furnished with chairs and tables. The food served on the tables prior to the residents' arriving at the dining hall and residents were seen to take their preferred seats. Some residents, particularly females, were noticed to take their food to their rooms (as they felt shy to eat with other residents). As with the Star care home, a large pot of tea was positioned on a table with every meal, and residents were free to top up their cups and drink their tea any time they liked.

Organisational structure and staffing roles

The Moon care home had the same organisational framework as the Star care home as both homes were regulated by the same authority (See earlier Figure 5.1).

As with the Star home staff's working hours were divided into three shifts which were identical in Star.

Table 5.3 Duty rota of staff in Moon care home

Shifts	Time	Kitchen Staff	Social workers	Manger/Assistant manager	Health staff	Housekeepers	Observer
Morning	07:00	2					
	08:00						
	09:00		1		1/1	1 doctor + 2 nurses	6
Afternoon	13:00						
	16:00		1			1	
	17:00						
Night	08:30						2

Whilst the staff duties were broadly similar between Star and Moon on paper, in reality they operated in differing ways. For example, unlike the manager in Star, the manger here spent most of her time in the office and was rarely seen on the resident wings, and the open access enjoyed by residents in Star was not noted here. Although all the staff had ready access to the manager, only some of the staff were frequently seen in her office. The level of residents and some staff involvement in decision making within the home was limited. The manager was generally present during the home’s activities and events.

As with the Star home more staff members were on duty throughout the morning shift and their roles were very similar. However, it was noted that staff tended to carry out their duties on an individual basis, with far less cooperation than there had been in the Star home. However, the staff were flexible in their roles but team work was less noticed among them compared to the Star care home.

In order to promote and maintain the health of residents, the Moon care home had its own health department; four nurses working in shift basis (one nurse at any one time) with one doctor working in the department, in which they provided the residents with immediate healthcare assistance and treatment, when needed. The healthcare provided

comprised of checking vital signs (blood pressure, pulse, and body temperature), intramuscular/intravenous injections, cannula insertion, wound dressing and administering medications for those residents who needed it. In addition, on a daily basis, the medical staff (the doctor and a nurse) had a follow up routine for those residents who required medical checks or suffered from chronic diseases such as hypertension, diabetes or stroke.

The health department also had a small pharmacy inside the care home; in which it provided residents with some medications such as pain killers, analgesic and antibiotics.

The care home medical staff were not always resourced to deal with medical situations and sometimes residents needed to be referred to a local hospital. If hospitalisation was needed, a referral form was prepared to be sent with the resident to hospital. As the care home did not have an ambulance for transfer, the residents went to hospital independently or with support from a member of staff, depending on their condition.

After treatment the resident was transported back to the care home where treatment could continue as appropriate. As was the case with Star care home, use was made of local pharmacies when needed. In addition, the health department has its own laboratory in which certain blood and urine tests are provided to residents, these tests include fasting and random blood sugar, complete blood count, general urine test, liver and renal function test.

Only a nurse was present in the afternoon shift, whilst no staff members with a medical background worked during the night shift. There was one social worker during the morning and afternoon shift and only two observers at night shift.

Two kitchen staff worked in the care home and their working hours were from 07:00-16:00. A catering company was responsible for providing the residents with meals and

also the kitchen staff were also employed by the same company. One possible reason that may account for the difference in numbers of kitchen staff between the two care homes is that a private catering company was in charge in the Moon care home.

Cleaners were responsible for keeping the home clean and maintaining the residents' hygiene in terms of washing their clothes, bed sheets, and rooms. Six cleaners worked for almost nine hours.

5.3 Policy and philosophy of care of the homes

Guidelines for care homes were issued by the Kurdistan Regional Council of Ministers and these included the rules and regulations that the care homes were required to follow. According to the latest guidance (No. 2) issued by the Council of Ministers on 25th February 2013, the main goals of care homes were to:

- Provide social, medical and psychological care for older people

This was to be achieved by providing residents with free services such as suitable accommodation, healthy food and providing them with daily necessities such as clothes and a monthly pocket money (45,000² Iraqi dinars (equivalent to £ 25) It is the care homes responsibility to create a wholesome sociable and psychological environment for residents and to provide them with appropriate healthcare. Although they were resident in the home it was also considered important to maintain their relationships with their families, relatives and wider community and to involve older people in the community and thereby maintain their identity as an individual. To so do might include the provision of library facilities and appropriate equipment to maintain their interests and activities.

² Exchange Rate: GBP £ 1.00 = Approx. IQD 1700 and this amount worth up to £5 in the UK.

Both homes stated that they wanted to meet residents' needs with respect, with their mission statement being to 'provide care with patience and love for older people and serve them as they serve their parents'. This was posted on the walls in the reception and administration rooms of both homes, and it was repeatedly cited by the staff and residents in both homes.

Whilst both homes shared fundamental principles and philosophical foci on paper there were variations in how these were enacted in practice, and these seemed to relate primarily to the leadership style adopted by the managers. For instance, the guidance stated that managers should hold a meeting at least once a month and whilst these happened observations revealed that they operated quite differently. In the Star home, the manager listened to every suggestion that staff made and took these into consideration in any decisions that were made. Residents were also actively involved. In contrast the Moon home manager used her power to make decisions independently or only listened to suggestions made by the staff members with whom she had a close relationship. Residents were rarely actively involved.

Based on the observations made in the Star care home, it was revealed that the care home practice advocated relationships between residents and staff. The staff members and the manager were frequently observed to mix with residents and spend considerable time with them. It was noticed that the relationships between residents and staff were often close and they were mutually engaged. In addition, the relationships between staff members themselves were seen to be based on cooperation and good teamwork. The manager had equal and inclusive relationships with his staff members. Overall, a positive relationship in the Star care home was one of the main characteristics of this care home. Thus, the care home practice was mostly relational.

In contrast, the culture in the Moon care home was slightly different from the Star care home, in which the practice was task-centred and little attention was seen to be paid on relationships. The relationships between most of the staff members were seen to be distant. In addition, the relationship between staff and the manager was inclusive for some, while it was distant and dominant with others. Detailed analysis revealed further dissimilarities and these will be highlighted below.

Having considered the stated aims and philosophies of the homes attention is now turned to what might be called a 'typical' day.

A typical day in the care homes

A 'typical' day in the care homes began in the early morning when most of the residents got up before sunrise to engage in Morning Prayer (Fajr³). According to Islamic law, there are five daily prayers, the first prayer being Fajr at around 05:00. After praying, some of the residents returned to their beds and slept again while others continue to pray, or watched TV/listened to the radio until breakfast time. Some residents slept until after sunrise, and in both homes residents were able to get up or go to bed at any time they wished.

The housekeeping and kitchen staff started their morning shift at 07:00 and signed in. The cleaners then started cleaning and the kitchen staff began preparing the food. The other staff commenced their work at 8:00 and social workers received verbal reports from the night shift observers. A handover report concerning residents' condition (leave, sickness and issues such as conflicts between residents) was written in a notebook for every shift which was only for social workers.

Three main meals were provided every day: breakfast, lunch and dinner. Breakfast was usually served at 08:00 and consisted of eggs, bread, butter and tea. The homes had a

³ Fajr prayer: is the first of the five daily prayers undertaken by practicing Muslims.

fixed menu of meals served on a weekly rota basis. Usually, food was delivered to the dining hall on a trolley from the kitchen located at the back of the dining hall. The catering staff set the tables and served the meal in the dining room. Whilst the broad patterns were similar in both homes, there were subtle variations that gave a further indication of the potential differences between the 'culture' of the two homes. For example, in the Star care home a certain resident was regularly seen to help the staff in setting the tables and serving the meals. While, in the Moon care home, although a resident used to help the kitchen staff in setting the tables and serving the meals, the managerial team did not allow the resident to do it anymore as the manager stated that it was interfering with the staffs' job. Residents were reminded about the meal time by the ringing of an electronic bell which was located in the corridor. The residents were free to sit anywhere; however most of them were seen to go to their preferred seat while others took their meals and ate in their rooms. The pattern of meals was comparable for lunch and dinner.

Meal times were usually quiet and there was seldom interaction between residents. Whilst, there was no specific reason for this it might be due to the Kurdish culture where in the past speaking during meals was not encouraged. However, staff in the Star home did interact with residents more than staff in the Moon home. After everyone had finished, the staff cleared the tables.

In the Star care home, those residents who were interested to continue or start working outside the home were able to do so due to the close nature of the relationships they had with the manager. Some residents (only three male residents) were seen to work outside the care home while they resided in the home and they were self-employed. Their jobs were varied from selling mobile top up cards to carrying out mechanics works. In contrast, in the Moon care home, none of the residents were observed to continue or to

start working outside the home. This was one such indication that the two homes were very different in terms of the ways in which regulation and rules were applied. Furthermore, it may be interpreted that this could be due to the relationships between residents and the manager, which were more distant in the latter environment (more detail will be given in the next chapter).

Therefore, those residents who worked outside the Star care home went to their work place and others stayed in the homes. For example, some of the residents returned to their rooms and sat alone, while others went to the communal places such as the halls and the gardens. The residents were offered choices in some ways such as deciding whether or not to involve in activities.

During the morning shift, staff were usually more available and their numbers were higher compared to other shifts. They engaged with residents in different locations either in corridors, communal areas or in the residents' bedrooms. Sometimes the situation was reversed and the residents were seen to visit the staffs' room. The culture of the Star care home allowed the residents to frequently go to either the social workers' room or the manager's room and talk about their queries (for example, if they wanted to take leave, or complain about food or hygiene of the home) and this was regularly observed. However, in the Moon care home, the residents were commonly noticed to go to social workers' room rather than the manager's room. The social workers were alone in their room most of time, while the manager's room was occupied by staff members, mostly those who had close relationship with the manager. The manager was seen most of the time in her office and rarely observed to be with residents, underlining the notion of social distance between her and the other staff and residents. With regard to the Star care home, the manager was mostly seen either visiting residents or being visited by

residents, in contrast to his counterpart in the Moon care home. This was the situation for the social workers too.

During lunch time, which was served at 12:00 noon, the residents gathered in the dining room to have lunch after the Noon Prayer while those who worked outside (in home one) used to have their lunch outside and did not come back for lunch and they had to pay for these themselves. The type of foods provided was of the generic Middle Eastern style, consisting largely of rice-based dishes, and different types of soup and meat; these kind of food are very common in Iraq as well as Kurdistan region. Additionally, they sometimes prepare Kurdish dishes like 'dolma', 'kuba' and 'kebab'. After lunch, most of the residents were observed to go to their beds either to relax or to sleep for some hours, and the number of residents in the communal room or in the garden was few. Milk and fruit were provided in the evening time.

The last meal of the day was dinner, which was served around 17:00. Usually, the provided food in dinner was slightly lighter than the lunch and might include soup, pasta and potatoes.

After dinner, some residents went to their beds either to lie down, read or sleep, some gathered in the gardens either talking or smoking cigarettes while others assembled in the communal room watching TV.

Most of the residents were seen in bed after 20:00, which was sleeping time for the majority of them which is common for older people in the Kurdistan region where they tend to sleep earlier as they needed to be up for prayer. The homes' entrances were closed at 20:00.

To sum up, although the policy and guidelines were theoretically the same in both homes, the way these homes operated appeared to be different as one care home (Star

care home) noticed to be more relaxed, less rigidly organised around regulation. I noted that the Star care homes was therefore based around a relational model. The other care home (Moon care home) tended to be characterised by regulation and routine and as such was more organisational in its practices.

Having provided an overview of a care home in Iraqi Kurdistan, its policy and philosophy of care, the focus is now turned to the admission process. As emerged from the literature reviewed understanding the process of admission is an important element in care home life.

Process of admission

Care homes in Iraqi Kurdistan are places where older people live, including those in need of personal care, because they are no longer able to care for themselves; and those older people who do not require care assistance but do need a place to live in. There are multiple conditions in the procedure by which older people are admitted by care homes.

The care homes had a fixed policy regarding the process of admission for new residents and both homes followed the same process. The main prerequisite for accepting new resident was that the older person should be an Iraqi citizen, aged not less than 60 or 55 (for men and women respectively) as it was thought that women age faster than men.

Some older people entered care homes independently (self-referral), some were brought in by family members, while others were referred by the government. Generally, the process of admission was similar for all cases. All the referrals go straight to the homes without involvement of another agency.

Upon referral a social worker would interview the potential new resident and open a box file for them. Afterwards, the resident would be referred to a specialist hospital to demonstrate mental integrity and investigations will be carried out such as X-ray to

ensure that the older person has no communicable diseases. Once the results are available, all documents (ID, photos and clinic results) will be put together in a box file with a report written by social workers and then these will be handed out to the manager. Based on the social workers' report and the other documents (investigations and specialist report), the manager will make the decision whether to accept the resident or not.

There is in fact some degree of flexibility in dealing with cases, and consideration of humanitarian grounds can allow the admission of younger people who do not meet the requirements, particularly if they have no shelter, or if a study of their personal lives and previous circumstances by social workers and specialist consultants (psychologist) determines them to be in need and deserving of care home admission. For instance, Ms Sharmin, aged 50 years at the time of the fieldwork in the Moon care home was 5 years younger than the required acceptance age of admission (See later).

During the admission process as observed in the Star care home, the responsible staff completed the paper work then a staff member, usually a social worker, accompanied a newly admitted resident and familiarised him with the homes' routines and allocated him to his bed. Some other staff members were observed to welcome the new resident but no counselling was offered to the newly admitted resident to help reduce his worries or anxieties and prepare him to adjust to the new environment. But I did see the assistant manager visit the new resident and welcome him. The assistant manager gave support to the resident and told him to ask for anything he required after a while, other existing residents welcomed the new resident.

Although both care homes had to follow the same process of admission for accepting new residents, there might be some differences in the way this process was undertaken as it was the case with the homes' policy. As stated above, at the time of my data

collection period, I have only observed new admissions in the Star care home but I have not encountered with any new admissions in the Moon care home at that time.

Based on the above description of both care homes being studied and the policy and philosophy of these homes it is important to acknowledge that even at an early stage some differences began to emerge about how the homes operated, suggestive of a possibly different culture, with more involvement and inclusion being apparent in Star. This will be built upon later. Attention is now turned to the participants who were the primary source of the data.

5.4 Participants' profiles

The profiles of residents and staff presented in this section are those who participated in the interviews.

5.4.1 Star care home

Residents

The total resident population in the Star care home at the time of the data collection period was 25 residents; their age range was varied between 60 to 87. The majority of residents were male and most of them were independent; the reasons for admission were different, however, the main reasons were not having a place to live and family breakdown. Most of the residents were independent with regard to their daily living activities as they were able to eat, dress, walk, and do their shopping by themselves.

All the residents interviewed were men, as the women chose not to be interviewed, with ages ranging between 61-87 years (see Table 5.4). The majority of residents had children (daughters and/or sons). Only one resident lived alone prior to admission, the others lived with their family (spouse or siblings) but had conflicts or could not get

along with them. The residents' reasons for admission were varied and will be discussed in the next chapter.

Table 5.4 Demographic data of residents in the Star care home

No	Name	Age	Gender	Year/month (s) of work	Marital Status
1	Tanya A	61	Male	Almost a year	Separate
2	Wasta	67	Male	5 years	Widower
3	Taqana	77	Male	Almost 14 years	Unmarried
4	Baxawan A	64	Male	5 years	Separate
5	Hawser	65	Male	23 years	Married
6	Tofiq	61	Male	3 years	Married
7	Haji	84	Male	5 years	Widower
8	Hassan	87	Male	5 years	Widower

Mr. Baxawan A

Mr. Baxawan A is 64 years old and has been living in the Star care home since July 2009. He is a reserved person who had limited interaction with others in the care home. His previous job was as a driver in a government office. After a family conflict, his wife and sons did not want him to live with them anymore and after being effectively forced to leave his family home at short notice he had no real option but to go into a care home.

Based on earlier experience of farming; he is now informally working as the Care Home gardener, cleaning up, watering, weeding, trimming and planting new flowers. He gains a great deal of pleasure from this but receives no other reward, with his work being voluntary.

Mr. Wasta

Mr. Wasta is 67 years old and has been living in the Star care home since April 2009. He separated from his wife in the 1980s and since then has been working and living in different cities across the country and living in hotels.

A friend of his told him about the care home and after some thought he decided to go and live there. Although, he has grown children, they are married, and he does not like to stay with them for long period but his son visits regularly and he occasionally stays with him overnight. Mr. Wasta continues to work in his prior job in the city and often therefore runs 'errands' for other residents such as buying cigarettes and mobile 'top up' cards. He frequently undertakes small jobs around the home.

Mr. Tofiq

Mr. Tofiq is 61 years old, and has been living in the Star care home for three years. He was a government employee prior to his admission and was living with his family. After having a conflict with his family, Mr. Tofiq moved to the Star care home.

Mr. Tofiq keeps to himself for much of the time and has limited interaction with other residents, he does not like to mix much and is rarely engaged in group activities. Despite this he has a good relationship with the staff. He often spends time alone by his bed or smoking in the garden.

Mr. Haji

Mr. Haji is 84 years old, and has been living in the Star care home since 2009. Mr. Haji is a widower and after his wife died he lived alone in a large house for a number of years. He felt lonely and isolated there so he decided to move into the care home. He is a sociable person and has good relationships with both residents and staff. He states that he is very happy with his life in the home.

Mr. Hawser

Mr. Hawser is 65 years old and is one of the residents who has been in the home for the longest. Like many of the residents a family dispute was the primary reason for him coming into the home, a decision that he made himself and was happy with. Whilst in the home he became friendly with one of the female residents and they eventually married, after discussion with staff. They are one of three married couples in the home. As Mr. Hawser has been in the home for so long he knows how things work, and helps new residents to settle in. On the whole he is quiet and spends most of the time in the gym hall where it was observed that the married couples tend to socialise. Although it would have been interesting to include a couple as a case study Mrs Hawser did not want to be interviewed.

Mr. Taqana

Mr. Taqana is 77 years old and has been living in the Star care home for almost 14 years. He is the second-oldest resident in the home. Mr. Taqana was unmarried man, and formerly lived with his brother and sisters before entering the care home. Following a disputes with his brother and not having anywhere else to live he decided to move into the care home.

Mr. Taqana usually prefers to sit alone and spends most of his time watching TV. He has very little communication with other residents as he feels that many are ‘troublemakers’ who don’t know the ‘rules’ of the home, although in reality few such ‘rules’ exist.

Mr. Tanya A

Mr. Tanya A is 61 years old, and has been living in the Star care home for approximately one year. He, like many other residents, moved in following a family conflict. He divorced his wife and although he has many children they are now all grown up with families of their own. Prior to moving into the home he lived with his

sister but after having a stroke he was unable to work and his sister could no longer manage him. He was persuaded to move into the home but was not very happy with the decision. He was an isolated resident and did not like to communicate or mix with others.

Staff

As Table 5.5 shows none of staff members had prior work experiences with older people before coming to work in the home. Their ages ranged between 31-51 years. The educational background among the staff members was varied.

Table 5.5 Demographic data of staff in the Star care home

No	Name	Age	Gender	Year/month (s) of work	Job Title	Marital Status	Educational Level
1	Barez	31	Male	9 years (3 years as a manager)	Home Manager	Married	Bachelor
2	Zerak	37	Male	7 years	Social worker	Married	Bachelor
3	Nada	34	Female	5 Month	Psychological worker	Single	Bachelor
4	Sarbast	38	Male	5 Years	Administratio n staff	Single	*Diploma
5	Raihan	51	Female	12 years	Nurse	Married	Intermediary School
6	Dlsaf	24	Male	2 and half years	Cleaner	Married	Can read and write

*Remarks: Diploma: Two years of study in institution after secondary school.

Mr. Barez

Mr. Barez is 31 years old and has being working in the Star care home for nine years. He was initially a social worker and had worked in every department (social worker, administrative work, observer and etc.) for almost five years. Then, he became the manager of the care home and still holds this position.

Mr. Barez has a separate office but was often found either with staff or residents in his office, talking and discussing issues related to their daily life. He likes team work and encouraged the staff to deal with any issues that arose as a team and to avoid any conflict.

Mr. Barez was often seen talking to and visiting residents in the dining hall, communal hall or in the corridors of the home as he saw it as important to the residents' views.

Mr. Zerak

Mr. Zerak is 37 years old, and has been working in the Star care home for seven years. He has a bachelor degree and graduated in sociology. He was initially the manager of the Star care home, position he held for 4 years. After he stepped down from the position (because of political reasons) he worked as a social worker.

Mr. Zerak had interaction with the residents on a daily basis and always seemed happy. He had established positive relationships with both residents and staff. Consequently, residents often approached him if they wanted to discuss anything.

Miss Nada

Miss Nada is 34 years old and has been working in the Star care home for only 5 months. Nada had a bachelor degree in psychology and had never worked with older people before. She worked day shift and had a direct contact with residents, often meeting them in the garden, the communal halls of the social worker's office. Miss Nada also visited the kitchen, to inspect the quality of food prepared for residents.

Mr. Sarbast

Mr. Sarbast was 38 years old and an administrative member of staff who had been working in the care home for 5 years. He works the morning shift, doing paper work and as well as visiting residents and listening to their requirements. He is also

responsible for store services and distributing daily necessity such as towels, clothes and shoes.

Mr. Sarbast is involved in several committees within the care home such as the finance committee, and food quality committee.

Ms. Raihan

Ms. Raihan is 51 years old and has worked in the Star care home for 12 years as a nurse. Her daily job involves checking blood pressure, and other observations and administering medications for those residents who need it. Her job was also to take ill resident to hospitals and stay with them if required. She was friendly towards all the residents, and had a good relationship with them.

Mr. Dlsaf

Mr. Dlsaf is 24 years old and has been working in the Star care home for two and half years. He had no previous work experience with older people. He is working as a cleaner and living in the care home. His daily job is cleaning the halls, organising the beds and washing the residents if required. In addition to this he was involved in many other jobs such as dressing and shaving the residents. Usually weekly or every two weeks he shaves and gives haircuts to those residents who require it. This aspect of his is role is purely voluntary.

Mr. Dlsaf had daily interaction with the residents, he enjoyed his work and had positive relationships with the staff members as well as the manager. Because he is living in the care home 24/7, he was ready to work even if it was not his shift.

5.4.2 Moon care home

Residents

The total resident population in the Moon care home at the time of the study was 38 residents; their age range was varied between 50 to 90. The majority of residents were male and most of them were independent. The reasons for admission were different; however, the main reasons were not having a place to live and family breakdown. Similar to Star care home, most residents here were able to continue on their daily life activities (eating, dressing and bathing). However, the minority of residents required assistance with their daily life. For example, three residents who lost their sight needed someone to help them go out and do shopping for them, if they needed.

Out of seven residents interviewed, there were six men and one woman with ages ranging between 50-89 years. Most of residents had been married and had son and/or daughter(s). The current marital status among the married residents was varied, for example widower, divorced and separated. See Table 5.6.

Table 5.6 Demographic data of residents in the Moon care home

No	Name	Age	Gender	Year/month (s) of work	Marital Status
1	Aland	58	Male	2 and half years	Widower
2	Baxawan B	89	Male	1 year	Widower
3	Sharmin	50	Female	5 months	Divorced
4	Awadan	74	Male	1 year and half year	Unmarried
5	Sharaza	63	Male	2 years and 2 months	Separate
6	Tanya B	63	Male	3 years	Unmarried
7	Raza	69	Male	4 years and 7 months	Unmarried

Mr. Aland

Mr. Aland is 58 years old, and has been living in the Moon care home for two years. When Mr. Aland's wife died of cancer several years ago he kept working in different

cities and lived with his sister for a while. Afterwards, he left his sister's house and went and stayed in hotels. During that time, he was working as a street vendor which was illegal. Then, he was caught by the police and his case transferred to court. After investigation, the court decided to send him to the Moon care home.

Based on previous experiences working and living in different cities, Mr. Aland was a social resident and liked to communication with staff and some residents. Mr. Aland conducts regular shopping trips to the local minimarket for himself and other residents and keeps his personal provisions inside the fridge.

Mr. Baxawan B

Mr. Baxawan B is 89 years old and has been living in the Moon care home since 2013. When Mr. Baxawan's wife died, he kept living his normal life with his sons and initially everything went well with him, but after several months he found that life was getting difficult due to some problems with his son's wife. He did not feel comfortable living with them and decided to go and live in care home, but in reality had no other option.

Based on prior experiences Mr. Baxawan B had in farming, he was working as a Moon care home gardener. His daily timetable was waking up early in the morning, praying, and then eating breakfast, after which he began working in the garden with his radio (which he either sits and holds or let's play while he works).

Mr. Baxawan B usually wears neat traditional Kurdish dress and spends most of his time in the garden with his radio, thus he is often surrounded by residents who like to listen to music or the news.

Mr. Sharaza

Mr. Sharaza is 63 years old and has been living in the Moon care home since January 2012. He is a former electrical engineer who worked in many cities. The main reason for his coming to the care home was family conflict after which Mr. Sharaza felt forced

to leave his house and become a resident in the care home. After he moved in his wife and son sold his house and he had no option but to remain.

Based on his past experiences and technological knowledge, he is now informally the technician in the home assisting residents and staff with any issues to do with mobile phones and TV. Since he was the only resident in the care home using the internet and understood how it worked he sometimes helped staff too. Mr. Sharaza was considered to be a particularly social resident by his peers.

Mr. Raza

Mr. Raza is 69 years old and has been living in the Moon care home for almost five years. Prior to this he worked as a teacher in the zones with the highest intensity of conflict and now he is retired. He came to the home as he could no longer live safely where he was and thus he made a decision to move into a care home. He is an educated man who loves reading and writing. He enjoyed creative writing producing children stories and health education literature. His room was very organised and tidy, with many flowers and some small book shelves.

His daily life includes joining other residents to chat, tell stories, and reminisce about their previous lives and experiences or sitting in his room writing or reading books or the Qur'an. Sometimes he does some gardening and waters the plants and trees.

He likes to join in all the activities of the care home, such as exercise, visiting and picnics.

Mr. Tanya B

Mr. Tanya B was 63 years old and has been living in the Moon care home for three years. Mr. Tanya B is single and lived alone prior to admission, working as a labourer in numerous places. When he retired he felt bored and lonely living alone, he decided to enter the care home.

He is a very quiet person, usually sitting alone in the corridors or in his room, rarely joining the other residents in chatting or discussions. However, he participates in the care home activities, especially picnics.

Mr. Tanya B suffered from a disease that caused lateral weakness; he cannot use his right extremities efficiently and he uses crutches for moving and walking. However, Mr. Tanya B is able to carry out his daily physical activities independently but sometimes the staff and other residents help him to carry his things. He does not do shopping by himself, but delegates someone from the staff or residents to do so. He is very satisfied with his life in the care home and he always thanks the Kurdish government for providing this place and for their concern about older people.

Mr. Awadan

Mr. Awadan is 74 years old and has been living in the Moon care home for a year and three months. He is unmarried, and was living with his extended family while he was working. He had a quiet and generous personality. He previously worked as a sheep farmer and enjoyed it. Through his nephew, he heard about the Moon care home and decided to go and live there, a decision he is happy with.

Mr. Awadan is satisfied with his life in the home and considers it to be his own home. In addition, the relationship between Mr. Awadan and his relatives remains positive and he continues to go and stay with them for short periods. He has good relationships with both residents and staff.

Mrs. Sharmin

Mrs. Sharmin is a divorced lady and has been living in the Moon care home since January 2014. She was mainly admitted because of the breakdown of relations with her husband. Her husband decided to take a second wife, prompting Mrs. Sharmin to leave her family home immediately. Although she has many relatives in the city, none of

them offered her a refuge and thus she felt she had to go and live in the Moon care home, but she was not happy about it.

During meal times, male and female residents often ate in the kitchen, but because she had a shy personality she chose to eat in her room. During formal interview she stated that, *“I feel shy to eat with other residents, therefore I asked the staff and they allowed me to eat it in my room”*.

Mr. Sharmin was happy with the current life in the care home, because it grants her some degree of autonomy, without being subject to various forms of control and coercion she experienced when she lived with her relatives.

Staff

Table 5.7 shows that the educational background for the Star care home staff was diverse, and their ages ranged was between 26-41 years.

Table 5.7 Demographic data of staff in the Moon care home

No	Name	Age	Gender	Year/month (s) of work	Job Title	Marital Status	Educational Level
1	Ban	41	Female	3 years	Home Manager	Married	Diploma
2	Farhad	33	Male	3 & half years	Social worker	Married	Bachelor
3	Roshinber	27	Male	9 months	Psychological worker	Married	Bachelor
4	Azad	24	Male	4Years	Nurse	Married	Diploma
5	Hawkar	32	Male	5 years	Observer	Married	High School
6	Jwana	26	Female	11 years	Cleaner	Married	Intermediary
7	Jaf	28	Male	7 months	Cleaner	Married	Primary

Mrs. Ban

Mrs. Ban is 41 years old and had a diploma degree. She started to work in Moon three years ago, and her first position with older people was as manager.

Mrs. Ban had a separate room in the staff's corridor, and usually she was surrounded by some of the staff members but residents were rarely seen in her room. As a manager she kept herself busy with paperwork in her office and very rarely visited residents or the public areas of the home.

Mr. Roshinber

Mr. Roshinber is 27 years old, and has been working in the Moon care home for nine months, his first position with older people. Mr. Roshinber had a bachelor degree in psychology and worked either morning or afternoon shift, during which he had direct contact with residents.

He is responsible for different types of activities within the home such as arranging visits to the museum, organising picnics, trips to the gym and showing films. He was not happy with some of the home's services and would like to improve them but feels frustrated in his efforts by senior staff.

Mr. Farhad

Mr. Farhad is 33 years old, a social worker and has been working in the Moon care home for 2 years and 5 months. He has a bachelor degree in sociology with no prior experience of working with older people. Usually, Farhad worked the afternoon shift and had a direct contact with residents, during which I noticed that he was a good listener and was regularly seen interacting with residents. His ambition was to help the residents and improve their quality of life by ensuring that the services in the home were of a high quality.

Mr. Azad

Azad is 24 years old and has been working as a nurse in the Moon care home for 4 years. Prior to this he had no experience of working with older people, but did care for his grandmother for 20 years. He had a diploma degree in nursing.

Azad's daily work in the care home involved looking after those residents who required medical check-ups such as monitoring blood pressure and medications. He either visited residents in their rooms or they came to the health department. In addition, Azad also took ill residents to the hospital.

Mr. Hawkar

Mr. Hawkar is 32 years old and has been working in the Moon care home for five years. He had no previous work experience with older people. Hawkar was working as a night shift observer and his responsibilities involved listening to residents if they had any queries and carrying out routine repairs such as fixing their wardrobe. In addition, he undertook other routine tasks such as setting up the table for dinner and collecting the dishes after residents finished eating.

Hawkar had daily interaction with the residents and was happy with his work, stating that *'I like serving older people and respect them as much as possible'*. Hawkar was regularly seen visiting the residents' rooms and making sure that everything was alright.

Mrs. Jwana

Mrs. Jwana is 26 years old, and was the longest serving staff member in the care home as she had worked there for 11 years. During this time, she has had a variety of roles such as cleaner, laundress and room and bed organiser. She had been promoted several times and now she is the chief cleaner. She had a good relationship with the staff members, as well as the residents.

Mr. Jaf

Mr. Jaf is 28 years old, and has been working in the care home for seven months. As with most of the staff he had no prior experience of work with older people. He is a cleaner and his daily job involved cleaning rooms, and organising beds. Sometimes he

is involved with washing and dressing the residents if required, as well as shopping for them.

Mr. Jaf is a very social person and had good communication with residents. He frequently helped residents and undertook tasks that went beyond his job. He is not always happy with the attitude that some of his colleagues have with some of the residents and there is some tension at times.

This chapter has provided a detailed description of the home and the main participants in the study in order to give the reader a background and context by which to better understand the results that follow. It has already been suggested that differing patterns of interaction could be identified between the staff and the residents and this will be explored further in the following chapters. The next chapter turns attention to the way in which residents entered the home.

Chapter Six: Trajectory of admission into the care homes

6.1 Introduction

The previous chapter provided a detailed description of the two care homes, both to introduce the environments and the participants and to provide a context in which to locate and better understand the following chapters. As will be apparent by now although the two homes were subject to the same basic regulations they were in some respects quite different on a number of fronts. One home, Star, had far less residents and was not purpose built, whilst the other, Moon, was far larger and was built as a home and therefore had more private accommodation for residents. Moreover, there appeared to be subtle differences in the ways the two homes operated with there being more contact between residents and staff in Star and a greater feeling of teamwork amongst staff at Star also. This, in part, seemed attributable to the differing leadership styles of the two managers. This will be explored in greater detail later.

The differences and similarities between the two homes are explored further in the following chapters which seek to provide potential explanations for any apparent differences by suggesting that different cultures existed, one which I termed a 'relational' culture, the other an 'organisational' one. The full nature of these two cultures will be explored in greater detail later. This chapter focuses on the nature of the participants' entry into the homes and the effect this seemed to exert on the way that they initially settled into their new environment. The literature had highlighted the importance of understanding the influence of the transition into a home as a key factor and whilst this related primarily to the western experience my data also indicated that the nature of the transition was important in a Kurdish context. The remainder of this chapter will explore this in greater detail. As will become clear whilst the reasons for admission were broadly similar for all participants some differences were apparent and

it will be argued that participants' reason for admission and their perception of it influenced their initial reaction to their new home, with some 'engaging' with the home quickly whilst others remained somewhat 'distant' from it. These early reactions were important as for some they coloured their longer term integration into life in the home. I now go on to consider the reasons why participants entered the respective homes.

6.2 Trajectory of admission into the care homes

Older people from different socio-economic and personal backgrounds became residents in the two care homes in the study. Their various stories highlighted a range of circumstances and changing contexts that acted as triggers for their experience of becoming care home residents. The factors leading up to admission related mainly to concerns about accommodation, financial problems, health issues, family breakdown or lack of family support, political conflict and concerns over personal security.

Understanding the influence that the reasons for, and experience of, admission, exerted is important as moving from one's home to live either temporarily or permanently somewhere else is a challenge and often represents a very difficult life transition, particularly for older people. For some admission to a care home may be associated with a decline in social and physical wellbeing, or even the end of an independent life. Conversely, for others it could mark the end of a period of isolation and neglect and the beginning of a more rewarding life. As this chapter will highlight when the latter was perceived to be the case residents were far more likely to 'engage' with life in their new home at an early stage. Conversely when people had a more negative perception of their admission then they were likely, at least in the early stages, to distance themselves from life in the home and to play relatively little part in it.

Based on the field observations and interviews, it was evident that in both homes there were two main types of reaction amongst new residents as outlined above. Whilst most of the residents had little real choice about whether to enter the home or not they could, and did, interpret the experience in differing ways.

As Government policy in Iraqi Kurdistan does not provide older people with social benefits or funds to pay for their individual accommodation, difficulty in maintaining their current living arrangements (for a variety of reasons outlined below) was a key factor behind admission for most of the residents. Therefore, when the participants encountered problems with their families or could not sustain their relationships with them, for any reason, their only option was to enter a care home. The data indicated that a number of social, cultural, and political factors provided the context for transition to a care home.

The following sections will consider how the context for admission and peoples' perception of it influenced whether they tended to engage with life in the home from the outset, or conversely remained more distant from it. The first section describes those who engaged with the home early, often from the start. These have been termed 'early engagers'.

6.2.1 Early Engagers

People usually take time to settle in to a new environment, especially if it is very different from their previous one. The literature would suggest that this is often the case when moving into a care home, especially in Western societies where such a move has increasingly been portrayed as a negative one. One might anticipate that this would also be the case in cultures where older people are generally held in high regard and the family is expected to support them. As will be clear from the following accounts family

conflict and related difficulties were often the main reason for admission to the care home but how the admission itself was interpreted and perceived seemed to exert a considerable influence on peoples' early reaction to their new home. This was certainly the case for the Early Engagers. Early Engagers were those older people who seemed to be more willing to accept the idea of moving into a care home prior to their admission and reacted more positively to the move subsequently.

As discussed earlier several factors played a major role in contributing to the older peoples' transition into a care home. The main factors amongst the Early Engager group were multiple and included: conflicts in the family, problems with accommodation, loneliness and changing personal circumstances. Whilst those who had problems in engaging with life in the home faced similar challenges it was the way that events were interpreted that shaped early reactions to admission. Therefore, most of the residents in both homes had children, siblings or relatives who they lived with prior to admission but conflict in the family often resulted in an unhappy home environment. The decision to enter the home had, for some, been a way of leaving this difficult situation behind and the move was therefore seen in positive terms.

For example, for Mr. Taqana the move into the care home was seen as a positive decision, even though in reality few other options were available to him. Prior to his admission, Mr. Taqana had been in conflict with his family, particularly with his older brother whom he could no longer endure. In order to avoid further conflicts, Mr. Taqana took the decision to enter the care home:

“I had some issues with my brother and couldn't live in a harmony with him. And, I didn't have any other place to live.”

Taqana-Star-R

Other residents had also had longstanding family conflicts that had often been going on for years, and had caused problems with their accommodation. For instance, Wasta, one of the Star care home residents, had lived in hotels for many years after separating from his wife. At the start he was able to find work and therefore to afford to pay to live in a hotel. But after he retired he had a limited personal income and could not afford to stay in hotels or to rent a house. Even though he had children and could, in theory, have lived with them, he did not want to be a burden and so he made a personal choice to enter the Star home, again allowing a positive perception to be created:

“First of all when I came here it was my own opinion and my option. Since 1980, when I separated with my wife, I worked in different cities like Sulaimania, Kirkuk, Mosul and Dohuk and slept in many hotels... “Even if my son asked me, ‘dad, come live with me and I will care for you’, I would not go, because one night or two nights is okay, but more than that will not be nice for his wife nor for him. For example, every morning my son will go to work and his wife should wake up and prepare the breakfast for me and I feel bad for her, that was my reason to come here.”

Wasta-Star-R

Other residents also did not wish to be a burden on their family especially when their spouse had died and they would need to rely on children or children-in-law. The decision to come into the care home was perceived by them to be an altruistic act on their part, putting a positive gloss on the move.

Whilst, it remains the normal expectation that the Kurdish family will look after their older members, this is not always the best solution as is clear from the above accounts. In other cases, there were no family members available and this again was one of the reasons why older people chose to enter a home. As with Wasta above one of the

residents of the Star home worked and lived in hotels prior to his admission. When his health started to deteriorate after having a stroke, he was unable to continue his work and spent all his money on health care. As he did not have his own home nor any family to support him, he discussed the possibility of entering a home with his friend and made a conscious decision that it was the right thing for him to do. His friend then assisted him with the process:

“At the time I had a stroke, I stayed in different hospitals for several months. After being discharged, I didn’t have a place to live in and a friend of mine advised me to go and live in a place where I can relax. He arranged everything and transferred me to the Star care home.”

Hassan-Star-R

For others it was the death of a spouse and subsequent loneliness that was their main reason for choosing to go and live in a home; this was the case for Mr. Haji. After the death of his spouse he remained alone. As his children lived a long way from him and were not in a position to have him move in with them Mr. Haji decided that moving into a care home was the right thing for him. He soon began to enjoy his new life and to make new friendships; he contrasted this with his previous loneliness:

“I was living with my family, once my wife died and my children got married, I stayed alone in the house for a while. I felt lonely and uncomfortable living alone in a big house.”

Haji-Star-R

Although loneliness can affect everyone, older people often remain extremely vulnerable after family separation and breakdown. A lack of social contact may diminish an older person’s physical and mental well-being, affecting their ability to live on their own and care for themselves adequately. Also once people retire they may

suffer a loss of income that further erodes their independence. This was the case for Mr. Tanya B whose money was running out and who struggled to manage household chores such as cooking, washing dishes and laundry even though he was supported by a friend. Once again he actively chose to live in the home, which he contrasted positively with his previous situation. From Mr. Tanya B's perspective the care home was the best option for older people like himself to maintain their physical and social well-being. Not only do they provide company but there are no personal costs associated with living there as accommodation, meals, health care and so on are free:

"I spent all my money on my health and myself. I didn't have a fixed salary, that's why my money decreased, slowly-slowly. When I was alone a friend of mine gave me a room and said 'stay in that room as much as you want'. Then I bought some furniture for the room, like a fridge, TV etc. So, I bought so many things, a washing machine it was a complete house. But I was alone and I could not tolerate it, I was tired, I was very annoyed and did not like it. It was difficult because I had to prepare food, wash dishes and wash clothes. So, this care home is much better than any other places."

Tanya B-Moon-R

The political conflict, insecurity and instability that affected Iraq at the time the study was being conducted had a devastating impact on almost every aspect of life. Older people were often the most badly affected, especially those who lived in the zones with the highest intensity of conflict. Not surprisingly therefore some residents found living in a care home offered them the security and safety they needed. This was described by Raza who could no longer live safely in his home and so moved to Kurdistan.

Unfortunately, he could not find a suitable job there and as his financial situation deteriorated he made the decision to enter a care home:

“I was working as a teacher in Kirkuk and the former regime was against me, I couldn't live my life there anymore. After a while I decided to go to Kurdistan region, because it is more secure and safe. Once I came to Kurdistan I was unable financially to rent a house and live in, people advised me to go and live in a secure place like a care home.”

Raza-Moon-R

As I explored the ways in which residents lived their lives in the homes it became clear, as will be described later, that some had engaged with life in the home very quickly and this included those participants whose transition to the home has been outlined above. Although it could be argued that in reality they had little real choice of whether to enter the home or not they were able to perceive the decision as one that they took mainly themselves and one that they perceived to be to their benefit. This seemed to shape their initial reaction to the move and the speed with which they settled into their new home. This stood in contrast to those who remained distant and detached from life in the home, their transitions are considered below.

6.2.2 Initial ‘distance’ from life in the home

As distinct from those residents who seemed to readily engage with life in the home others appeared to resent the move, at least initially, and seemed to remain distant and detached from their new environment. Many of the reasons for their admission were similar to people who readily settled into the home but the main difference seemed to be the extent to which they had been able to play a major part in the decision and/or see it

as being of benefit themselves. Some of these circumstances are described in more detail below.

Contrary to the experiences of residents who engaged with life in the home those who remained distant often entered the home quickly, following a crisis type situation and felt that they had no real part to play in making the decision. Indeed, some felt that the decision had been contrary to their wishes, and was an affront to their dignity and status or that their families had actively colluded against them.

In Kurdish society (and throughout the Middle East), the male breadwinner is the most powerful person and head of the family. Other family members (e.g. parents, spouse and children) are generally seen to depend on him as a source of income, and he is the major decision-maker. In the traditional model, as the male breadwinner ages, power and authority are gradually ceded to sons (particularly the eldest son) until the former becomes a venerated elder maintained and respected by the young. The data indicated that, in some families, this traditional pattern had been eroded and the role of the elder resulted in conflict and tension in the family. This could result in admission to a care home. This was captured by Baxawan's story which recounts how he was effectively 'kicked out' of his home due to family conflict:

"I had a conflict with my son and wife and they kicked me out from my own home four times. I kept silent and tolerated them, but for the fifth time when we fell out, I couldn't get along with them anymore. Afterwards, I went to my brother's house and lived there for three months. Well, finally I had no choice I came to the care home."

Baxawan A-Star-R

An acrimonious family breakdown was a key factor for a number of residents who found it difficult to accept moving into the home. This often occurred over an extended

period during which alternative solutions might be tried out. For example, Mr. Hadi, one of the Star care home residents, had experienced family issues that resulted in separation and breakdown. After separating from his wife, he initially lived with his sister. While he was well and healthy, he was able to work and look after himself but when his health condition deteriorated (after having stroke), he could not work and stayed at home. While his sister provided care and assistance to him he came under persistent pressure from other members of the family to enter a care home. Eventually the pressure became unbearable and he agreed but with reluctance:

“Wa’Allah, I had family issues, I wasn’t in a good relationship with my wife. I had some conflicts with my wife; it lasted four years then resulted in a family breakdown. After separation with my wife, I started to work in a different city and lived with my sister. Then I got this stroke. After a period of time, my relatives persuaded me and told me ‘you need to go to somewhere and settle in. Then I came to Star care home.”

Hadi-Star-R

For other residents, family conflicts led to financial control being taken away from them, without their consent, effectively leaving them destitute and with no option but to seek entry to a home. This is what happened to Sharaza, as he describes below:

“I had some misunderstandings with my wife and with my son... I gave her the money and I sold my apartment. She took the money and she bought an apartment without telling me that my son will stay in that apartment... So, they kept me, both of them [son and wife] kept me with no money.”

Sharaza-Moon-R

Another case of family breakdown was precipitated by the wife’s inability to conceive, when she was forced out of the family home. Although she sought alternative

accommodation with her brother and his children this situation rapidly became unsustainable and she felt she had no choice but to apply for immediate temporary admission to a care home. This was something that she did not really wish to do, hoping that her family would take her back. When they refused she had no choice but to stay where she was:

“Wa’Allah, I was married for approximately 20 years, until one day my husband kicked me out in the house. He handed me over to my brother; I went back to my brother’s house and stayed there. After almost three months of the conflict, my husband married again because I had been unable to conceive. Thus, I got divorced. While I was in my brother’s house, my nephews were so bad with me. One night they kicked me out in the house at 1:00 am. So, the next morning I immediately came here. When I was admitted into a care home, the staff members here contacted my relatives but they didn’t come to take me back, that’s why I settled in here.”

Sharmin-Moon-R

In some cases, external forces, such as the local authority (KRG) or the courts made the decision that the older person must go into care as they were felt to be unable to support themselves on their own. This is what happened to Aland. After experiencing family difficulties, he worked as a street vendor to meet his daily needs but was told by the authorities that he did not have a permit to do so and that it was illegal. When he continued in that role he ended up in court and was told that he must enter the home, even though he strongly disagreed with the decision and was very unhappy about it:

“When my wife died of cancer, several years ago, I kept working in different cities and lived with my sister for a while. Afterwards, I left my

sister's house and stayed in hotels. During that time, I was working as a street vendor selling chewing gums, which was illegal. I was caught by the police twice and I was transferred to court. After investigation, the court decided to send me to the Moon care home because I didn't have any places live in."

Aland-Moon-R

All of the above participants struggled to initially settle into the home and remained detached from life within it. As a consequence, they largely kept to themselves and did not engage with activities that were available to them. Many were loners and took to their rooms. What seemed to mark their transition out as different from those who engaged with home life early was that this latter group had little or no perceived part to play in the decision to enter the home and could see no real benefit at the outset to themselves. Rather others took the decision that entry to the home was the only option and participants often disagreed with and resented this.

6.3 Summary

The data analysis exploring the nature of people's transition to the home evinced that most of the residents had no **real** choice about their admission due to a combination of personal circumstances. However, what appeared to shape their early adaptation to the home and the extent to which they actively engaged with life in the home or tended to remain distant from it was the extent to which they **perceived** that they had played an active role in the decision to enter the home and could see it as being of having benefit to themselves and/or others. There was also a time element at play. Those who engaged with the home had at least some time to reflect on their decision and to think about it prior to entering the home. For others there was an element of urgency and this, coupled

with the perceived lack of control and choice, further compromised their admission experience and their early reactions to the home. As will be described shortly some of those who initially chose to distance themselves from the home eventually settled in and took a more active part in home life. How this occurred will be explored using the concepts of '**Freedom From**' and '**Freedom To**' which seek to capture participants' later perceptions of the benefits of living in a care home when compared with their prior lives. However, 'Freedom From' and especially 'Freedom To' were not only determined by the residents' perceptions but also in large part by the culture operating in the two care homes and the extent to which both residents and staff were 'free to' exercise choice and control over various aspects of their lives. Prior to considering this, this section concludes with two case studies illustrating in more detail how various aspects of the transition into the home shaped participants' early reactions to life there.

Case study 1 – Mr. Wasta: An Early Engager

Mr. Wasta is 67 years old and an independent man. For many years prior to entering the home he was living with his family but conflict with his wife resulted in family breakdown and separation. At this time he had his own business which he continued to run, living in different hotels across the country. However, as he became older he felt increasingly lonely and did not like living a nomadic existence. Despite having a son with whom he still had good relations he did not want to be a burden on him and his family so he began to think about alternatives.

One day, while Wasta was sitting in a coffee shop discussing his future a close friend brought up the idea of living in a care home and they talked about the potential advantages it offered. Afterwards, Wasta thought about the idea for some time and eventually took the independent decision to seek entry. As soon as he entered the home he felt that this had been a really good idea and he was soon making relationships with both staff and other residents in the home. His settling in was helped considerably by

the policy of the Star care home of allowing residents to work while they reside in the home. Wasta took advantage of this and continued his prior job in the city centre. Because of his regular trips to the city many other residents asked him to buy items, such as cigarettes for them, quickly establishing Wasta as a well-known character in the home who was known for his sociable and generous personality.

Very quickly Wasta came to see the home as his “real” home and engaged fully with life there. He was observed to be entirely happy living in the home and maintained contact with his son and his family. The flexibility of life in the Star home gave him all the freedom that he needed to pursue his interests whilst at the same time providing him with the stability that he previously lacked. He actively engages in the home’s activities and also feels a certain responsibility to support other residents who are not as able as he is. He states that he is ‘*very, very satisfied*’ with his life as it now is. As will be explored further shortly living in the home now means that he is ‘**free from**’ previous concerns and worries, whilst being ‘**free to**’ live a life that he is happy with. This however was not the case for everybody.

Case study 2 – Mr Hadi: Remaining ‘distant’ from life in the home.

Mr. Hadi is 61 years old and originally from the capital of Kurdistan but more recently he worked and lived in the capital of Iraq. He had previously been married and had three children. Mr. Hadi was the family breadwinner and worked as a government employee. He was however unhappy with his marital life and after having many problems with his wife he decided to leave her. Eventually they were divorced. At the time of the divorce, all of his children were grown up and living with their own families in different cities. After the divorce he lived with his sister in her house for several years but his health condition started to decline and he suffered a stroke. As a result of this he could no longer maintain his work and subsequently retired. Whilst living with his sister

he had his own room, fully furnished (having his own bed, cupboard, table, chair, table lamp and small radio) and his sister provided him with help and support. However, after a period of time other family members began to suggest that Mr Hadi needed to go into a care home as his sister was finding it difficult to cope. Although he was reluctant Mr. Hadi agreed, under increasing pressure from his family.

Although the care home met all his requirements Mr. Hadi could not settle and stated '*I was uncomfortable from the first moment in this place, unhappy with the new environment in terms of meeting new people, new bed, new life and so on*'. Despite having been in the home for some time when the study began he still felt very unhappy there. He took his meals with the other residents but once he finished these he went back to his bedroom and stayed there most of the time. As a result, Mr. Hadi is very isolated and very rarely gets involved or engaged in any activities in the home. He makes no real contact with other residents and prefers to stay alone. Although he says he has a good relationship with staff members he was observed to have very little interaction with them. He gets his primary care (medication) from the staff members because he has hypertension along with stroke.

For Mr. Hadi a care home is a place for older people to spend the end period of their lives. He describes dissatisfaction with own his life, as he cannot see any meaningful future: "*I am living in this place and waiting to die. Always I'm saying 'oh God, when will I die?!'*"

For Mr. Hadi whilst the home may have provided him with 'Freedom From' certain responsibilities he did not see it as providing him with 'Freedom To' live the life that he wanted to. These two concepts of 'Freedom From' and 'Freedom To' are now used to further explore how residents and staff experience living and working in the care homes on a longer-term basis.

Chapter Seven: 'Freedom From' and 'Freedom To': Resident and staff perspectives on life in the care home

7.1 Introduction

As described in the Literature Review, one of the main goals of this study was to explore the experience of living and working in a care home from the perspectives of the residents and staff within the two homes. In the previous chapter the influence of the transition to the home on the residents' early reactions was explored. This chapter considers in detail how residents and staff perceived their day-to-day life in the care home on an on-going basis. Day-to-day life is the term used to describe how the residents and staff talked about, felt and acted on a daily basis in the care homes.

The chapter begins by looking at the resident's perspectives and in so doing builds on the previous findings. The previous chapter suggested that initial reactions to either engage with life in the home or remain distant from it were shaped largely by the perception of whether residents felt that they took an active part in the decision to enter the home and could see the admission as being of some benefit to themselves, or not. As time went by and residents could reflect on what it was like to live in the home all of them could see some form of advantage, even if they remained largely distant from life in the home. These advantages can be best understood by the extent to which living in the home meant that residents were 'free from' the previously difficult situations that they faced, and some were subsequently 'free to' have a richer life. It will be clear from the previous chapter that all the residents had entered the home largely because of their difficult life circumstances and that living in the home now meant that they were largely 'free from' these.

For some residents however living in the home had further benefits because as they were 'Free From' prior worries they were now 'free to' explore other aspects of their lives that they had previously had to ignore in their struggle to meet basic daily needs. Those residents who actively engaged with life in the home from the outset appreciated this new found 'Freedom To' very quickly. Other residents who were initially distant from life in the home took longer to appreciate new potential 'freedoms', but once they did they began to engage more fully with life in the home. Conversely those residents who, whilst seeing the advantages of being 'free from' prior difficulties, could not see any new 'freedoms' in the home remained distant. The first part of this chapter explores these dynamics. Later in the chapter it will be argued that whilst appreciating 'Freedom To' was in part a judgement or perception on the part of residents it was also facilitated by the 'culture' of the home and the extent to which staff themselves were 'free from' unnecessary rules and regulations and 'free to' use their own initiative to shape residents' lives.

7.2 Freedom From and Freedom To

The data presented in the previous chapter has described the transition from the community to the care home environment. It was evident in much of what was described that the living conditions and circumstances of the residents prior to admission were often insecure, chaotic and uncertain. The basics of life, such as somewhere to live, personal security and positive relationships were described by many as being continually under threat. Early on in my analysis I felt that the care homes were offering the residents a respite from their experiences prior to admission. There was within the data a sense that the care home provided residents with a form of 'sanctuary'. I began to explore the data still further to understand what constituted this experience. The residents in both homes expressed the feeling of 'Freedom From' many hardships that

they had encountered prior to their admission to the care homes and following the move into care were offered security on a number of levels. The experience was, however, more than this in that some residents also expressed a sense of 'Freedom To' pursue a new life in the care homes. The data suggested that such residents highly valued these aspects and considered them as important to the quality of their daily life. It was also noted in the previous section that residents were identified along the lines of 'Early Engager' or 'Remaining Distant' from life in the home and I was keen, therefore, to explore how residents regarded the care home sometime after the move. As noted above as they reflected on life in the home all of the residents, even those who remained distant, could see some advantages in terms of the 'Freedom From' that they now enjoyed.

7.2.1 Freedom From

As the data indicated, the reasons residents gave for entering the care homes were varied but the most common were problems with accommodation, loneliness, financial issues, and family conflict and breakdown. After living in the home for some time residents began to appreciate and expressed the relief and liberation they felt from the adverse circumstances of their lives prior to their admission to the care homes. A number of specific 'freedoms' emerged from the data, relating to the nature of life in the home, such as; freedom from an uncertain home life; enhanced personal and physical safety; freedom from loneliness and isolation; and freedom from financial insecurity. I will now consider these.

Freedom From an uncertain home-life

Notable within the data regarding transition to the care home was how residents described the precarious nature of their home lives, this being cited as one of the important factors in making the decision to move into care. As the data indicated many

residents entered the care homes due to their desperate need for a safe and secure place to live; this was achieved by the admission:

“Wa’Allah, it’s a safe place for those older people who are homeless, and cannot afford even a small place to live in”.

Media-Moon-R

“We have this place and we do not need to go and sleep for example in hotels”.

Wasta-Star-R

This was appreciated by the staff members in the Moon care home who stated that the main aim of building such care homes was to provide a place for those older people who were in need:

“This care home has been established for older people, particularly, those who don’t have a place to live....We are employed here to look after them”.

Farhad-Social Worker-Moon

After entering the home, it was apparent that most of the residents thought that they did not now have concerns about meeting the necessities of daily life as the care homes provided them with services such as food, clothes, and health care. Despite varying perceptions of the quality of these services, most of the residents appreciated the fact that they were available but those who more fully engaged with life in the home seemed to be more satisfied with not only the availability but also the quality of the services they received, and expressed such appreciation to the staff:

“I am very satisfied with the provided services in this home and I never said this service is bad. I am always telling the staff members ‘thank you very much for everything’”.

Hawsar-Star-R

The data also revealed that many residents saw the provision of care homes as an indication that they were still perceived by the government as people of value who deserved support. However, in addition to allowing them to feel simply ‘free from’ concerns and worries those who engaged fully with life in the home as also saw it as their ‘real’ home, as opposed to a only a form of refuge:

“Here the government cares about you. We do not need to go and sleep for example in hotels. The government cares about you.... it’s like a home the government gave to us. It’s like my home ... my home”.

Wasta-Star-R

“It’s a place for poor and homeless people. I am very thankful to the government that provided this place to older people in order to live in and care about them. I am living here and staff providing care of us”.

Taqana-Star-R

Therefore, whilst both those who engaged with life in the home and those who remained distant from it valued the ‘Freedom From’ concerns about the necessities of daily life that entry provided, the former group were more likely to also perceive it as an indication of their continued worth to society and therefore to perceive it not just as ‘a home’ but rather ‘their home’. Another important ‘Freedom From’ that the home provided was freedom from loneliness and isolation.

Freedom From isolation and loneliness

Prior to admission loneliness was also cited as a feature of life for many residents. Those residents who lived alone or who had no family members they could live with often felt lonely and isolated. After their admission, they appreciated the fact that living with other residents resulted in an end to their isolation. The nature of relationships and community within the care home will be explored later but for now it is important to note that

residents appreciated the presence others, both residents and staff members, who were there for company and to assist them (if needed). This enhanced their feeling of freedom from being alone, but for some they also felt safer as there was someone there if they needed help:

“I was living alone for almost seven years and I didn’t feel safe. If I stayed at my own house alone and if something happened to me, nobody would have noticed that. Here, I’m not alone, sitting and talking with other residents; and staff are coming to see us 10 times a day to know how we are doing.”

Haji-Star-R

As will be noted later those residents who engaged more fully with life in the home had closer relationships with other residents but for all of the residents freedom from isolation provided not only company but an enhanced sense of freedom from threat or harm.

Freedom From physical harm or threat

Most of the residents valued the protection that the home gave them from harm and threats, for example from being robbed, especially those who had been victims of crime and physical threat prior to entry. Whilst the presence of staff was important the spatial and organisational aspects of the care homes also afforded this sense of security. While I was conducting my fieldwork, I observed that both care homes had a designated area at reception where gatekeepers were located. The gatekeepers were responsible for keeping the care homes safe and secure in terms of keeping any external threats at bay. The presence of gatekeepers provided the homes’ residents with a sense of freedom from external threats, as the following field note highlights:

'Each care home has a reception where gatekeepers are based, and they provide the homes with security, in order to maintain a safe environment for their residents. No one from outside could access the care homes without the reception knowing'.

Field observations-Moon and Star

Whilst conducting my observations at night in the Moon care home and walking the corridors, passing room by room, I saw some residents in their rooms and others were outside either watching TV or sitting or chatting in the garden. Although some doors were open and I could view the residents inside their rooms, other doors were closed. Whilst this was personal preference I also took it as an indication that residents felt safe in the care homes in the knowledge that no one from outside the home could enter. This was in contrast to the prior experiences of many:

'It is night time (8:00 pm), and usually during this time, you will find most of residents in their rooms, either sleeping on the bed or on the floor, or just lying down. Once I crossed Mr. Raza's room, his door was open; I observed that he was asleep in his bed without having closed the door'.

Filed observations-Moon

In addition to locking all the homes' entrances at night, an observer was on duty in both care homes meaning that security was available 24 hours a day, seven days a week to protect the residents from any harm or threats such as burglary. Although this might seem unnecessary when considered from a Western perspective it was an additional layer of security for older people who had been used to living in difficult and unsettled personal and political times. This is captured in the quote below:

“This home will be closed and locked at night and I do not close my door. You know why? Because I know it’s secure and we have observer staff at night. I can sleep comfortably; because I am sure no one will enter my room”.

Raza-Moon-R

This is not to say that this perspective was shared by all residents. Despite the precautionary measures that were in place in both care homes, a few residents still had concerns about security within the home as they felt vulnerable and uncertain about the safety of their personal possessions. This was often a legacy of their previously precarious situations. Baxawan A below explained that he had fears of being robbed or of losing his possessions. He eventually locked the door in order to keep his belongings secure and protected:

“Personally, I feel secured when I lock my door because many people are around and they have different personalities; I cannot trust anybody”.

Baxawan A-Star-R

As an additional layer of security it was observed that in the Moon care home CCTVs were in place inside and outside the building such as the main corridors, kitchen, dining room, and the home’s yard and main gates. The main purpose in providing this system was to monitor the home’s security and eliminate the occurrence of any potential dangers. Residents were aware of this security system within the home and rather than seeing it as a potential intrusion it was viewed as another thing that allowed them to live free from fear. For some residents, especially those who had suffered violent crime prior to entering the home, this was very important. For example, prior to entering the Star care home, Mr. Haji lived alone and had been burgled in the past. This incident had a significant and lasting impact on him. He subsequently felt unsafe and insecure about

living alone at home and feared being a victim of crime again. Thus, he sought to live in a secure environment where he could socialise and enjoy life feeling safe:

“One night I came back from the mosque it was around 4:30am, I entered my house and it was very dark. Suddenly a thief pulled me down on the ground and tied my hands. He stole my money and left the house. I became traumatised and could not stay safe in the house any more. I can now mix with others and do things that I like.”

Haji-Star-R

In addition to the homes themselves the geographical region in which they were located was seen to be far safer than other parts of the country that were much closer to conflict zones. This was very important for those residents who had moved out of the conflict zone prior to entry to the home. As Raza stated *“the region is secure in general”* and this point was highly valued by him. Indeed, just how safe he felt is reflected in his comments below:

“Wa’Allah, to me this place is quiet and secure. For example, it is safe if you want to sleep in the garden”

Raza-Moon-R

Clearly freedom from direct physical threat was very important but the home also provided freedom from financial insecurity, which was another fact of life that many residents had to live with prior to entering the homes.

Freedom From financial insecurity

In addition to their daily needs being met residents were also provided with a monthly stipend which allowed many of them to gain a sense of financial independence and provided them with an opportunity to leave their financial insecurities behind. This was

something that many had not enjoyed for a long time. The happiness and freedom that this brought to some residents is captured by Aland below:

“As a resident in the care home, every month we are receiving 45000 ID from the government and this is very, very good amount for us if we didn’t go outside too frequently. We can do our shopping, for example, buying fruits, drinks, distilled water, and sometimes eating meals outside the care home. We can also top-up our mobile phones to talk to our relatives or friends; really it’s very, very good for us”.

Aland-Moon-R

However, after the start of the political conflict between the KRG and the central government which resulted in the cessation of the budget of the Kurdistan region this aggravated the financial insecurity that residents as well as staff members felt and most of them were worried and uncertain about receiving this grant in the future:

“The government always tells us that ‘we don’t have the financial possibility’ because we don’t have enough funds. Even the residents worry about their salary. In fact, we can’t manage the lives here easily”.

Sarbast-Administration Staff-Star

Whilst clearly such factors were well beyond the control of staff and residents they serve to highlight the precarious nature of daily life, even within an apparently secure environment. But despite these uncertainties the idea of ‘Freedom From’ provided a means of understanding how entry to the care homes had provided residents with a degree of protection from major threats and risks. For residents the care home provided the very fundamentals of life and this had given them relief from some of their major concerns prior to admission. Both care homes were similar in this respect in that they offered a physical and cultural place of sanctuary and safety. Not surprisingly therefore

all of the residents, both those who actively engaged with life in the home and those who still remained somewhat distant and detached from it, saw the benefits of being ‘free from’ prior worries and concerns. However, over and above this entry to the homes had enabled many residents to now be ‘free to’ enjoy aspects of their lives that had been denied them for many years and to explore new directions. A flavour of this was provided in the quote by Aland above and this is explored in more detail below.

7.2.2 Freedom To

So far this chapter has explored the notion of ‘Freedom From’ in the lives of residents. Participants expressed a feeling of ‘Freedom From’ prior insecurities about issues of, for instance, accommodation, finances, loneliness and even physical harm. Not surprisingly removing such concerns was seen as a major benefit of moving into the care home and for many this provided a foundation that enabled them to move on with their lives and gave them a feeling of being, often for the first time in many years, ‘free to’ do things differently. The notion of ‘Freedom To’ emerged as an important part of the data that helped to encapsulate the ways in which residents could build upon these foundations in order to further augment their lives within the home. Many residents in both care homes referred to ‘Freedom to’ as gaining relative autonomy to live their life and pursue what was important to them. Such residents felt free to be themselves in a number of ways from spending time as they wished (within the opportunities available to them) to expressing their feelings and emotions, to contributing to the life of the home. As might be anticipated such residents were those who were more actively engaged with life in the home and felt free to do physical things such as pursuing their activities, shopping, working, gardening, praying and sleeping, any time they wished. They were also free to socialise with other people either inside or outside the care homes. It became clear, however, during my analysis that the idea of ‘Freedom To’ was moderated by the

context and culture of the home. For example, the observational data revealed that the residents in the Star care home were more active in terms of engaging in the home's activities and contributing to the life of the home than those in the Moon home. A flexible culture within this home allowed them to have more autonomy in pursuing their life as they wanted. This idea will be discussed more later when the notion of a 'relational' as opposed to an 'organisational' culture will be explored, together with the impact this had on staffs' 'Freedom From' and 'Freedom To'. At this point the various dimensions of freedom to, as they were experienced by the residents, will be considered. At the heart of this 'Freedom To' lay the ability to make choices.

Freedom To make choices

For many residents it was being able to make choices about how they spent their day-to-day lives that provided the building blocks for a wider feeling of 'Freedom To' do things. How this was interpreted varied. For example, for one resident it was the freedom to rearrange his physical space that was important, as was the help that staff provided:

"...first, they located this wardrobe there and the bed was on the other side, but I didn't like the design of the room. I then decided to change their locations as I wished...and that fridge was over there. One day, I asked Mr. X, and told him 'Mr. X, could you please change the place of the wardrobe and put it there?' He said 'yes, why not'. Then he changed the bed's location as I told him and it became more comfortable to me".

Tanya B-Moon-R

Of course this was easier to achieve in the Moon home were residents did not have communal sleeping areas. This illustrates, as will become clear, that whilst it was the

'culture' of the home that exerted the most influence the physical environment was not without impact.

Beyond freedoms to rearrange personal space (where the layout allowed) aspects of day to day life were also open to personal choice. For example, in both homes residents could choose both when, and to a degree where, to sleep:

"In this place (a care home), thank God, I can sleep here or there (on bed or floor in his room) and any time I like. No one can stop me from doing this or blame me; it is good, thank God."

Awadan-Moon-R

The freedom to choose, even relatively simple things, within the homes was one of the ways in which residents were able to experience as sense of continuity with those valued aspects of their past lives. Indeed, continuity with the past formed an important part of the overall satisfaction with the care home, especially when the new life was embraced. One of the most obvious connections with the past was through personal possessions. The analysis showed that the residents valued the flexibility in the policies of the homes in terms of freedom to bring their possessions in with them:

'Now I am standing in one of the halls in the Star care home. I can see a computer, a computer table, and a printer beside it. Mr. Nusar is a writer and used his computer at home. When he came to the Star care home, he brought all the possessions with him in order to maintain his job as a writer'.

Field observations-Star

The residents described diverse ways in which they were able to maintain a sense of personal continuity. The most common means was by personalising their room or bed space. Those residents who had a private room constructed a more personal place

furnished with comfortable and familiar possessions, to maintain continuity with previous environments and lifestyles:

‘While I was conducting my observations in the Moon Care Home, I came across a room, and now I am standing in front of the door and I can see a very organised and tidy room. On the left side, there is a small fridge and a table and many flowers and accessories are located over the table. On the right side, a wardrobe and a modest library are located at the end of the room beside the resident’s bed’.

Field observations-Moon

Clearly this degree of personalisation was easier to achieve in the Moon home. In addition to being independent and exercising choice in the basic daily activities such as eating, dressing, bathing/showering, personal hygiene and toileting, some residents, particularly those who did not socialise with others, also undertook activities such as laundry, dusting, cleaning their rooms, rubbish disposal, and arranging and storing their belongings. For some this was because they had their own standards to maintain and wished to keep control of these types of activities. For instance, Aland resented others doing chores in his room, hence he did it all himself:

“Usually, cleaners coming daily to clean our rooms and bathrooms, but I wouldn’t let them do so. I prefer to do it myself; I do clean my room and bathroom. I clean and sterilise my bathroom. I also have my own broom for sweeping my room.”

Aland-Moon-R

For a small number of residents, who had entered the home reluctantly and remained distant from life within it, keeping control of most activities was a way of, possibly symbolically, reinforcing their separation:

“I don’t want my clothes to be mixed with other residents’ clothes. Therefore, I would like to wash my clothes and dishes by myself because they (staff) are not doing the services in a way which I like. I obtained permission from the staff to wash my stuff by myself”.

Baxawan A-Star-R

However, whilst a degree of freedom of choice was possible this was not without its limits, for example meal times were fixed, and in some cases the menus showed little variation. The meal times were fixed in both homes but as some residents had their own fridges this was not always an insurmountable problem:

“The time of meals is always fixed and you have to be in the dining room on time, if you missed one, you will have to manage yourself either to go outside or eat what you have in your fridge”.

Tofiq-Star-R

Greater concerns were expressed when there was little variation in the type of food that was provided. This was especially so in the Moon home, and this could be a cause for complaint amongst some:

“The only thing I told Mr. Farhad (social worker) several times is about the food. The food you know when it is always repeated not like home, this makes us bored and most of them you know most of the time rice and things are the same. So, the type of food must be changed. It is not about the quantity; sometimes the quantity is too much. It is about the quality and the type that should be changed”.

Sharaza-Moon-R

There was some awareness of this amongst staff in the Moon home but they felt unable to raise this as an issue due to the largely top down nature of the manager’s approach:

“Every resident has different personality as our fingers are not alike (a Kurdish idiom to express that not everybody is similar). For example, this evening they have soup for dinner and only 25% of residents like that soup, 75% of them don’t like it but they have to eat it, because they can’t do anything.”

Jaf-Cleaner-Moon

Such constraints will be explored more fully later but despite these limitations the homes still provided residents with ‘freedoms’ that they had not enjoyed for a long time.

The link between continuity and choice however went well beyond personalising space and included the opportunity to maintain a resident’s life-long activities, values or beliefs (some of these aspects are discussed in more detail below). For example, one resident had a life-long love of gardening, which was closely linked to his former occupation of working in an agricultural company. On moving into the home he began to look after the home’s garden, which became a major role for him, and a source of pride:

“When I saw the garden, it was unorganised, I went to city centre and bought stuff for gardening on my expense and started arranging it. I do like farming and caring about the garden. In the past I was a gardener and been busy with gardening. That’s why I like to continue on it now. I worked with an agricultural company for almost 10 years, planting new plants.”

Media-Moon-R

In addition, the observational data indicated that there were other residents who used strategies to maintain links to their past lives. For example, Mr. Sahir was a gatekeeper at one of the governmental organisations prior to his transmission into a care home. After retirement and becoming a resident in the Star care home, he continued to practice

his former job and although this was not formally recognised or asked for by staff they were happy to let him carry on:

'I am standing in the garden of the Star care home and observing a resident sitting on a chair beside the main entrance of the home, acting as a gatekeeper of the home, and directing visitors or anybody entering the care home'.

Field observations-Star

As the above quotes indicate for those who engaged fully with the homes one of the important freedoms was being free to be active and engaged.

Freedom To be active and engaged

The extent to which residents were free to pursue activity and remain engaged was a significant theme within the data. The residents identified several kinds of activities that they were involved with either within the home or outside it. The two most important kinds of activities that residents described were social activity and physical activity. These aspects were highly valued by the residents.

To pass the time many residents undertook a variety of largely solitary activities such as reading newsletters, magazines, books and the holy Qur'an. Playing games such as dominoes and cards was a common shared activity amongst others. In addition, residents used the communal area of the homes either for watching TV, listening to the radio, or chatting and talking together. Moreover, it was observed that many residents participated in activities that were organised outside the care homes such as picnics.

The type and the extent of activities that the residents engaged in were different. Some residents, especially those who were more distant from the home, did not seem to like

group activities and were often observed to be engaged in individual activities such as praying or reading newspapers, frequently in their own rooms:

‘Sometime, I passed some rooms and saw residents busy reading newspapers, magazines, books and the Qur’an. While I was walking along the corridor, I looked at Mr. Baxawan’s room and saw him sitting on his bed and reading a newspaper’.

Field observations – Star

In contrast others embraced the opportunities available for collective activities and enjoyed participating in shared undertakings. In order to provide a sociable environment for residents, both care homes had communal areas which were fitted with furniture such as chairs, tables and television. The communal areas were one of the most common places the residents used to get together for chatting, watching TV and/or playing games together. The Star and the Moon care homes endeavoured to create opportunities for their residents to be engaged in activities through providing several types of games such as dominos, cards and backgammon. These games were usually kept in the communal areas.

The most two common games observed among the residents were dominos and backgammon. Some embraced the idea of playing games and socialising with other residents and were frequently seen in the communal halls:

‘In the communal hall, Mr. Kazim and Mr. Saeed were sitting and playing dominos together and intermittently watching TV. After greetings, Kazim said ‘we are enjoying our time’, and Saeed said ‘it is better than sitting alone and thinking or staying in bed; playing games is useful for our brains’.

Field observations-Star

Hassan, a Star care home resident expressed his joy at being able to share activities with his fellow residents seeing it as a way of forgetting his prior negative experiences:

“I love playing games and I really enjoy spending my time with games. I like to play games and spend my time with it because I don’t want to sit alone and think about my previous life.”

Hassan-Star-R

Usually, in fair weather, the garden of the care homes was another popular place for residents to gather either for chatting, walking, smoking or listening to the radio. It was observed that some residents assembled as a group while others sat or walked alone:

‘As usual, in the early morning, most of the residents went out to the garden, some of them were sat as a group smoking cigarettes and talking, while others enjoying the sunshine and doing some Islamic “dhikr” by their “Tasbih”. Mr. Nali offered a cigarette to Mr. Danial and they started smoking and chatting together.’

Field observations – Star

The data revealed that the most common topics discussed amongst residents were political and economic issues in Iraq, and their past experiences. They also talked about health issues such as the disadvantages of smoking. For example, a non-smoking resident was seen to advise smokers about the impact of smoking on health and suggested some strategies for quitting smoking:

‘It is morning time; Mr. Kazim and Mr. Tofiq are talking together in the garden. While Mr. Tofiq was smoking and listening carefully, Mr. Kazim was explaining the disadvantages of smoking and its impact on the body. Mr. Kazim was suggesting Mr. Tofiq to reduce the number of cigarettes gradually, for example, cutting down from 10 cigarettes per day to 9 then 8 and so on;

that way “you can save money and spend it on something else like orange juice, biscuits or sandwiches.”’ he stated.

Field observations - Star

After a while, the size of the group increased and they started talking about the political situation:

‘After few minutes, another two residents joined the group and started talking about the current situation in the country in terms of politics and economy and then everyone was talking about different topics from their past experiences.’

Field observations - Star

It was this type of informal, but clearly shared, activity that marked the ways in which many of those residents who were more fully engaged with the homes spent much of their time. In both care homes staff made efforts to encourage shared activity by, for example, providing lunch in the garden of the care homes or local nearby parks instead of having it in the usual dining place. The staff members prepared the meal and some residents helped them in organising the event for example, setting tables, doing a barbeque *etc.* In one such activity in the Star care home the impact on residents was clear to see. Throughout the lunch all the residents and staff sat and ate together, creating a genuine feeling of community. A clear example of this was the way in which the manager took a highly active part in organising the event and encouraged others to join in:

‘One day, the staff planned to hold a barbeque for residents to eat their lunch in the garden. Most of the staff were observed to be busy working, for example kitchen staff, cleaners and social researchers, and the manager was observed moving tables and taking the chairs out from the kitchen and putting them in the garden in preparation for dining al fresco. Many residents and staff as well as the manager asked me to join them for lunch and I accepted. Some

residents and I also helped in some tasks for the barbeque. After the activity, happiness was very clearly seen on residents' faces. They liked the activity, especially eating their lunch in a different environment.'

Fieldwork observations - Star

The shared lunch created a positive feeling among both the residents and staff who looked like one large family, as noted by the staff member below:

"We as well as the residents enjoy this kind of activities and repeat it quite often throughout a year, especially in the spring season".

Sarbast-Administration Staff-Star

Spring time in the region is considered the most suitable season for holding picnics (which could be in local parks or in resort areas); and the care homes were no exceptions. Both care homes arranged picnics regularly during this season. As part of my observation, I participated in several of them. Many residents and staff joined the picnics and travelled together by buses which were provided by the General Directorate of Social Care. The residents were free to sit wherever they liked on the bus:

'I am on the bus; I can see some are chatting together (resident with resident or staff), at the back of the bus Mr. Saeed is singing and people surrounded him are clapping and singing along with him'.

Field observations-Star

After reaching the picnic area, the staff members and most of the residents took responsibility for arranging the area by setting chairs around the picnic carpets. Some residents sat on chairs as they felt more comfortable while others sat on the ground in a circle in order to fully see each other as they began chatting, joking, laughing, singing and playing games. Also, some staff members were seen to play games with residents:

'Outside the sitting circle, a staff member 'Mr. Roshinber' and one of the resident 'Mr. Sharaza' were playing chess together and were deeply immersed in their game'

Field observations- Moon

Other activities, such as exercises classes were also available to, and appreciated by some of the residents:

"We have an exercise class on weekly basis, the trainer is very supportive. This class is very useful for health; we do need these kinds of activities."

Raza-Moon-R

For some residents, engaging in such activities was of major importance. They described the health benefits of being active on a daily basis. For example, a resident from the Moon care home explained that he did some activities in order to keep his body active and lessen the strain on staff members simultaneously:

"I water the garden every night. Once I saw Mr. Kaiwan (a social researcher) watering the home's garden and I told him please don't do that, this is not your job. Staff members here have a lot of work and I should help them and it is even better for us. On one hand, I am helping the staff and on other hand, it is like an exercise for my body because my body will stay active, no muscle stiffness and so on."

Raza-Moon-R

"If you sit only, your body will be lazy. I had always been working before coming here, that's why I don't like to sit."

Media-Moon-R

In order to keep the residents in touch with the local community, the care homes created opportunities for their residents to engage in purposeful activities such as visiting

museums and popular Chaikhana⁴ (tea houses) in the city. A resident from the Moon care home expressed his happiness about visiting the Chaikhana as it was a good opportunity for him to chat and keep in touch with the local community:

“Last time we went to a Chaikhana down town, I really miss that place, and their tea. We had a good time with other people”

Media-Moon-R

In addition to the above a number of residents who still had good relationships with families valued the opportunity to keep their social networks alive. They wished to preserve their previous relationships with relatives and friends and they were allowed to visit them any time they wished. In addition, families and friends of the residents were welcome to visit them. Even those such as Mr. Hadi who remained distant from life in the care home appreciated the home’s policy that allowed residents’ freedom to maintain their contacts outside the home:

“I’m totally free to visit my relatives and friends anytime I like, of course after informing the staff about the visit, for instance, when, where, to whom and for how long... my family are also free to visit me anytime they wish”.

Hadi- Star-R

Visiting relatives/families was not the only way that residents maintained their links with the community. The Star home in particular encouraged residents to work or travel outside the home if they wished, as the manager notes below:

“We tried our best to not separate the residents from the local community, for example those who worked before are still working, and those who liked to go outside frequently are going out frequently. Some residents were employed and they kept their job after being a resident in the care home. Those who

⁴ Chaikhana: is a place which primarily serves tea.

wanted to travel are traveling now. So, here we left a link with the local community. It is not like I am locking the door on the residents and not letting them to go or work outside.”

Barez-Manager-Star

Three residents took this opportunity to work during the data collection period and for these people it was a ‘freedom’ that was highly valued.

For those residents who were less keen on shared pursuits or going outside the home reading was one of the individual activities that was popular among residents in both care homes and different local newspapers were distributed in the care homes on a daily basis. A few residents used the internet to spend some of their time browsing or contacting families. For instance, a resident, who preferred his own company used the internet to contact family members and relatives, whilst another resident used it to keep in touch with regional and global news:

‘Mr. Nusar was using internet to contact his son as he was living abroad. I have seen Mr. Nusar calling and talking to his son frequently in order to know his news.’

Field observations - Star

‘I have observed Mr. Sharaza using his mobile internet during free time, either for reading or answering emails or just browsing.’

Field observations - Moon

On daily basis, listening to the radio was another valued activity among the less sociable of the residents; they listened to it either for music or news on the local channels. A resident from the Moon care home was holding his radio most of the time and listened to his favourite programmes:

“Usually I sit in the garden and switch my radio on and listen either to the news or music.”

Media-Moon-R

As can be seen from the above accounts residents engaged in a range of activities, some individual, others collective. All residents were encouraged to join in the shared activities but unless these were formally organised those residents who kept themselves more distant from the life in the home tended to engage in more personal and individual pursuits. Whilst in some instances this was a facet of their personality in others it was clear that the residents who had entered the home perceiving themselves to have had little or no choice in the matter were less likely to actively engage in the wider life of the home, something that some residents had decided upon from the outset, as Aland reflects below:

“My relationships are superficial, I told you that I’m not socialising with people, I don’t socialise with anybody. From the day I came here, I rarely talked to anyone.”

Aland-Moon-R

However, irrespective of the extent to which residents interacted with others and the life of the home they valued the freedom they now had to express their cultural identity.

Freedom To express one’s cultural identity

In both care homes, there were a number of residents who practised their religious worship individually, as they considered worshipping as an important part of their daily life. The most common form of worship was praying and doing *tasbih*⁵. As one of the residents commented worshipping constituted most of his daily life and he spent hours either praying or doing tasbih:

⁵ Tasbih: in Islam, tasbih is a kind of dhikr that comprises short sentences glorifying God.

“I swear my experience was either being busy with praying or doing tasbih, I was busy with either praying or doing tasbih. After praying, I usually lie down; sometimes I fell asleep while doing tasbih. That’s all”.

Tanya B-Moon-R

Interestingly there were gender differences apparent here. It can be difficult for women in Iraq to express themselves quite as freely as men, as culturally they may feel family pressure to conform to expected types of behaviour. However, for some female residents being in the home ‘freed’ them from these constraints and they now felt ‘free to’, for example, go out shopping. They therefore were more engaged with the community than they had been previously.

In addition to individual expressions of faith and cultural activities it was common during national events for the care homes to convene special gatherings for residents and staff members. For example, during the Kurdish clothes festival, which is celebrated on 10th March, the majority of residents and staff in the Star home were observed wearing Kurdish clothes. Also, refreshments were provided in the communal hall and all residents were informed that there would be a meeting with the manager and staff members. The manager invited me to join them. It was also noticed that there was much reciprocal discussion among the attendees including both residents and staff members. The manager in particular used this as an opportunity to seek residents’ views:

‘In the meeting, the manager started congratulating everyone about the Kurdish clothes’ day and then asking them about their life in the care home and if they have any questions or suggestions. Different topics were discussed in the meeting, such as hygiene, meals, clothes and health services. Residents were noticed to be happy about the meeting and they suggested many ideas to the manager’.

Field observations-Star

Throughout the data collection period in the Star care home the manager and the staff members enthusiastically worked on improving the services for the residents. Several times, they asked me to provide them with ideas and information on effective care homes in developed countries; in order to improve the services and apply what was affordable and accessible to them. This was again another indication of the rather differing way that things were done in the Star home, an aspect that will be explored more fully later.

In addition to the above ‘freedoms’ that the homes provided there was another important dimension to life in the home that further enhanced the lives of many residents and this was the opportunity to contribute to the life of the home. This was apparent in a number of ways.

Contributing to life in the home

One of the ways that some residents contributed to the life of the home was in a tangible form by providing some kind of ‘service’ such as, for example, undertaking a variety of tasks. For Wasta below this had its own reward and no other form of recognition was needed:

“I have repaired many things in the home without informing them {staff} such as water tap, remote control and some electricity problems. I have fixed many things over time. Sometimes TV, or air conditioner is not working, I will fix it without telling anyone because I consider this place as my home...I have the feeling to take the responsibility without showing off. I don’t need any thanks or encouragements from anyone.”

Wasta-Star-R

As is clear from this quote such a level and type of activity, although not formally asked for by staff, cannot have been undertaken without them knowing and this suggests that a

high degree 'freedom' existed that allowed residents to contribute in this way. This was more typical in the Star home which, as will be discussed later, exhibited a differing culture from that in Moon.

Moreover, as Wasta above states he viewed the home as his 'real' home indicating a high level of engagement with life there. Others who had engaged with life in the home sought to contribute in differing ways. Sharing time together was popular amongst the more engaged residents and a group gathered regularly in the garden of the home especially when the temperature was cooler and talked about different life experiences. Each time, one of the residents used to treat others either to a drink, a cigarette or an ice-cream, as captured in the field observation below:

'It is a lovely sunny day, it is afternoon time. I can see a group of residents sitting in a circle in the garden of the home, chatting and laughing. I noticed that one of the chairs was vacant and after a while a resident as he just came back from a nearby supermarket holding a carrier bag full of ice-creams joined the group and started to distribute the ice-creams. They started eating the ice-cream and continued with their chatting'.

Field observations-Star

Such contributions are either tangible and/or visible but other, more subtle, types of contribution were also in evidence in the way that residents showed care and concern for each other, through individual or collective acts. Below a resident describes how he assists an older, frailer roommate with everyday activities:

"The older person, who is living with me in this room, is poor sighted. I'm always helping him in taking his clothes on and preparing his "Jamadani"⁶ to put on his head. I have a good relationship with him."

Media-Moon-R

⁶ Jamadani: Is a traditional Kurdish hat and turban which is a type of headwear, usually worn by men.

Other residents contributed to the life of the home in differing ways. For example, some helped sick residents by taking them to the home's physician, shopping for them, assisting them with treatments, or providing company and observations after hospital treatment:

'Many times I saw Mr. Aland helped unwell residents by holding their hands and walking them to the medical department in order to be seen by the home's physician. In addition, I have seen Mr. Aland shopping for supplies for residents such as cigarette and juices.'

Field observations - Moon

"Mr. X has daily medication; he is suffering from skin problems in his hands. I apply creams to his hand twice a day because he couldn't do it by himself."

Raza-Moon-R

'Mr. Nadr was admitted to hospital for eye surgery (cataract), after being discharged from hospital, a staff member brought him back to the care home. The residents went to his room, welcomed him back and gave him support. They also prayed for him and wished him a speedy recovery. Being made to feel welcome back was of particular importance for those residents who had been admitted to hospital due to health issues. This kind of relationship was common among residents themselves.'

Field observations-Star

Examples of care offered by residents were not restricted to those with whom they had already established relationships. It was observed that some residents took the initiative to build relationships with newly admitted residents, to make them feel welcome and help them become familiar with life in the home. For example, during the observation

period in the Star care home, an older person was newly admitted to the home. When I passed the social researchers' room, I saw a social researcher interviewing a new resident and afterwards taking him to his room. The new resident was welcomed by his new roommate and he was in the process of showing him around:

'After the staff had taken the new resident to his bed I saw Mr. Haji (a roommate next to the new resident's bed) welcoming him and familiarising him with the equipment located in the hall such as fridge and wardrobe.'

Field observations-Star

Such contributions to the wider life in the home were most often observed to be made by residents who had engaged with life in the home, and were indeed, a manifestation of such engagement.

In this section the concepts of 'Freedom From' and 'Freedom To' have been used to illuminate the differing ways that residents perceived life in the home. For all residents, both those who actively engaged with life in the home from the outset and those who were initially distant (some of whom remained so) the homes were seen to provide important 'freedoms from' many of the harsh aspects of their lives prior to entering the home. For many residents, especially those who actively engaged with life in the home, living in the home now also provided a number of opportunities to be 'free to' maintain important aspects of their prior lives or develop new ones. On the basis of this it is possible to suggest that a typology of differing groups of residents could be identified.

7.3 Developing a typology of residents

The data had indicated that there was little difference between the experiences of those who were identified as early engagers and those who were initially distant in terms of the impact of 'Freedom from'. These aspects of day-to-day life were universally valued

and formed part of a set of expectations that one would be cared for and looked after. In this sense both homes had achieved a degree of safety and security for the residents that was seen as beneficial.

When looking at how differing residents experienced 'Freedom to', however, the data suggested that some residents actively took advantage of the opportunities to engage with life that the homes presented to them. Unlike 'Freedom From', which was experienced by all the residents, the data indicated that those residents who initially embraced their stay in the care homes and took the opportunity to make the most out of living there were far more likely to see the home as their 'real home', with some even viewing it as 'heaven':

“Wa’Allah, personally, I would say this place is a heaven for me but I don’t know about others.

Raza-Moon-R

Those people who engaged with life in the home early for example, Mr. Kazim and Mr. Saeed continued to express satisfaction with life in the care home long afterwards and as has been noted above they enjoyed the collective activities available to them, and were very sociable. For others it was the opportunity to maintain important roles that was one of the major benefits of moving into the home. For example, Mr. Nusar expressed his satisfaction at being able to maintain his role as a writer, noting continuity as a key feature of life in the home.

It was therefore clear that for those residents who were positive about entering the home and engaged with their new life early, living in the care home at least met, and often went beyond, their expectations. Indeed, many saw it as being far better than the life they had left behind:

“This care home is 1000 times better than my real home. No one can blame me here”.

Awadan-Moon-R

“Staff are serving us even better than our home, for example, in our home our clothes been washed weekly, but here its daily. We have to be honest, we have a very comfortable life here, and God help us and keep it like that. God bless those people who are serving and looking after us.”

Haji-Star-R

Such early engagers had now fully embraced life in the home and it had clearly improved their quality of life considerably. Such individuals could be thought of as ‘embracers’.

Conversely, others, such as Mr. Baxawan, who was initially distant from life in the home and remained so, lived largely solitary lives, isolating themselves from home activities even after living there for a period of time. Those who continued to keep themselves distant from the home saw little to keep them stimulated, and believed that their life now had no real purpose:

In here, you have nothing to do; just sit, eat and sleep. That is all, just going to the dining room, eating and then going back to the bedroom and sleeping.

There is no progress here, there is no vision. Our meals are free and they provide us clothes free of charge, but nothing else”.

Hadi-Star-R

Such individuals might best be considered to be ‘isolates’. Thus my analysis revealed that one’s initial reaction to admission did, to some considerable extent, shape future perceptions of day-to-day life among the residents. To a large degree this initial perception continued to exert an influence so that even after living there for a period of

time there were residents who ‘embraced’ life in the home, and those who remained ‘isolated’ from it. However further analysis also revealed that there were a group of people who whilst being initially distant from life in the home overtime seemed to become more engaged with it, and who whilst not actively embracing it at least saw it as tolerable, these could be called the ‘Tolerators’.

Tolerators might be viewed as those residents who neither fully embraced life in the home, nor did they largely isolate themselves from it. Rather they came to recognise that care home life had both its positives and negatives and that on balance they are happy to continue to live in the home for the time being. For such residents the care home was not seen to be a place of permanent residence but rather somewhere that afforded a temporary respite from a difficult situation. Some of these individuals hoped to leave the care homes once they found a better alternative:

“...for some people may be they find it’s their solution, they have no other choices. But for me it’s not like that because I still can work and move and travel and do many things. So, it’s like [laughing] temporary jail or something like that. Temporary jail yes, yes, Em, I want to work, I still have energy, I have experience, and I can do many things”.

Sharaza-Moon-R

“I have to be satisfied with my life here because I don’t have other choices. Maybe I will be able to go back to the community and start a new life?”

Tofiq-Star-R

The analysis suggested a ‘typology’ of residents who held differing perspectives of life in the care home. As noted above I have termed these ‘Embracers’, ‘Tolerators’ and ‘Isolates’ and they could be characterised as follows:

- **Embracers:** refers to those residents who actively engaged with life in the care homes. They saw the home as providing both ‘Freedom From’ past troubles and also ‘Freedom To’ live a better life in the future. They were likely to view the home as their ‘real home’ and an improvement on what they had experienced in the past.
- **Tolerators:** refers to those residents who entered the care home and were initially distant from it. They valued the ‘Freedom From’ that living in the home provided but saw their time there as being temporary. They consequently made the best of life in the home until something better came along. They therefore were neither isolated from life in the home nor were they fully engaged with it.
- **Isolates:** refers to those residents who were initially distant from life in the home and remained so. Whilst they valued the ‘Freedom From’ that they perceived the home to provide they compared their present lives unfavourably with their past lives and often saw themselves as ‘existing’. They were more likely to be unhappy with some of the services they received and remained isolated and distant from life in the home.

These ideas are summarised in the table below:

Table 7.1 Residents’ typology and daily life features

Daily life features	Embracers	Tolerators	Isolates	Field observation
Freedom From	<p>-Obtained freedom from worrying circumstances such as no accommodation, family conflict, loneliness etc.</p> <p>- Highly appreciative</p> <p>- <i>“I can sleep with no fear because all the homes’ entrances will be locked at night.”</i></p> <p><i>“It is a heaven.”</i></p>	<p>-Same as Embracers</p> <p>Accepted as a temporary situation</p> <p>- <i>“Already both the city & the region are secure.”</i></p>	<p>-Same as Embracers</p> <p>Not always 100% happy with their situation.</p> <p>- <i>“I cannot trust anyone; I lock my room’s door.”</i></p>	<p><i>‘Each care home provided a shelter and a secure place for residents’.</i></p> <p><i>‘Free services such as accommodation, and food.’</i></p>
Freedom To	<p>Exploited every opportunity to pursue their life within the care homes (e.g., freedom to gain autonomy to live their life and freedom to socialise).</p>	<p>Less interested to engage with the home as saw it as being a largely temporary</p>	<p>Kept themselves distant and isolated from life in the home</p>	<p><i>The Embracers were seen to be active and involved in discussions during meetings about life in the home.’</i></p>
	<p>Kept their contacts, practiced their previous jobs.</p>	<p>Worked to maintain outside links in order to move out of the home</p>	<p>Majority lost the link between past and present.</p>	<p><i>Used varied means, eg a computer to continue with his writings’.</i></p>
	<p>Highly active and engaged in daily activities within the home whether it was individual or shared activities. Mostly enjoyed shared activities.</p> <p><i>“I like playing games with my colleagues and I really enjoy the time spending with it.”</i></p>	<p>Less active in engaging either in shared or individual activities.</p> <p><i>“My daily activities are either praying or doing tasbih.”</i></p>	<p>Inactive / individual activity; generally avoided taking part in activities.</p>	<p><i>‘Sitting and chatting together as a group was a common activity among the Embracers. However, the ‘Isolates’ kept themselves distant</i></p>

The identification of the typology goes some way to allowing us to describe the position that residents took with regards to their life in the care home. However, it is important not to see these positions as fixed and the data did indicate that some movement was possible. Therefore, some people who initially kept themselves distant from life in the home did, overtime, develop more positive perceptions and came to more actively embrace their new lives. In large part this seemed to be due to the nature of the ‘culture’ and the relationships in the homes and the extent to which both actively promoted ‘Freedom To’.

For example, when Sharmin entered the home she did not want to be admitted and whilst recognising that she was better off in the home than outside it she kept very distant from most aspects of the home's life. However, as she developed a close relationship with one of the Staff members (Jwana) she started to socialise with others and developed warm relationships with most of the staff members and she began to think more positively about the home. This is captured in the case study below.

Case study

The data analysis revealed that the life situation of the residents prior to admission played a key role in determining their preconceptions of care homes, their initial reactions to admission and their later perceptions of life in the home. Based on the above a broad typology of residents was identified comprising of the 'Embracers', the 'Tolerators' and the 'Isolates'. However, these were not fixed positions and the case study below illustrates how movement between these positions was possible. Prior to her admission one of the female residents (Sharmin) had experienced serious family breakdown, due to her inability to conceive a child, culminating in divorce. This had resulted in what she perceived as a 'no choice' move into the home which resulted in an initial negative perception and a feeling of being distant from life in the home.

Upon admission therefore Sharmin was quite withdrawn and did not take part in life in the home. This pattern remained for some time and she isolated herself from most activities in the home. Following the trauma of her family break up she found it very difficult to relate to anyone in the home, even the female resident with whom she shared a room. However, over time she slowly began to adjust and opened herself up to some people in the home, especially one particular member of the staff. Slowly she was able to relax, as she describes below:

“To be honest with you, in the beginning it (care home) was like a jail to me. But now I have a good relationship with the staff and I feel so relaxed with them”.

Sharmin-Moon-R

With the encouragement of this member of staff she began to take more part in the daily life of the home, including forming relationships with some of the residents. As a result, she started to think differently about things, and gradually accepted her new life. Whilst she only tolerated her situation at this point, overtime she formed a more favourable impression of what the home could offer her. In particular, her relationship with Jwana, her closest contact amongst the staff, enabled her to start to embrace aspects of the home. However, she only really engaged when Jwana was on duty, and was more isolated when she was not:

“Usually I am spending my day time with Jwana, chatting, sitting, working or shopping with her from early morning until afternoon. As soon as Jwana leave the care home usually at 3 pm, I will be upset and start missing her because she is close to me”.

Sharmin-Moon-R

Despite this during observation, I noticed that she did contribute to life within the home, by for example helping staff members to perform their duties such as arranging beds and changing bed sheets. She was also observed helping kitchen staff members during meal times by setting the table. So whilst still not fully embracing all aspects of home life she had, over time, developed a much more positive perception, demonstrating that movement from an isolated to a more engaged position is possible with the right support.

7.4 Summary

As has been demonstrated the initial perceptions of residents about the degree of choice they exercised when entering the home and the extent to which they could construe moving in as being of benefit to them largely shaped their initial reactions and the degree to which they embraced or remained relatively isolated from life in the home. It was also argued that whilst the homes could be said to provide all the residents with relative 'Freedom From' prior concerns it was primarily those residents who more fully engaged with the homes who experienced the greatest 'Freedom To' improve their quality of life. Building on this analysis a typology of three differing groups of residents: 'The Embracers'; 'The Tolerators'; and 'The Isolates'; was identified. Although the physical environment of the homes played some part in creating opportunities to have 'Freedom To' exercise choice in, for example, the layout of personal rooms, it has also been suggested that the 'cultures' operating in the homes were far more significant. Attention is now turned to these cultures and the extent to which they facilitated 'Freedom From' and 'Freedom To' for both residents and staff.

Chapter Eight: ‘Freedom From’, ‘Freedom To’ and Care Home Culture

8.1 Introduction

As the literature consulted before data collection began indicated the way that life is experienced in a care home by residents, staff and relatives is in large part shaped by the ‘culture’ operating in a given home and that this culture is significantly influenced by the type of leadership within the home. But as pointed out most of this literature comes from studies carried out in Western as opposed to Eastern cultures. There has been very little prior work on care homes within a middle-eastern context. Whilst homes in such settings clearly operate in a vastly different ‘macro’ culture I was interested in the extent to which the ‘micro’ culture within a given home (if indeed one could be identified) exerted an influence over and above the macro culture within which the homes operated. The following findings and discussion presented in this chapter address the last objective of the study which was ‘How these interactions shape the culture the Kurdish care homes and how this culture influences the lives of those living and working there?’ The findings described in chapter five denote to two distinct cultures in the care homes as one advocated positive and mutual relationships between its residents and staff, while other one focused on getting the task done with little attention paid to relationships between its personnel. The day-to-day life of the homes described above further suggested that differing cultures, for both residents and staff, did seem to exist and further analysis confirmed this. This chapter seeks to build on this analysis. The two cultures that emerged have been termed a ‘Relational Culture’ and an ‘Organisational Culture’ and the following section describes their key features and outlines the impact that they had on both residents and staff. The focus here is primarily on the latter group as considerable attention has already been given to how residents experienced life in the home. The chapter begins with a brief overview of each culture before going on to

describe their key features in greater detail. As considerable attention has already been given to the notions of 'Freedom From' and 'Freedom To' for residents, the same concepts will now also be applied to staff. It should be noted at this point that neither home could be said to be exclusively relational or organisational in their focus as some elements of each could be found in both homes. Nevertheless, Star was more evidently relational than organisational and the reverse was true of Moon.

8.2 Relational culture

What has been termed a 'relational culture' is mainly characterised by the relationship-centred nature of the interaction between staff and residents, between the staff and amongst the residents themselves. This type of culture was most clearly manifest in the Star home and as has already been described it was here that residents seemed to enjoy greater 'Freedom To' in their day-to-day lives. This type of culture enabled residents to think, choose, and act for themselves to the extent that is possible in a communal setting. In this care home culture, there was a strong emphasis on valuing different perspectives and the importance of mutual relationships. Although the building was old and was not designed specifically as a care home, other important factors within the home more than compensated for this, making the home a relaxing place to live and work.

The presence of an effective and passionate leader who focussed on the needs of both residents and staff seemed central to this. The manager at Star endeavoured to create a positive reciprocal relationship with staff and residents by enabling them to have a voice and involving them in making decisions, which ensured that both staff members and residents felt valued and supported. In this way it could be said that there was a degree of interdependence between the two groups.

In Star the home manager was observed to engage frequently with the residents and staff members, for example, visiting the residents' rooms and listening to any concerns that they had. He took an active part in many aspects of life in the home, for instance, the quality of the food. He was regularly observed to work late, well beyond his allotted hours to ensure that all the necessary work was completed.

Largely as a result of the atmosphere that was created the relationships between residents and staff were close. Staff appeared to enjoy their work and supported the residents to enjoy the 'Freedom To' live their lives as they wished within the necessary constraints of communal living. Staff were enabled to do this as they too were free from unnecessary rules and regulations and free to exercise a degree of autonomy. There was a spirit of teamwork and cooperation amongst the staff and whilst everyone knew their role there was also a degree of flexibility.

Both the residents and staff members felt that they had a voice, which could be heard, both informally and formally. For example, residents had ready access to staff, including the manager, whose door was 'always open'. There were also formal structures such as regular meetings in which residents and staff were actively encouraged to speak and voice any issues that they might have. The data also indicated that the home had flexible policies for example in relation to the residents working or leaving the home for extended periods to visit family if they wished. The manager and staff encouraged the residents to actively contribute to the life of the home in whatever way they wished, but this was not forced and residents were free to make their own minds up about how much they wanted to engage with life in the home. The culture within the home empowered everyone (staff and residents) to contribute positively. Both staff members and residents frequently described the care home as feeling like a 'big family', and as noted already many residents considered that it was now their 'real

home' rather than simply a refuge. This did not happen by accident as all the personnel were endeavouring to make the home feel like a 'real home' for residents. To this end they conscientiously sought feedback, both individually and collectively from residents, and the manager did the same with staff to ensure that all staff felt that their contribution was valued. During the observations it was evident that the residents had a sense of belonging and many actively contributed to the life of the home in a number of ways. For instance, some 'took charge' of the garden, while others helped the cleaners or repaired household items; residents were especially drawn to tasks with which they had prior experience. For example, one of the residents was a former security officer in a government school, so he worked as a 'guard' in the home. As a consequence of this engagement by residents the home could be said to be working as a 'community'. This is something that will be explored in more detail in the discussion. Things were somewhat different in the Moon home where what was termed an 'organisational culture' existed.

8.3 Organisational culture

In contrast to the Star home, where there was a high degree of flexibility, in the Moon home there was a routine-centred culture which restricted both residents' and staff autonomy. It seemed that the focus of the home was primarily outward facing and that presenting a positive image of the care home to the external 'world' seemed to be the core purpose. For example, considerable effort was expended to raise the profile of the home whether this be by organising activities outside the home so that the residents could be 'seen' by the local community or by increasing the profile of the home on its social media webpage which posted pictures of events such as picnics, visits and celebrations. Whilst this might be a very positive thing if it was complemented by an environment of engagement within the home this was not the case. So whilst the

number of external activities available to residents in Moon was far higher than in Star the residents were not involved in decisions about such activities. Nor indeed were they involved much in the life of the home at all, unless this was encouraged by certain staff members on an individual basis. Whilst considerable effort was expended to ensure that residents' daily physical needs were met (they were therefore 'free from' concerns about these) far less attention was paid to their emotional needs and wider aspirations and so opportunities to be 'free to' pursue activities that the residents wanted were relatively limited. The profile and needs of the organisation took precedence.

To achieve this leadership within the home was far more autocratic than it was in Star, with the manager and a small group of her 'favourites' making most of the decisions. Compared to Star staff roles were far more clearly defined and there was less of a feeling of teamwork. Moreover, whilst policies were in place which clearly defined staff roles, 'junior' staff were sometimes expected to undertake tasks that were not their own, not at their discretion but because they were 'told' to do so. Furthermore, whilst 'meetings' were organised which residents and staff could attend neither group were encouraged to actively contribute but rather the meetings were an opportunity for the manager and her close circle to 'inform' others of decisions that had already largely been made.

The manager, whilst participating in most of the home's indoor and outdoor activities, was rarely seen in the residents' wing visiting their rooms. Nor did she encourage residents to approach her directly. As such the opportunities for residents both to raise any concerns and to have their voice heard were limited. Although there was good communication between some of the staff members and the residents many relationships were characterised by authority and power. This seemed to mirror the 'favouritism' that the manager also displayed towards some of the staff.

As a result of this whilst staff often said that relationships between themselves were 'OK', such relationships were often superficial and some staff were critical of the hierarchical nature of interactions in the home, describing inequality in power and decision making. There was an 'inner circle' of staff who had ready access to the manager and had her 'ear', whilst others felt excluded. There was little opportunity for these excluded members of staff to influence life in the home nor to exercise any real degree of autonomy in their actions. Whilst staff could introduce some changes these were allowed only as long as they did not interfere with the 'status quo' in the home and were resource neutral. Staff received no active encouragement to suggest or make changes, nor was there any recognition of their efforts if they did. For example, one staff member worked very hard to introduce changes that might improve the residents' engagement with life in the home, but constantly had to struggle to do so without access to support or resources. Indeed, he often paid any extra required out of his own pocket. Not surprisingly therefore there was little teamwork evident within Moon. As a result, there was no real sense of community present.

As will be clear the existence of these two differing cultures, one 'relational' and one 'organisational' were in large part a result of the approach taken by the managers within the home, what he or she prioritised and how decisions within the home were made. In particular, the way that staff were encouraged and enabled to actively help shape life in the home, or not, seemed central and this related largely to the extent to which they were, 'free to' make a positive contribution. A number of key factors could be identified, especially the extent to which staff were actively consulted and involved in decision making, encouraged and enabled to act of their initiative and received positive feedback on their efforts. Moreover, as will emerge below, in Star it was not just staff who were involved but also the residents. These aspects are explored in more detail below.

8.3.1 Involvement in decision making

Within the relational culture that operated in Star, Barez, the manager, made sure that all staff had an opportunity to contribute to and take an active role in decision making. He also made sure that residents' views were given equal consideration as is reflected in the quotation below:

“I accept my staffs’ ideas, I listen to them because I realise that their ideas are often better than mine. If I make a suggestion I sometimes withdraw it and adopt their idea. We don’t take personal decisions. For example, if I want to know about the food service provided I will ask a social researcher to sit with some of the residents and listen to their suggestions on how the food could be improved. I regularly ask the social workers to get feedback from the residents on the provided services, which are liked or disliked. ...If I have made a decision I will change it if I find that the residents don’t agree with it.”

Barez-Manager-Star

Whilst the Manager obviously consulted with his senior staff first, it was clear that their views were not in any way ‘imposed’ on the rest of the home, as Sarbast explains below:

“Decisions here can’t be made alone. For example, most of the critical decisions will be discussed by the manager, assistant manager and me first, we are always asking each other. But we don’t have any dictatorial decisions here and we share ideas.... comments from everyone can be very useful”.

Sarbast-Administration Staff-Moon

As was noted above the manager made deliberate efforts to ensure that residents' views were heard and this extended to an 'open door' policy with residents having ready access to staff, as the field observation below highlights:

'In Star care home, I observed that residents can go to staff's room any time to ask about their requirements or needs. I noticed that staff were usually listened to their needs and were tried to help them'.

Field observation-Star

Because of this approach there was, as described previously, a feeling of teamwork amongst the staff:

"One of the positive points in this care home is we are working as a team; this point is very helpful. For example, if we, the manager, assistant manager, nurses, social researchers and caregivers did not support each other, I wouldn't be able to work here".

Sarbast-Administration Staff-Star

This was in contrast to the situation in Moon where the Manager admitted that she often did not listen to the views of all her staff. Staff were well aware of this but seemed reluctant to challenge things for fear of incurring the manager's displeasure. Staff, apart from those close to the manager, felt that they played little part in decision-making. There was consequently little feeling of teamwork apparent. The quotations below highlight this:

"In some cases, I don't listen to the staff members and decide to change things the way I want".

Ban-Manager-Moon

"I do not think I have made any decisions, I never been involved in any decisions, I only attend meetings but most of the decisions have already been

made by the manager and social workers.... We do not have any authority, they do not consider that we are all complementary to each other and we have to work together. They feel that you are inferior to them and they are the superiors. Here, the positions are hierarchical, if any staff tells me to do any kind of works, I have to do it. I can't say no, because s/he got a position and I am afraid they will harm me or work against me."

Hawkar-Moon-S

"There is some kind of favouritism applied by the managerial team towards some staff".

Farhad-Social Worker-Moon

In addition to the staff being kept 'under control' it also seemed that residents were also expected to 'know their place':

"The residents should know that this is a governmental organization; it has some policies and regulations. They should obey and follow these regulations such as behaviour, morals and style."

Ban-Manager-Moon

From the above one can begin to see the origins of the two different cultures in operation and, as with the residents, these can be understood in terms of 'Freedom From' and 'Freedom To'. The Star staff were 'free from' any fear of censure and actively encouraged to be 'free to' express their views and take an active and equal part in shaping life within the home. For some staff in Moon this did not seem to be the case. This was also apparent in the extent to which staff were encouraged to act on their own initiative, were supported to grow and develop and were recognised for their efforts.

8.3.2 Acting on initiative, being enabled to grow and receiving positive feedback

Staff in Star had clearly defined (but flexible) roles and providing that they consulted with the manager it seemed that were actively encouraged to suggest and implement changes that they believed would improve life in the home. The quotations below give a flavour of this:

“Any charity donation, including money and equipment, to this home I am the person to deal with it, of course under the supervision of the manager (Barez) because we should inform the manager about everything in this home”.

Sarbast-Administration Staff-Star

“Many times I have suggested and made decisions, for example, when the company responsible for providing the care home with food supplied what I thought was low quality food, fruits, vegetable and meat, I refused to accept it and asked them to change for better quality food”.

Raihan-Nurse-Star

“If I want to do something here for the residents, I will discuss it with the manager first. One of the things that I have modified is a form which was used when residents leave the care home and visit their relatives/ friends. The previous form was a bit complicated so I created an easy form that only needs a resident’s signature and I showed this to Mr. Barez (manager) and he agreed”.

Nada-Psychological Worker-Star

In addition to being encouraged to act on their initiative the Manager at Star also made a point of recognising and praising the efforts of staff at all levels, and helped them to

reach their full potential. As the quote below shows this engendered a real sense of significance amongst staff, both for themselves and the residents:

“Every day, I am cleaning all rooms and I can get very tired, but when the manger tells me ‘well done and perfect work’, I forget all my tiredness and become very happy and relaxed. This encourages me to serve them (residents) in the best way. If it wasn’t for him (the manager), I would have left this place long back! First time I worked here I didn’t know anything about elderly care and I haven’t even worked with older people before. In the beginning I was responsible for cleaning only one hall, then became two halls. Now I became a chief cleaner of the home. Then I told three of my friends about the job and brought them to work here”.

Dlsaf-Cleaner-Star

The manager also made a point of working with new staff and helping them to ‘learn the ropes’ so that they could get a clear idea of what was expected of them:

“I didn’t work with older people before. But as I worked here I have learned. In the beginning, I was working with Mr. Barez during all working days, weekends and holidays too from 8:00 – 20:00. My experience was built from working in this place”.

Sarbast-Administration Staff-Star

This approach seems to have been based on the experiences of the manager himself who had worked in the home for some time, and in a variety of roles, before becoming manager. The quote below would suggest that he had learned a lot from this experience and that this now informed his own leadership style:

“I have worked in all the departments in the care home for about 6 years before becoming a manager. Throughout my long experience, I recognised the

positive and negative points in each department and now as a manager I am trying to adopt all the positives and avoid the negatives in order to provide a suitable environment for all”.

Barez-Manager-Star

Once again things seemed quite different in Moon. Here, as illustrated above, only senior staff or those close to the manager took an active part in decision-making, others more or less ‘did what they were told’. Not surprisingly therefore the same applied to acting with relative independence, with only senior staff being able to do so:

“I have been involved and made decisions to better older people’s lives based on my investigations and judgment. I am authorised to take prompt actions based on the situation”.

Farhad-Social Worker-Moon

More ‘junior’ staff however seemed to be in a somewhat different situation. Whilst there were a number of policies outlining peoples’ responsibilities it seemed that these were not always adhered to and that staff sometimes were ‘told’ to do things that were not their role and were possibly outside their area of competence:

“There is a policy that explains each single duty for all such as manager, social researcher, medical staff and cleaner. But it is not applied”.

Roshinber-Psychological Worker-Moon

“In this home, I have to do many things which are not my duties. For example, sometimes I have to prevent residents from going outside the care home, serve the food to residents and administer medication. In fact, none of these are my duty but I have to do it because they (staff) will tell me to do so”.

Jaf-Cleaner-Moon

“Even though I like to help and do everything for residents sometimes the staff misuse me by telling me to do their job instead of them. For example, it’s the health staff’s responsibility to take residents to hospital but they don’t and ask me to take residents to hospital”.

Jaf-Cleaner-Moon

The above serve to reinforce the hierarchical, and somewhat domineering nature of the culture operating in some aspects of Moon. Given this it was no surprise that staff suggestions for change and their ability to act on them were very limited. This led to frustration for some staff, especially when staff felt that their suggestions were right and could easily be implemented but were ignored because of who had made them:

“Sometimes, if you highlighted something wrong here, the staff who are in positions (of authority) don’t like it. Even if you give them a new idea or a right idea, they will not accept it, even if they know that you are 100% right; because they don’t us like to give them any idea. For example I have suggested taking the residents to the swimming pool at least once a week but they (staff) didn’t listen to me. The care home has a bus and they can easily transport the residents”.

Jaf-Cleaner-Moon

One particular staff member, Roshinber, made repeated suggestions for improvement but these were often ignored, or he was allowed to do something provided that it did not interfere with the running of the home or make any demands on resources. Sometimes he even paid for things out of his own pocket. From the numerous quotes below it is possible to get a sense of his frustration:

“I suggested many ideas to the manager such as holding a monthly meeting or putting a time table for staff. By doing this, we can find solutions for problems, if any, and we can improve the care, but nobody listened to me”.

“I have tried to set up a work schedule for staff describing their roles and duties based on the guideline from the ministry. We have followed the schedule for a while but everything just went back as before”.

“Again, it was my idea to have a cinema time weekly and even for that I had to buy the movies at my own expense because they have not funded me”.

However, despite resistance and numerous obstacles he preserved and achieved some success, despite of, rather than because of, the dominant culture in the home:

“I collaborated with one of the volunteer trainers ‘Frishta’ to deliver an exercise lesson. When we started there were only 4 residents doing exercise and gradually the number has increased, session after session”.

“The residents were complaining about the meals and the food schedule in general. So, we held a meeting with the residents to discuss this issue. I have modified some of the contents in the food schedule. For example, at the time fizzy drinks were provided daily (which residents didn’t like). So, we decided to replace it with bottled water”.

The existence of these two cultures also impacted on the nature of the relationships between residents and staff. Whilst close relationships existed in both homes, in Star residents and the whole staff group appeared to enjoy such relationships whereas in Moon close relationships were either had with those staff who actively tried to treat all residents equally or for some staff were limited to their ‘favourites’.

8.3.3 Resident/staff relationships

In Star care home in particular there was evidence that relationships between residents and the staff group as a whole were friendly and open. Staff expressed a high level of satisfaction with their work and genuinely seemed to like engaging with and listening to their stories. There were several instances where residents and staff members had become friends and residents and the staff were seen to be talking, joking and playing together on a regular basis:

“I like older people, I like their conversations and stories so much. I always like to be here mixing with our older people. I like their talks and I never get bored with them. I listen to them and enjoy their stories and I like hearing them talk about life and other things”.

Jwana-Cleaner-Moon

The data showed that in Star most residents and staff developed personal and mutual relationships in which residents spontaneously expressed themselves and shared personal information about their lives with staff members. Both, residents and the staff, saw themselves as members of a big ‘family’. Staff members proudly talked about their relationship with the residents and they frequently used the word ‘family’ to describe this relationship. Some staff members, in both homes, described the residents as being like their ‘parents’ and ‘grandparents’:

“I feel they are my parents. I never felt they are strange to me. I always feel like I’m in my family when I am working here and this point is very important.”

Sarbast-Administration Staff-Star

“I am always treating them the way I treat my parents and not differentiate between them, I am treating new residents similar to old residents. I don’t differentiate between X and Y, to me, all are equal”.

Jaf-Cleaner-Moon

Of course it was more difficult to establish relationships with those residents who kept themselves distant from life in the home and in such cases residents sometimes formed a close relationship with a particular member of staff, as was the case with Sharmin, who only really engaged with life in the home when a particular member of staff was on duty. Indeed, in her absence Sharmin, as was noted in the earlier case study, said that she ‘switched off’:

“If you noticed, last time I didn’t go to the picnic with residents, because Jwana (a staff member) didn’t participate in the picnic. Even Mr. Roshinber told me to join them but I refused. I knew that I won’t enjoy without Jwana. When she is here, I am so happy and we are always together, we just like sisters. Once her shift is over, I switch off and feel bored and waiting to see her again the next day”.

Sharmin-Moon-R

Because there were generally closer resident/staff relationships in Star staff members tended to have more opportunities to listen and pay attention to residents’ concerns and worries. Therefore, in addition to the fact that residents had more of a voice in meetings at Star the greater informal contact provided yet another means by which staff could engage with residents, especially if they suspected that they had concerns:

“I am always giving them (residents) the right to complain. For example, sometimes one of the residents will look anxious but I take it easily and I listen to them, they always have the right to say what they want”.

Dlsaf-Cleaner-Star

However, the data suggested that this happened less often in the Moon care home and when it did was more likely to be confined to certain members of staff who paid particular attention to and gained great satisfaction from their interactions with residents:

“My long experience in this place helps me to know every resident well. I am spending most of my time here with the residents, I think I would not be able to work and cope in another organisation or place other than this care home, I can’t imagine that!”

Jwana-Cleaner-Moon

Therefore, in Star it was the staff group as a whole who actively engaged with the residents whereas in Moon it was more often an effort made by particular individuals.

The table below summarises the main characteristics of the two cultures.

Table 8.1 Characteristics of the care home cultures

Characteristics	Type of Culture	
	Relational Culture	Organisational Culture
Values	Relationship and person-centred	Task-centred and organisational centred
Goals	Focus on residents’ autonomy and staff satisfaction	Focus on external image and smooth running of the home
Policies and practices	Staff have clear expectation of their roles but these are flexibly interpreted.	Policies exist but are often not enacted. Junior staff expected to act beyond their role.
Relationships between resident and the home	More residents actively engaged with life in the home	More residents distant from life in the home
Relationships between residents and staff	Often close and mutually engaged	Positive relationships with ‘favourites, others more distant. Some staff make efforts to engage all residents
Relationships between staff	Cooperative, good teamwork	Favouritism, little evidence of teamwork
Relationships between staff and manager	Equal, inclusive relationships	Inclusive relationships for some, distant and dominant relationships with others.
Decision-making	Opportunity to contribute, active role in decision making, equal consideration.	Staff with fewer opportunities for engagement and control. Little part in decision-making for some staff.

8.4 Summary

The preceding chapters have presented the results of data analysis, beginning with an overall description of the three homes before proceeding to consider the manner in which residents moved into the homes and its effect on their immediate reactions, how residents and staff experience day to day life in the homes and the influence that the 'culture' of the homes and, to a lesser extent, their physical environments, had on these experiences. In so doing the study has provided answers to the overall questions and more specific aims of the study that are reproduced below:

Overall objectives of the study

- How do residents and staff perceive their life within Kurdish care homes?
- How does the 'culture' in Kurdish care homes influence the experiences of residents and staff members?

Aims of the study

To explore:

- The trajectory of older peoples' admission into a care home.
- Life in the care home from the perspectives of older people and staff.
- How residents and staff relate to and interact with each another.
- How these interactions shape the culture the Kurdish care homes and how this culture influences the lives of those living and working there.

The extent to which these questions have been met and what, if any, new insights the study provides are considered in the discussion which follows.

Chapter Nine: Discussion and conclusions

9.1 Introduction

This chapter considers the extent to which the study's initial aims were met and goes on to discuss the key findings of the study and place these findings in the context of the wider literature relating to different factors that shape the way older people and staff members live and work in care homes. Following this it is suggested that the concepts of 'Freedom From' and 'Freedom To' can be used to distil central aspects of an 'enriched environment' (Nolan et al., 2006). In doing this links will be forged between 'Freedom From', 'Freedom To' and the 'Senses Framework' (Nolan et al., 2006) and it is argued that this approach can help to illuminate how care homes, not only in Kurdistan but also those operating in a range of settings and contexts, can use the ideas of 'Freedom From' and 'Freedom To' to help create enriched environments for all who live and work there. Finally, the thesis concludes with a consideration of the implications of the study for policy, practice, education and further research. However, before this it is important to consider if the findings of the study accord with ideas of good quality in the light of the strengths and weaknesses of the work.

9.2 Quality criteria

I believe that the findings and the resultant typology was truly grounded in the data, however, it is still essential to highlight the robustness of the findings and the quality of the study. Therefore, the quality criteria of the study will now be discussed.

The issues of rigor with qualitative studies have been a source of long debate as they have been criticised for failing to explain rigor. Whether to impose the standards of validity and reliability of quantitative research on to the qualitative research has been a major issue (Sandelowski, 1986). However, such arguments have shifted to judge the

qualitative research studies based on identifying quality criteria (Hammersley, 1998; Mays and Pope, 1995). Some ethnographers reinforce the usage of a single quality criteria being used to assess a diverse range of quantitative studies, while others emphasise the usage of a distinct set of quality criteria for assessing an ethnographic study (Hammersley, 1998). In the current study, adopting Hammersley's quality criteria for judging an ethnographic study has already been justified and provided in the Methodology and Methods Chapter (Chapter Four). According to Hammersley, when it comes to assessing quality of an ethnographic study, three questions should be considered. These were named as plausibility, credibility and relevance (Hammersley, 1998). I will now consider each of these questions with examples of strategies being used to enhance the quality of the current study.

- ***Plausibility***

Hammersley claims that "*we can never be absolutely certain about the validity of any knowledge claims but it suggests that we can still make reasonable judgements about the likely validity of such claims*", in which this includes assessing their plausibility and credibility. (Hammersley, 1998 p.78). Hammersley argues that the first question we should ask regarding the 'knowledge claim' is how plausible it is. Whether or not the description and explanation provided sound reasonable and realistic. He states that in some cases, some knowledge claims are so reasonable that we can accept them at "face value", even without searching to know anything about them (i.e., without considering how a writer constructed them or searching for evidence to confirm them). Nevertheless, with regard to the main findings of a piece of research study, this will be uncommon (Hammersley, 1998).

Hammersley states that based on our existing knowledge, we can assess the plausibility of the knowledge claims. For instance, a claim sounds plausible (i.e., realistic or

reasonable) when we all know about that claim and no further information or evidence is required to assess how a researcher ended up with such claim or inference. However, if we could not accept a claim, it is not to say that we find it “implausible” but rather it is not reasonable enough to accept it at face value.

In ethnographic research studies, few, if any, of the main knowledge claims are so plausible that they require no evidence. It is important to note that if they were, they would not be contributed to our knowledge. Therefore, the second step should be considered which is assessing its credibility.

I have already mentioned in Chapter Four that I believe that the audience/reader of this thesis or the wider community should judge about the quality of the study instead of the research community. For that purpose, I intended to provide a thick description of the homes under study (in terms of geographical and organisational configuration, their culture, staffing levels, philosophy of care and social characters), how the research was conducted, what role I adopted as a researcher and so on. Thus, by providing a rich description, explanation and understanding of the context where the research was conducted and how the data was collected, the reader of this thesis is in a better position to assess the quality (i.e., credibility) of the claims and inferences I have made (Geertz, 1973).

- *Credibility*

In order for readers to judge about the credibility of an ethnographic study, they must have given enough information regarding the nature of the phenomena concerned and the characteristics of the researcher and whether the research study comprised the researcher’s own observation alone or relied on the informant’s accounts or both (Hammersley, 1998). By doing this, the reader can then be able to judge whether the claim is plausible or credible.

The credibility of any ethnographic studies can be achieved by the sufficiency of gathered data to support/confirm the findings; evidence of connections between the presented data and analysis; clarity in presenting research process and its product. Thus, the readers can assess the validity of these evidences or judge their quality (Hammersley, 1998).

The process of which the evidential claims (i.e., descriptions) have been produced should be taken into consideration in assessing credibility. In ethnographic studies, these include the extracts from researcher's own observational reports and the extracts from informants'/participants' interviews. The main sources of error that may arise from an ethnographic observation reports are the potential effect of the research process and the researcher's characteristics (including personal and social characteristics) on the behaviour of people under observation. This issue has been recorded as 'reactivity' as people might change their behaviour once they have known that they had been under observation.

To tackle this issue, several strategies have been applied. For instance, I spent considerable time in both homes prior to the actual data collection period. This was purely aimed to aid gaining familiarity with the setting and the people under study and is outlined in more detail in Chapter Four. Subsequently, the lengthy engagement in the homes facilitated to produce a wealth of data from both observations I have made and interviews of different categories of participants (i.e., residents, different categories of staff and managers). These data were selectively presented in order to support the claims I have made throughout my findings. Hammersley (1998) suggests that employing triangulation in ethnographic studies is "*a useful form of check*" on the credibility of claims especially descriptive ones. It has been documented earlier that this study employed observation, interviews and fieldnotes in order to generate a rich data

from different perspectives and different sources. It is worth mentioning that the generated data throughout the different sources were complementary to each other. For instance, the interview accounts were supported by observational data; only in one case there was some discrepancies between what the participant (the Moon care home manager) has claimed and what the observation and fieldnote have produced.

Another kind of evidence that might be provided to ensure credibility is to present the data back to selected participants (both residents and staff). This is referred to as “respondent validation” which is helpful to ensure that a clear understanding is sought from the respondents. After each interview, I immediately made an individual conversational approach with the participants to give brief summaries of what has been discussed in order to clarify and rule out any misunderstandings quickly. Providing a prompt verbal comment after each interview was noticed to be a desirable and highly acceptable tactic by the participants as opposite to asking them to write written comments. This is mainly because most of the participants could not read and write or had sight problems or did not have free time to write their feedback.

It is essential to note that the time when this empirical study has been carried out was just prior to the crisis (ISIS war) that recently started in the region and the country. This crisis brought many insecurities to the Kurdish people as it had a huge impact on the economy of the Kurdistan region as a result the quality of life for all Kurdish people including care homes (as they are part of that environment) has been affected. As far as I know, several aspects of the care homes have changed because of this situation. For example, food provision and number of activities. Therefore, perspectives of residents and staff and their experiences might have been changed by now.

- ***Relevance***

The third question that Hammersley suggested to ask in order to judge the quality of an ethnographic research was about relevance. He argues that there are two aspects of relevance that are essential to be considered. He describes them as “*the importance of the topic*” and “*the contribution of the conclusions to existing knowledge*” (Hammersley, 1998, p.111). Both the importance and contribution are conjointly necessary aspects to assure relevance of any ethnographic research. If, for instance, findings from a research concerned about an important issue but not contributed to existing knowledge or vice versa, it is still considered not relevant.

In the current study, the research topic was carefully chosen prior conducting an empirical study as it is related to an issue of public importance. Besides, there was little known about the research area which I believe this study added new insights and made a significant contribution to the knowledge of area being studied. However, eventually, it is up to the readers of this thesis to decide and judge whether or not this study contributed to the knowledge. In addition, the nature of an ethnographic approach in exploring a culture of Kurdish care homes which grounded in various sources of data was remarkably appropriate to this inquiry. As a result, the different perspectives and experiences from different personnel enabled us to understand the way Kurdish care homes run and the way residents and staff live and work there. The findings of this study helped to develop new knowledge with regard to Kurdish care home context. Since the discussion of the main findings of the study with the existing literature which is documented in the subsequent section, overlaps with this aspect (relevance), therefore, the significance of these findings and the amount this study has contributed to knowledge in relation to a care home context will be discussed later. As I have presented a methodological critique of the measures applied to ensure the quality

criteria of the findings of this study, I will now discuss the strengths and limitations of my work before addressing the findings in the light of the literature.

9.3 Strengths and limitations of the study

This is the first piece of work of this kind to be undertaken in care homes for older people in Kurdistan. The care home sector in the region stands to benefit from my study and has the potential to learn from my findings. As has already been noted I also maintain that the length of time that I have been able to spend in both care homes undertaking this detailed piece of research also adds to our understanding of the cultural characteristics of the homes. As such I have identified particular features of care home life which might facilitate or inhibit progress towards enriched environments of care. As well as this the nature of transition into care homes in Kurdistan has been explored. I have been able to draw attention to some of the key processes through which care home transition may be understood from an older person's perspective and how this might contribute to the lives of those people and their perspective on the nature of their lives post-transition.

The study has sought to employ a reflexive strategy throughout. It has been noted that the care home literature is certainly predominantly drawn from empirical studies undertaken in the West. I was keen not to use the knowledge which was derived on this basis to influence too heavily my thinking, particularly at the outset of my work. More important, however, are my own taken for granted assumptions about the world. I have arrived at my doctoral work via the professional practice of nursing. Whilst nursing itself draws upon a range of disciplinary forms, there may have been the potential to focus upon those aspects of care that were related to physical and personal care. Indeed, my original study ideas were very much focused upon quality of care issues. It was not until I began to explore care home culture in more depth did I begin to move beyond the

assumptions of care as being situated in the physical to consider the social and relational nature of environments of care. Throughout I have attempted to employ this reflexive approach which, I believe, has been an important strength of the study.

However, I can identify a number of limitations. The findings of the current study were limited to Kurdish residents, therefore it would be argued that the views of other non-Kurdish respondents might be different from those who participated in the current study, and this may not completely represent all views across both care homes as ethnic minority participants were not included. However, it was clear from the beginning of the study that the intention was not to generalise the findings of the study to a wider population, since the main aim of the study was to explore residents' and staff's view in Kurdish care homes.

In both care homes, I used purposive sampling and relied on those participants who were willing to participate, and it comprised of those residents who were more able to participate and those staff who were more available. Although there were other female residents, albeit a much smaller number than their male counterparts in the care homes, only one female resident participated in the current study. However, I was unable to observe or interview them, this was due to several reasons: either they did not consent to participate or they felt 'shy' and not happy or prepared to talk and some of them stated that "we do not know what to say and talk about". This might be due to the values and tradition inherited in Kurdish culture, in which the older female generation are quite reserved.

As mentioned earlier in the methodology and methods chapter, the current study did not include relative's views, due to the fact that the majority of cases entered the care homes because of family breakdown, and this had influenced their relationship with their relatives. As a result, the visits by their relatives was rarely seen. So whilst the

relationships between residents and relatives were maintained where they existed, these interactions did not always take place in the care home itself. This piece of research is unlikely to provide full exploration of the care homes, for instance, the relative's views.

9.4 Did the study meet its original aims and what does it add to understanding?

As was noted in the introductory chapters this was the first study of its kind ever to be undertaken in Kurdistan and one of very few yet completed in Kurdish/Arabic culture. As such it could be argued that whatever the outcome, providing that the study was basically sound, that the results would add to understanding. It will be recalled that in seeking a direction for the study, I was only able to draw upon insights derived, in large part, from the western literature on care homes. I was clear from the outset that the broad aims of the study would be to explore how life is experienced for residents and staff in care homes in Kurdistan and what influence the culture within the home had on this experience. I was equally clear that I did not wish to impose western concepts on the study but at the same time wanted to be aware of potentially fruitful directions to follow. Given the emergent state of care homes in Kurdistan and following discussion with my supervisors it was agreed that the most useful insights could be gained from early studies on care homes in western countries together with the extensive synthesis undertaken as part of the *MyHomeLife* project. This provided a number of very important methodological and conceptual insights, summarised below. From the early literature it was clear that:

- Important insights could be gained from using a qualitative approach informed by the principles of the 'new ethnography';

- It was important to understand the route by which older people enter a care home;
- There was need to consider the role played by the physical environment;
- It was essential to capture the perspectives of multiple actors and their interactions in order to understand the ‘culture’ of care operating within a given care home setting.

These points were reinforced and augmented by a number of key conceptual themes emerging from the *MyHomeLife* review. The authors concluded that these themes were central to an understanding of the nature of life in a care home. I did not include all the themes, as some, for example end of life care were not part of my study. Those themes that did inform the study were as follows:

- Transitions into a care home;
- Working to help residents maintain their identity;
- Creating community within care homes;
- Shared decision-making;
- Promoting a positive culture within care homes.

The last point above was considered especially important as virtually all of the literature had highlighted the central role played by the ‘culture’ operating within each home in shaping the way that residents and staff experienced life in that home. Culture, however, is a complex concept and is often left implicit rather than explicitly defined. Indeed, no universally agreed definition of culture could be located in the literature and therefore the characteristics of a ‘positive’ culture as presented by the *MyHomeLife* review was adopted in this study. The review concluded that a positive culture should:

- Be person and relationship centred;

- Foster a ‘complete’ community as defined by Davies (2001);
- Recognise the complex and multidimensional nature of life in a care home;
- Have interdependence as a core value (Dewar, 2007).

Whilst I was certain that I did not wish to slavishly follow or impose the above ideas on my study I nevertheless wanted to consider if, and in what ways, they were relevant in a Kurdish context. This desire resulted in the formation of more focussed aims for the study, which were to explore:

- The trajectory of older peoples’ admission into a care home.
- Life in the care home from the perspectives of older people and staff.
- How residents and staff relate to and interact with each another.
- How these interactions shape the culture of Kurdish care homes and how this culture influences the lives of those living and working there.

Here I want to explore the extent to which these aims have been met and relate the results not only to a Kurdish context and the literature that informed my initial aims but also to the relevant literature that has emerged since. I believe that it is only in this way that the relevance of my findings and their potential contribution to knowledge can be judged, not just in Kurdistan but also further afield. After completing data collection and analysis, I therefore undertook a focused review of the literature that had emerged between 2007 (after the *MyHomeLife* review was published) and 2015, that addressed the above issues. This literature is therefore included in the discussion that follows, which considers the broad aims of the study sequentially, as outlined above, starting with the nature of the transition into care.

9.5 The trajectory of older peoples' admission into a care home

All of the literature stressed that understanding why and how older people enter a care home is essential in the appreciation of their early, and often ongoing, adjustment and this was a major theme in the *MyHomeLife* review. My own results reinforced this and suggested that the extent to which older people played a part in the decision making process and could see the move into care as being of some benefit to themselves played a key role in whether they were likely to be an 'early engager' or 'remain distant' from the home. This was often linked to the nature of their lives prior to entry to the home and the factors influencing their admission to the home.

This finding is consistent with those from earlier literature. For example, Nolan et al. (1996), in charting admission to care homes over several studies, suggested that there was a typology of admission ranging from the 'positive choice' through the 'rationalised alternative' and the 'discredited option' to the *fait accompli*'. In the positive choice older people play a full and active part in the decision to enter care and have time to consider other possible alternatives. The 'rationalised alternative' exists where older people can find an acceptable reason to enter care even if this is not an ideal choice, for example their life might be better in the home than outside it, or they enter the home to relieve other people of the need to care for them. The 'discredited option' describes a situation where older people have been promised benefits to admission, for example, rehabilitation, which do not subsequently materialize. In the *fait accompli*' the older person plays no part in the decision, has no choice but to enter care and can see no benefit to themselves. Many of my participants experienced a positive choice and these were likely to be the 'early engagers'. Others could also provide a 'rationalised alternative', especially when the care home offered a better alternative than their prior life circumstances. However, for a number the conditions of a *fait accompli*' existed and these were likely to be people who were 'distant' from life in the home.

Other, more recent studies, have also highlighted the importance of older people being able to exercise some control over the admission and have stressed that those who have little or no control (often still in the majority) have greater problems with longer term adjustment (Lee et al., 2013). A number of authors have also indicated that if older people feel that they are involved in the decision to enter care and have time to talk about and prepare for it then they are better able to adjust (Shin, 2015; Tak, 2014; Marshall and Mackenzie, 2008). Clearly the nature of the admission remains a key component and this is a true in Kurdistan as it is in the west and elsewhere. **This has a number of implications that will be considered in greater detail later.**

However here it is suggested that extending the idea of creating an ‘enriched environment’ (Nolan et al., 2001) to the period before and during entry to care offers one way forward. As was highlighted in the literature chapter Nolan and colleagues (2004) suggested that an enriched environment was one in which all parties in care homes (residents, staff and relatives) experienced six ‘senses’ (Security, belonging, continuity, purpose, achievement and significance). This approach was adopted by *MyHomeLife* to underpin their overall approach to making care homes better places to live, work and visit. Later it will be argued that the senses can be illuminated by using the concepts ‘Freedom From’ and ‘Freedom To’. To date, however, when used in the context of a care home the senses have largely been applied to creating an enriched environment within the home itself. The continued emphasis on the importance of the transition into care, and the ongoing accounts of poor admission experiences for many highlights the need for greater attention to this area. I would argue that an enriched environment needs to be created before and during the transition to care. To achieve this, for example, older people should be ‘free from’ undue coercion to enter a care home and ‘free from’ the need to make rapid and poorly informed decisions. Rather they should be ‘free to’ think carefully about the benefits of entry, consider other

alternatives, consult widely and so on. **Some of the practical implications of this suggestion will be considered later.**

What is also striking from my results is the similarity in the reasons leading to admission to a care home between the early and current literature and my findings. Townsend's (1962) early and seminal study highlighted that many older people had no real choice about entry and that it was precipitated by various factors including loneliness, lack of close relatives, isolation and financial insecurity. Because of these adverse conditions many older people who entered care were frail and fearful. Townsend's conclusions are remarkably similar to my own and probably reflect the early genesis of 'residential' homes in the UK which were established to cater for older people primarily with 'social' problems. Of course in the west the care home population has changed dramatically in the last 50 years and is now far older and frailer, with health problems being the major reason for admission (Cook et al., 2015; Lee et al., 2013). However, the convergence between Townsend's work and mine reinforces the idea that many older people enter care in order to be 'free from' adverse life conditions.

Similarly, Townsend saw the primary benefits of entry to a home as being the provision of diet, warmth and escape from conflict in relationships, and other more recent work has highlighted the benefits of security, company and assistance with care that entry to a home provides (Nakrem et al., 2012; Boggatz et al., 2008). These again closely mirror my results, suggesting both considerable overlap between differing contexts and that care homes (at least when the quality of care is good) are successful in ensuring that older people are 'free from' major concerns. This of course should be considered a basic minimum requirement.

Townsend was far less positive about care homes in terms of their lack of privacy, the way in which they stripped older people of their identity and self-worth and their failure

to provide meaningful occupation. It is continued problems with these latter areas that prompted initiatives such as *MyHomeLife* and more recent work continues to highlight the importance of purposeful and meaningful activity (Timonen and O'Dywer, 2009; Cook et al., 2015; Adra et al., 2015) for older people and their ability to play a part in decision-making within the home (Ragsdale and McDougall, 2008; Hooyman and Kiyak, 2008; Cook et al., 2015; Shin, 2015).

These are factors that will be considered in more detail later but they reinforce the potential value of the concept of older people being 'free to' enjoy key aspects of their lives in understanding what life in a care home should be like. **As noted above the concepts of 'Freedom From' and 'Freedom To' will be linked to the 'senses framework' at a later point and it will be suggested that these notions have implications for the ways in which care homes consider their primary purpose and how they may shape an 'enriched environment' (Nolan et al., 2004).**

As this section has highlighted the nature of the transition into care remains of central importance in understanding older peoples' reaction to their lives there, irrespective of context. Attention is now turned to the second of the initial aims of the study, how life in the care home is seen from the perspectives of older people and staff.

9.6 Life in the care home from the perspectives of older people and staff

It is clear from the above that the transition into a care home has a potentially considerable effect on older peoples' early reactions to life in the home. In seeking to better understand life on a day to day basis the concepts of 'Freedom From' and 'Freedom To' were explored further and it was suggested that all residents in both homes benefitted from a wide range of 'Freedom From' including difficult family

circumstances, accommodation problems, financial insecurity and physical harm and threat. These benefits were recognised by all the participants, irrespective of whether they were 'Early Engagers' or tended to 'Remain Distant' from life in the home. Over and above this the data suggested that for some residents, again in both homes, but more so in Star, the homes provided opportunities for them to be 'free to' explore or develop aspects of their lives that were either new to them or that they had not been able to enjoy for some time. These included the 'Freedom To': make choices; be active and engaged, to contribute to life in the home and to express cultural beliefs.

The freedom to make choices varied from relatively simple things such as how to rearrange their personal space and to bring in personal belongings, to when to get up and go to sleep to more extensive choices such as whether to work or not, and if, and to what extent, to contribute to life in the home.

Whilst in part some of these freedoms were linked to the physical environment and were therefore easier to achieve in Moon, as it was purpose built, they were more heavily influenced by the culture of the home, something that will be discussed in more detail later. It was also argued that the extent to which residents were 'free to' engage in the above choices was influenced in no small measure by the 'Freedoms From' and freedoms to' that staff enjoyed and that this again was largely a function of the predominant culture in the home. However, residents' own personal preferences were also important. Some chose actively not to take part in the life of the home or not to enjoy the 'freedoms to' that were potentially available to them. This may have been a facet of their personality but was also influenced by their early reactions to the home. Residents who had been early engagers were more likely to go and 'embrace' life in the homes whereas as those that were distant from the start and remained so seemed to be isolated from life in the home. On this basis it was suggested that a typology of

residents could be identified comprising the ‘Embracers’ and the ‘Isolates’ as described above and an in between group termed the ‘Tolerators’ who ‘put up’ with life in the home and recognised the ‘Freedoms From’ that they enjoyed but saw the home as a temporary residence that they hoped to move out of when their circumstances allowed. **This typology is similar to the one suggested by Nolan (2008) as pertaining to older users of respite care and again has implications for practice. For example, how do staff ensure that residents engage with life in the home early and encourage them to embrace life there? These aspects will be considered later.**

The results also suggested that residents were more likely to be enabled to be ‘free to’ when staff were ‘free from’ too many rules and regulations and were ‘free to’ take an active part in decisions, encouraged and enabled to take the initiative and were actively praised for their efforts. This was more likely to happen in Star where a ‘relational culture’ was identified, as opposed to Moon where an ‘organisational culture’ seemed dominant. The potential influence of these cultures will be considered in more detail later.

The convergence of the ‘Freedoms From’ residents enjoyed with the early and recent literature has already been considered. But there are also considerable overlaps with respect to the ‘freedoms to’.

As already noted Townsend (1962) lamented the limited privacy, removal of identity and lack of meaningful occupation that existed in care homes in the UK in the late 1950’s. As the early literature from western countries, especially the UK and US, went on to demonstrate such factors contributed to the largely negative image of ‘institutional life’ that emerged, and which to some extent still predominates. It was the desire to provide an alternative, more positive, vision of care homes that led to the *MyHomeLife* project.

The *MyHomeLife* review identified the importance of meaningful activity and of residents being able to maintain or create a sense of identity and several other more recent studies have reaffirmed this. For example, the central role of meaningful activity has been highlighted repeatedly (Timonen and O’Dywer, 2009; Cook et al., 2015; Adra et al., 2015), with Cook et al. (2015) in particular arguing that a failure to provide meaningful activity negatively affects the lives of older people and that “*just doing something, anything to fill the day*” (p.1604) is beneficial. Of course in terms of maintaining their identity it is far better if the activity they engage in is meaningful, and this is more likely if the activity has some continuity with a resident’s prior life and biography (Cooney, 2012; Nakrem et al., 2012; Adra et al., 2015). It is worthy to note that the recently published study by Adra et al. (2015) is one of the first to consider living in a care home from an Arabic context (Lebanon) and that their conclusions not only mirror many of my own, but also have close parallels with a number of concepts in the western literature, just as mine does.

With respect to the notion of continuity my own results highlight the importance of this, with a number of residents not only continuing to work but also linking many of their contributions to life in the home to their past lives and interests, such as gardening or technology. **The notions of activity and continuity again have implications, not only for care homes in Kurdistan, but more widely, that will consider later.**

As already noted other ‘freedoms from’ that residents enjoyed were concerned with their ability to exercise personal choice and to contribute to decision making about the wider life of the home. The former freedoms were available to residents in both homes but the latter were only really available to those residents in Star. Once again the wider literature would support the importance of these dimensions. The notion of shared decision-making was a major theme in the *MyHomeLife* review and the value of

residents exercising control and having freedom to make decisions has been reiterated several times (Cook, 2008; Ragsdale and McDougall, 2008; Hooyman and Kiyak, 2008; Shin, 2015). This is an aspect that will be explored further when greater attention is turned to the culture operating in the home.

Again there is considerable convergence between the ideas emerging from the literature and my own results with regard to the day to day life of residents and, as will be considered further below, how this relates to staff practices. As well as being probably the first study to explore such issues in Kurdish culture my study has added the concepts of 'Freedom From' and freedom to' as a means of better capturing how the complex interaction of factors operating in a care home shape life there. One of these complex factors was explored in my third initial aim: How residents and staff relate to and interact with each another.

9.7 How residents and staff relate to and interact with each another?

One of the founding principles of the 'new ethnography', described in the literature review and methods, and adopted for this study, was the belief that it is essential to understand the complex and multifaceted factors that shape life in a care home and that it is primarily interpersonal interactions that determine many dimensions of the 'culture' that exists. Since then notions of person centred and relationship centred care have emerged and have been widely adopted (see Bradshaw et al., 2012 for a review). *MyHomeLife* for example has one of its central pillars of a positive culture the belief that it should be 'person and relationship centred'. Several recent authors have built upon this notion (Brown-Wilson, 2009; Nakrem et al., 2012, Bradshaw et al., 2012), with the recent study in Lebanon reaffirming the vital role played by the relationships between residents and staff in determining quality of life in the home (Adra et al., 2015). Therefore, whilst the relationships between residents themselves are important,

as are their continued relationships with family, friends and the wider community outside the home (Cooney, 2012; Wiersma and Dupuis, 2010) it is the interactions between staff and residents and amongst staff themselves that seem pivotal, especially the former. *MyHomelife* stresses the need for these relationships to be reciprocal and underpinned by equality and interdependence. These are typical of the relationships that exist within a 'complete' care home community, as described by Davies (2001). In building on this work Brown-Wilson (2009) identified three broad types of relationships between staff and residents in care homes, these being:

- Pragmatic: These are cordial but based primarily of the need to get the 'work' done.
- Personal and responsive: These still have an element of task focus but are more tailored to the individual needs and wants of residents and these are addressed to the extent that they can be without compromising the needs of the home as a whole.
- Reciprocal: These are characterised by 'give and take' and mutual recognition by staff and residents of each other's' needs. To achieve this requires a degree of 'negotiation and compromise' between staff and residents (and, in Brown-Wilsons' study, relatives).

In my study there were differences in the nature of relationships between varying individuals and groups. Those individuals in both homes who were isolates, as the name suggests, had limited interactions with anyone. Others, often Tolerators, had close relationships with a few chosen individuals, sometimes a single member of staff. Conversely, the embracers tended to engage more fully with all aspects of life in the home, including building relationships. These residents were often warm and cordial with both residents and staff.

Staff in both homes were noted to have close relationships with residents, but in Moon this was likely to be limited to some residents, with some suggestion of favouritism. The extent to which reciprocal relationships were apparent again varied but these were much more evident in Star. Whilst such relationships did develop between some staff and some residents in Moon they were usually confined to one to one interactions and did not feature as a part of the wider life of the home. Conversely those Star residents who wished to were actively encouraged to develop reciprocal relationships with all staff. The reasons for this will be explored below when the cultures that existed in the homes are explored.

Again variations in staff relationships were apparent with there being a close 'clique' of staff favoured by the manager in Moon, with few examples of teamwork. The reverse was true in Star where far more inclusive and equal relationships were identified, and there was far greater teamwork. This again could be understood using the concepts of 'Freedom From' and 'Freedom To', which helped to shape the culture in operation in the homes. This was the subject of the fourth aim of the study and it is to here that attention is now turned.

9.8 How do interactions within the home shape the culture and how this culture influences the lives of those living and working there?

Ever since the early critiques of care homes began to emerge from the 1960's onwards the idea that the 'culture' of the home exerts considerable influence has grown and has now become widely accepted. Although culture and the attitudes of society as a whole towards older people and long term care provision are important in shaping societal responses, it is the way that things are played out on a daily basis in homes themselves that has the most impact on residents and staff.

Certainly creating a positive culture, both in terms of according greater societal value to the role that care homes play but especially to those living, working and visiting there, was central to the *MyHomeLife* vision. My work would suggest the application of the concepts of 'Freedom From' and 'Freedom To' can go some way in helping this to be achieved.

My analysis identified two cultures in the care homes studied, a 'relational culture' and an 'organisational culture' and although neither home could be said to be entirely relational or entirely organisational, nevertheless Star was far more markedly relational and Moon organisational. The main characteristics of these cultures were summarised in Table 8.1, which highlight the differing values, goals and other features of the respective regimes. In essence the relational culture placed great emphasis on involvement in decision making and the genuine engagement of both residents and staff in shaping the life of the home. In contrast in Moon decision making was largely confined to a relatively small and select group close to the manager, with the overall aim being to project a positive external image for the home and to ensure that its organisational aims and objects were met. In large part these cultures were a product of the leadership style of the manager and again can be understood with respect to the 'freedoms from' and 'freedoms to' that he/she facilitated for both residents and staff, but especially the latter group.

Staff in the Star home were largely free from rules and regulations, and had far more freedom to take part in decision making, act on their initiative and introduce change. They were also encouraged to develop and given recognition for their efforts. Whilst a few staff members close to the manager had such 'freedoms' in Moon the majority did not and a largely top down structure existed. The 'freedoms to' enjoyed by staff in Star were also expressly available to residents, and whilst residents in Moon did have a

range of ‘freedoms’ these did not really extend to playing a full role in the wider decision making processes. The importance of this latter aspect of participation in decision making and of older people being able to exercise a degree of control has been highlighted a number of times in recent studies (Cook, 2008, Ragsdale and McDougall, 2008; Hooyman and Kiyak, 2008; Nakrem et al., 2012, Shin, 2015) and many of these studies re-affirm the importance of the culture within a home.

As has already been noted no widely agreed definition of culture could be found in the literature and therefore the features of a ‘positive culture’ as identified by the *MyHomeLife* review were adopted for this study. These indicate that a positive culture should:

- Be person and relationship centred
- Foster a ‘complete’ community as defined by Davies (2001)
- Recognise the complex and multidimensional nature of life in a care home
- Have interdependence as a core value.

As will readily be seen the ‘relational’ culture described in Star meets these criteria and on this basis can be said to be ‘positive’. This description would certainly accord with the views expressed by participants and my observations at Star. At this point it is important to point out that there were many ‘positive’ aspects to life at Moon, and indeed compared with many accounts that still appear in the literature Moon was providing what could be considered good care in many respects. However, it did not match up to Star as being a complete community that was primarily relationship centred.

This begs the question as to whether the above criteria, derived from a Western context, have any relevance to Kurdish/Arabic setting. I have repeatedly pointed out that whilst I did not want to impose Western concepts on my study I nevertheless wanted to see

whether or not they might also be useful in understanding care home life a quite different culture. On the basis of the above I would say that they can be of great value, and the same conclusion was reached in Lebanon by Adra et al. (2015). These researchers wanted to explore the concept of quality of life in two care homes in Lebanon from the perspectives of residents, staff and relatives but were concerned that the definition of quality of life that existed were exclusively Western. Whilst my focus was not quality of life per se I was in the exact same position. They, as did I, drew on some of the Western literature and, also like me, concluded that older people, staff and relatives in Lebanon want more or less exactly the same things as the same groups in a Western context, but that there was a greater emphasis on the importance of spiritual beliefs. This was also one of the important 'freedoms to' that emerged from my study.

So it seems, despite very different contexts and macro cultures, the day to day life in care homes are influenced by very similar factors. Certainly one thing that was strongly reinforced by my study was the complex and multidimensional, but largely relational, array of factors that need to be taken into account if the experiences of people living and working in care homes are to be improved. Grasping and simplifying this complexity so that it is more readily understood by those who live and work in care homes, without at the same time losing its subtle dimensions is a major challenge.

This may help to explain why something like the 'Senses Framework' seems to have had some success in projects like *MyHomeLife*. Would it also apply to a different context? In addition to being one of the few studies to explore what it is like to live and work in a care home in a Kurdish culture I hope that the concepts of 'Freedom From' and 'Freedom To' have the potential to inform debate and practice in other contexts and settings. One way that they might do so is by linking these ideas the 'Senses Framework'. How this could potentially be achieved is considered next.

9.9 Working towards an Enriched Environment of Care: The case of care homes in Kurdistan

A brief introduction to the Senses Framework, its development core ideas and relationship to the notion of an ‘enriched environment’ is outlined on page 34 of this thesis. The thesis has alluded on several occasions to my reluctance to impose Western ideas on my study, particularly those being drawn from the care home literature. The use of early western seminal literature and the *MyHomeLife* report have so far featured as a means of providing fruitful direction in the early stages and as a source to help further illuminate my findings. The Senses Framework is important in the central place it occupied within the *MyHomeLife* review and as such its presence is a consistent strand to my work. I am aware also of the relationship that my supervisors have to the Senses Framework and have always been sensitive to the risk that it might have an overbearing influence on my own thinking, particularly my analysis. I am confident that this has not been the case. Further consideration of my findings, which occurred during the preparation of my thesis, has led, however, to its explicit inclusion here. This inclusion is not, however, limited to a further source of illumination, but rather I am confident that my findings can assist in further developing of the Senses Framework itself. The Senses Framework has always been viewed as an intuitive tool, which is on one level a simple heuristic device with the potential for usage across the care home sector. In this sense the similarities with my own ‘Freedom From’ and ‘Freedom To’ findings are apparent, it too is conceptually complex but has the potential to communicate such ideas in a simple way. This is something that I will return to later.

What is perhaps more important at this stage are the conceptual linkages between my own work and the Senses Framework and in discussions with supervisors I began to see how these might be used to augment or further add to it. I will address the linkages

between 'Freedom From' and 'Freedom To' below, but first briefly wish to explore these ideas in relation to 'relational' and 'organisational' cultures.

9.10 Relational and Organisational Culture and the Senses Framework

It has been stated already in this thesis that I am in no way claiming that the two homes in this study could be located exclusively within a relational or organisational culture, it is more the case that the Star care setting could be more closely aligned with the former whilst Moon with the latter. The summary table provided on page 195 identifies a number of cultural characteristics identifiable for each of the care home cultures outlined in Chapter eight. These characteristics can be related closely to the Senses Framework. The goals of 'relational' care home culture emphasize autonomy and satisfaction for both staff and residents, contrasting those of the 'organisational' culture which stress an external image with a priority given to the smooth running of the home. Both sets of goal characteristics are manifestly associated with a sense of significance in how they facilitate or restrict the extent to which staff and residents 'matter'. Other characteristics identified within the 'relational' culture that I was able to identify exhibit aspects of a sense of achievement and a sense of purpose in that there is an enhanced consideration of both staff and residents being actively engaged. Contrast this with 'organisational' culture which displays a propensity to distance residents from activity which is meaningful and closely related to the running of the home. Furthermore, the nature of relationships (between residents, between staff and between residents and staff) is closely aligned to a sense of belonging in that 'relational' culture emphasizes mutuality, cooperation and inclusivity, whilst 'organisational' care home culture is reflective of hierarchical structures, poor teamwork and social distance.

9.11 ‘Freedom From’ and ‘Freedom To’ and the Senses Framework

As noted above the purpose of drawing attention to the introduction of the Senses Framework into this chapter is to both recognize the manifest connections between these findings and also to explore the contribution that they can make to the further development of it as a model. First, it is often noted that the Senses Framework can be understood via nuanced approach in that the fundamentals of care (for example being pain free or feeling part of a valued group) are reflected by a sense of security and belonging and provide the very platform or ‘building blocks’ upon which other aspects of care are constructed. These important ‘building blocks’ help older people and staff to establish the core characteristics of an enriched environment upon which other aspects of care and care work can flourish via a sense of continuity, purpose, achievement and significance. This notion of moving from the fundamentals of care towards achieving an enriched environment is also present within my own ‘Freedom From’ and ‘Freedom To’. The core or fundamental aspects of the provision of care, and indeed the employment and management of care staff, are to be detected within ‘Freedom From’. Residents in particular articulated care home life as providing a sanctuary from the hazards of former lives, but my findings also suggest that ‘Freedom From’ censure and being part of an inclusive team as important characteristics and essential features of care home work. As is the case with The Senses Framework the ‘building blocks’ that exist as a result of experiencing ‘Freedom From’ may also evolve or develop towards other more aspirational ‘Freedom To’.

By seeking to provide services which promote ‘Freedom From’ and ‘Freedom To’, the care homes in this study were, to varying degrees, were able to create conditions akin to an enriched environment. By making the links between my findings and those elements of an enriched environment apparent here I am able to both point to direct comparisons, but also identify the means to achieve the circumstances within which the ‘senses’ are

created. In the case of ‘Freedom From’ residents in particular were able to articulate the absence of uncertainty, financial worry as well as physical harm or threat, all of which are a means of achieving a sense of security. Providing older residents with the opportunity to experience ‘Freedom From’ loneliness or isolation can be viewed as establishing the means to create a sense of belonging. Furthermore, if we suppose that being able to achieve an enriched environment we will need to plant the seed for this, in order for these seeds to be grown it needs a right soil or environment (i.e., culture). The notion of using my findings as a means to achieve other elements of the Senses Framework via ‘Freedom To’ can also be observed. By enabling residents, the freedom to express one’s cultural identity, care homes create the conditions for a sense of continuity. Further to this the residents’ sense of continuity was achieved since they were able to preserve their links and connection of past with present and future. The present findings indicate that personalising one’s own place preserves personal continuity. The residents brought in personal possession into their room or bed and this was highly valued by them. Additionally, by allowing the freedom to be active and engaged, care homes will go some way to achieving both a sense of purpose and a sense of achievement. Furthermore, by establishing and underpinning services which seek to promote the freedom to make choices, the conditions for a sense of significance are also met.

Table 9.1 Framework: Freedom From and Freedom To

Senses Framework	Freedom From	Freedom To
Security	→	✓
Belonging	→	✓
Continuity	X	✓
Purpose	X	→
Achievement	X	→
Significance	X	→

Although the Senses Framework developed in the UK in long-term care environments and uses Western notions of care home life, it can be applied to experiences of Kurdish residents and staff who are living and working in care home settings. It has been noted above that the Senses Framework resonate with the observations that I have made through the 'Freedom From' and 'Freedom To' framework since the elements of Sense Framework are important to older people in Kurdish care homes and staff working there as they are in the West.

The application of the Senses Framework to my own data and the potential that my findings ('Freedom From' and 'Freedom To') can potentially assist in the achievement of an 'enriched environment' is worthy of note. Furthermore, at several points within the discussion it has been noted that, despite my initial concerns, Western notions of care home life were useful to me in being able to understand the experiences and culture of care homes in Kurdistan. It has also been noted that this is the case for a recent study conducted in the Lebanon (Adra et al., 2015). Whilst this is interesting in itself, I think that it is appropriate to suggest that the same may be true for my own findings as they might be applied to care homes in the UK and elsewhere. It was noted above that the Senses Framework itself has heuristic qualities in that it provides an opportunity for those engaged in the provision of care to ask questions of the environment in which care is being received. The same might be said of my own 'Freedom From' and 'Freedom To' findings. These too may also be used to explore and investigate the degree to which residents might be assisted in experiencing particular aspects of care, akin to an enriched environment. The fact that 'Freedom From' and 'Freedom To' is also a simple 'device' also has appeal in being adopted more widely. This, of course, is something that may be further explored in future research studies.

9.12 Implications of the study

A number of implications can be identified through the work that I have undertaken. It has already been noted that this is the first study of this kind to be carried out in the Kurdistan region and one of the very few to have been undertaken in an Eastern context. I do, however, see that the implications are important both to these geographical areas as well as elsewhere.

First, it has been noted here that seminal work in the field of care home research can be used to understand Kurdish care homes as they currently exist. It was noted earlier in this chapter that in many ways the reasons for entry into care homes in contemporary Kurdistan mirror those identified by early care home research in the West, as such these early seminal works continue to be important. Whilst I did not wish to impose Western notions of care upon the study itself I did, at the outset, use such ideas as fruitful directions on which to base my data collection. It is notable, however, that such notions are important comparators for my work and have been used here as a means for further understanding the findings of this study. Markedly the key themes from the *MyHomeLife* report resonate with the observations that I have made and as such are in many ways as important to older Kurdish care home residents as they are in the West. Furthermore, the Senses Framework is noted here as a means for further understanding my work. Again the key implication being that those features of care home life considered to be important in the West may also be important in Kurdish/Arabic settings and although these may differ in exact nature, the overarching policy aims should remain constant.

Second, the data relating to care home admission suggests that the process of decision making, as to the timing and place of care, shape the way in which older residents make the transition. This is not a new phenomenon in the Western literature, but is an

important consideration for Kurdish policy-makers. Much has been written here about the ‘enriched environment’ of care and typically this has been used to describe the care home as demarcated by a physical care home. The implications of my study suggest that this ‘enriched environment’ should extend beyond the walls of care and include the decisions making process as it relates to admission itself. By this I mean that older residents should experience ‘Freedom From’ pressure to move and ‘Freedom To’ make positive choices in the care home that they enter.

Third, I identified a number of older residents who valued the new care homes where they now lived, indeed regarding them quite rightly as ‘home’. There were others, however, who remained isolated from fellow residents and staff. I have suggested that a relational culture, as opposed to an organisational culture, provided the conditions whereby such isolation may well be addressed. This was not always the case, however. The implication here is that there is a lot to be done in understanding how to work creatively and effectively with such residents in order that they themselves feel comfortable in the new environments in which they find themselves.

Fourth, continuity has for a long time now been recognised as an important component of care home provision as it allows older people to build their present day experiences upon the biographical past. Continuity for the older people in this study was again highlighted as an important aspect of care and many examples were in evidence. The examples identified here are indicators of genuine attempts to contribute to the life of the home (for example gardening). Care home providers should maintain these opportunities and indeed seek to continue to explore the prospects to extend these. Kurdish care home policy-makers may find themselves at an important cross-roads and should be dissuaded from developing policies which deny the opportunity to continue to

contribute, especially if this allows for the continuation of care home residents passions, interests and favoured activities.

Building on this is an overarching implication in the ways in which care home culture evolves, specifically in relation to leadership styles and approaches. It is demonstrated here that a relational culture is evocative of an environment which allows for innovation, is centred on resident satisfaction, has collaboration, mutuality and equality as central goals. According to my data this culture, however, relies upon a particular leadership approach. Such an approach is more akin to a facilitative leadership approach, stressing a less hierarchical structure where shared decision making and an open style are viewed as important.

Finally, it has been demonstrated here that the key findings around the notions of 'Freedom From' and 'Freedom To' are useful 'tools' in helping us to develop an enriched environment. This has already been noted above in relation to the transition process, but is also an important implication for care home culture and developments to nurture an enriched environment of care. For the most part care homes should be meeting the very fundamental aspects of care included within a 'Freedom From' approach. An implication here is that by focusing on a 'Freedom To' approach care homes will go some way to meeting the kinds of aspirations which resonate with a truly enriched environment. Further to this 'Freedom From' and 'Freedom To' may also have the potential to become a useful heuristic device which can be used to help innovate and evaluate care home practices, not just in the Kurdish region but also elsewhere.

9.13 Recommendations

The study has recommended the following recommendations, these are organised around those aimed at practice, policy and research:

Practice

1. Health & social care practitioners should use assessment practices which seek to support older people to make their own decisions about the timing and placement into care. As such older people should be well informed about the move to care homes; make better informed choices and should be active decision makers prior to their admissions. Trial visits should be encouraged and older people should have the 'Freedom From' making quick decisions and the 'Freedom To' choose their own destiny.
2. Leadership and management practices should focus upon nurturing an enriched environment in Kurdish care homes through paying particular attention to residents' and staff views and experiences in order to facilitate cooperation and mutual engagement. These 'relational' practices should be used to foster cultures of care which enhance team-working and inclusivity.
3. Assessment practices should focus very much on ensuring that care home residents are integrated into the life of the care home. Where problems arise managers and staff of care homes need to devise a way to work creatively and effectively to enable residents (isolates) to engage and participate in the home life.

Policy

1. Kurdish policy-makers should consider the ways in which Western care homes have developed and seek to avoid those policies which have led to organisational cultures that are task-oriented as opposed to relationally

orientated. The notions of 'Freedom From' and 'Freedom To' should be used as the basis for further establishing care homes across Kurdistan. Kurdish care home policy-maker should adopt a mechanism that reinforces the importance of the person and relationship-centred care.

2. Finance should continue to be allocated to care homes' directly in order to provide residents with opportunities that improve their care home experience and that they continue to have 'Freedom From' anxieties and concerns about money. The care homes should be well equipped with a sufficient number of staff, in particular, social workers.
3. Residents should be encouraging to pursue their life in the care homes through reinforcing the 'Freedom To' framework. Staff members should also be given the opportunities to experience more 'Freedom To' to do their job.

Research

1. The 'Freedom From' and 'Freedom To' findings of this research should now be used as the basis for a set of indicators used to measure the extent to which care homes can be said to be 'enriched environments'. The first task will be to develop a measure or profile for Kurdish care homes and seek to test face, content and criterion validity with further psychometric and field testing to follow.
2. Whilst it was not possible here to explore relative's views of care home life, further research should now look to do this in Kurdistan. This research might seek to use the 'Freedom From' and 'Freedom To' model as a potential starting point.
3. Further research with looking to explore the nature and experience of those care home residents who continue to demonstrate isolation from their peers and staff

needs to be undertaken. This will allow further elaboration of the factors which contribute to isolation and how this might be overcome.

9.14 Summary and conclusion

This study is the first of its kind in that it has sought to explore the cultural characteristics of two care homes for older people in Kurdistan. This final chapter has sought to set a number of important aspects of my study. First, it has sought to evaluate the quality of the work by using a quality criteria framework and outlined the strategies used to ensure that the work has merit. Second, it has drawn attention to the key findings of my study, principally those which relate to transitions made by older residents entering the care home system, the ways in which both residents and staff were able to experience 'Freedom From' and 'Freedom To' a number of positive or negative aspects of care and finally the nature of care home culture. In addition, the discussion chapter has set out to compare my findings with the most important care home literature. Furthermore, it has made very clear links with the Senses Framework with identification of the potential for the findings of this study to act as a means for achieving an 'enriched environment' of care. Finally, this thesis has concluded several implications and recommendations for policy, practice and research.

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Appendices

Appendix A: Interview Guide

Demographic questions:

- What is your age? What is your nationality? Education level?

RESIDENTS

1. Can you tell me why did you come into care home?
2. Can you describe what 'care home' means to you?
3. Can you tell me your experiences in this care home?
4. How satisfied/dissatisfied have you been with your life and provided services in this place?
5. Do you want to make or want to engage in making some decisions for yourself and your life in this home?
6. What kind of care do you need and how is it provided in this care home?
7. How is your relationship with other residents? Satisfied/dissatisfied.
8. How is your relationship with the staff who work here?
9. Is there anything else you would like to talk about it?

STAFF

1. How long have you worked here and how long have you worked with older people in care?
2. Can you describe your experiences within this care home?
3. What type of care and how have you provided care to the residents?
4. How well do you know the residents and the type of care they need in this home?
5. How satisfied/dissatisfied are you with your relationships with the residents?
6. Can you tell me your experiences of any decisions you have made with residents?
And have you been involved in any decision making?
7. Are there any policies within the home to guide the care you provide to older people?
8. Is there anything else you would like to talk about it?

Appendix B: Ethical Approval

Ethical Approval: The University of Sheffield



Karwan M-Amen
Flat 9
Shore Court
Shore Lane
Sheffield
S10 3BW

Dean of School
Professor Anne M Peat
School of Nursing and Midwifery
Barber House Annexe
3a Clarkhouse Road
Sheffield
S10 2LA
Telephone: +44 (0) 114 222 2055
Email: j.l.gray@sheffield.ac.uk

6th March 2014

Dear Karwan

Re: ERP 134: Exploring the lived care experiences of the older persons in Erbil Elderly Care Home, Kurdistan Region, Iraq.

The panel has approved the ethics application with the following suggested, optional amendments (i.e. it is left to the discretion of the applicant whether or not to accept the amendments and, if accepted, the ethics reviewers do not need to see the amendments):

That consideration is given to the inclusion of an additional strategy for contacting the primary supervisor in the section "What if something goes wrong" of the participant information sheet. It is not inconceivable that some older residents might find it difficult or intimidating to contact the supervisor from their Iraqi care home. An alternative might be for a resident or member of staff to contact the care home manager who could then communicate concern to the supervisor

Also, that thought is given to the potential for clients with a diagnosis of dementia to be living in the care homes where the observations will be carried out. If this is a possibility, the researcher should discuss with his supervisory team how he will address capacity to consent with regard to the observations.

That the researcher thinks through what he will do if a person in the care home refuses to be observed. How will this work in practice when, as an ethnographer they will be immersing themselves in the care home setting? What happens if they observe something happening between two participants or a group of participants where one person has not given consent – can this still be used as data?

Yours sincerely
Jennifer Gray
Ethics Administrator
cc Dr. AW Ryan – Supervisor
Prof. M. Nolan - Supervisor

Ethical Approval: Hawler Medical University



Ethics application

Number...20
Date...16 / 1 / 2014

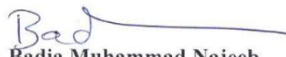
Researcher name : **Karwan M. M. Amen**

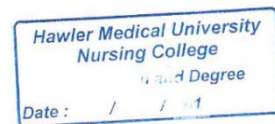
Researcher affiliation: PhD Nursing Science


I am writing regarding the application for ethical approval for research titled **(Exploring life in Iraqi Kurdistan care homes: A focused ethnographic study)**.

This project has been reviewed by the Ethical committee of research in college of nursing/Hawler Medical University regarding confidentiality and anonymity of participants.

I am pleased to inform you that the ethical approval has been granted by chair's Action for your applicant.


Dr. Badia Muhammad Najeeb
Deputy Chair
College of Nursing
Research Ethics Committee



<p>حكومة إقليم كردستان - العراق رئاسة مجلس الوزراء وزارة التعليم العالي و البحث العلمي جامعة هلال الطبية كلية التمريض شؤون العلمية و الدراسات العليا</p>	 <p>ههولێری پزیشکی HAWLER MEDICAL UNIVERSITY کۆلیژی پەرسااری Iraqi Kurdistan Region Council of Ministers Ministry of Higher Education and Scientific Research Hawler Medical University College of Nursing</p>	<p>حکومەتی هەرێمی کوردستانی عێراق سەرۆکایەتی ئەنجومەنی وەزیران وەزارەتی خوێندنی بالا و توێژینەوهی زانستی زانکۆی ههولێری پزیشکی کۆلیژی پەرسااری کاروباری زانستی و خوێندنی بالا</p>
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پۆستکۆد: ٨ / ١٠٤٢٠٢
پۆستکۆد: ١ / ٢٧١٢٢٧

ژماره: ١٥٠ / ٢٠٢٤

بۆ / زانکۆی ههولێری پزیشکی / نووسینگەی یاریبەدەری سه‌رۆکی زانکۆ بۆ کاروباری زانستی و خوێندنی بالا
ب / ئاسانکاری

ههولێری پزیشکی
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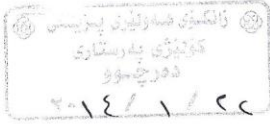
سڵاو و ریز / / / /

داوا له به پزیزتان دهکەین زه زامه ندى بفره مومون نه سه ره ئاراسته کردنی ئوسر او تک بۆ به رێوه به رایه تی جاود پزیری کۆمه لایه تی / (کاروان محمد محمد امین) که قوتابی دکتورایه له زانکۆی شیفیلد / وولانتی به ریتانیا به مه به سستی کۆکردنه وهی زانیاری ده رباره ی توێژینه وه که ی له ژیرناوینشانی :

Exploring life in Iraq Kurdistan care homes: A focused ethnographic study .

ئه گه ل ریزماندا

م. د. فیان عه مان توشبندی
پاگر به وه کاله تی
٢٠١٤ / ١ / ٢٢



وێنه یه ک بۆ / / / /

- نووسینگه ی به ریز واگری کۆلیژ / بۆ زانین، ئه گه ل ریزدا
- کاروباری زانستی و خوێندنی بالا
- ده رچوو

کاروباری زانستی و خوێندنی بالا
پاگر به وه کاله تی
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Appendix C: Participant information sheet

Participant Information Sheet (Resident)

Research Project Title: Exploring life in Iraqi Kurdistan care homes: A focused ethnographic study.

Invitation paragraph

You are being invited to take part in a research project. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read (or I can read it out to you) the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What is the project's purpose?

One of the biggest challenges facing the world over the next century is the global ageing population. With the shifting demography towards an ageing population, care homes will continue to be a necessary service provided to individuals for the foreseeable future. In the Iraqi Kurdistan, although the percentage of older people to total population is low compared to developed countries, the absolute size of the aged population is considerable and still there are only two care homes across the whole region. Little is known about older people and care for this specific age group with its relation to different lifestyles for old age persons in care homes.

The study aims are:

- To explore the life from the perspectives of older people and staff in care homes.
- To explore how residents and staff relate to each another.
- To explore what type of community exists in Kurdish care homes.
- To explore how decisions are made in Kurdish care homes.
- To explore what sort of culture exists in Kurdish care homes

Why have I been chosen?

You have been chosen because you are one of the residents living in Iraqi Kurdistan care homes. Other care home residents will be recruited.

Do I have to take part?

It is entirely up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and you will be asked to sign a consent form then. If you decide to withdraw, you are free to do so at any time without giving a reason and your rights and any services you receive will not be affected in any way.

What will happen to me if I take part?

There are a number of different ways in which you can take part in the study. If you decide to participate you will be observed in the communal areas (dining and living rooms), or you will be interviewed, or you can agree to be observed and interviewed.

Observing will involve the researcher spending time in public areas of the care home. Whilst spending time in these areas I will be making observations of what is happening and will make some written notes. Sometimes I will join in the activities of the home. You have the right to ask me to stop making observations at any given time.

For interviewing, you will be asked to answer some questions within semi-structured in-depth interviews with me. It is expected that the interview will last approximately 45 minutes. After your permission, the interview will be audio-recorded in order to facilitate the typing up and analysing process in a later time.

What will happen if potential participants refuse to allow the researcher to observe them?

I have to respect the decision and therefore I will not be able to observe you. However, you can still give permission to be interviewed if you are interested in taking part in the study. You have the right to refuse to answer any questions or withdraw at any time without giving any reason. Also, I will assure you that participating in the study is completely voluntary, and withdrawal from the study will not influence the care provided by the homes.

In case if you feel tired during the interview, you can stop the interview and decide when to start the interview again.

What are the possible disadvantages and risks of taking part?

This study will take your time for a while and this will be appreciated. If there are any questions which make you uncomfortable, you can decide to not respond to these questions and terminate the interview any time you feel uncomfortable without having to give a reason. This will not affect your rights and any services you receive in the homes.

What are the possible benefits of taking part?

Whilst there might be no immediate benefits to you, it is hoped that this work will help us obtain a better understanding of how communities and cultures formed in Kurdish care homes and what are the views of older care home residents in Kurdistan about their lives in care. This information will be used in a constructive manner and aid in improving the provision of care for residents in Iraqi Kurdistan care homes.

What if something goes wrong?

If you have any complaints in the first instance regarding your treatment by me, please contact the primary supervisor Dr. Tony Ryan, School of Nursing and Midwifery, The University of

Sheffield/UK. The contact details are provided at the end of this sheet. Alternatively, you can contact the care home manager who could then communicate concern to the supervisor.

Will my taking part in this project be kept confidential?

All the information that you provide us during the research will be kept strictly confidential. You will not be able to be identified in any reports or publications.

The following strategies will be taken to ensure the privacy of personal data, audiotapes and transcripts:

- All your data will be secured in password protected computers as confidential and will be kept in a locked cabinet.
- Also all observations, interviews, audio-recordings, and field-notes will be anonymised and no participants original names will be written on the reports arising from the study.
- Fictitious names will be used during the analysis and present of the study findings.
- The only people who will have the ability to access to the data are the researcher and his supervisors.
- After the completion of the study, all audio recordings will be destroyed at the end of the analysis of the data. All transcriptions and observational notes will be stored in archive storage at the University of Sheffield.

What will happen to the results of the research project?

The result of the study is likely to be published following the study completion of the study in the local journal and magazines in Kurdish language. In addition, the result of the study is also likely to be published in academic journals or/and conference presentations.

Who is organising and funding the research?

This study will be organised by the primary researcher (Karwan M. M-amen) and Dr. Tony Ryan and Professor Mike Nolan are his supervisors. This study is sponsored by Kurdistan Regional Government.

Who has ethically reviewed the project?

This study has been ethically reviewed and approved by both the University of Sheffield's Research Ethics Committee and College of Nursing Ethics Committee/Hawler Medical University.

Contact for further information

In case if you wish to obtain further information about the study, you can contact the following addresses:

- The researcher: Karwan M. M-amen, College of Nursing, Hawler Medical University, Erbil/Iraq.

Participant Information Sheet (Staff)

Research Project Title: Exploring life in Iraqi Kurdistan care homes: A focused ethnographic study.

Invitation paragraph

You are being invited to take part in a research project. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read (or I can read it out to you) the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What is the project's purpose?

One of the biggest challenges facing the world over the next century is the global ageing population. With the shifting demography towards an ageing population, care homes will continue to be a necessary service provided to individuals for the foreseeable future. In the Iraqi Kurdistan, although the percentage of older people to total population is low compared to developed countries, the absolute size of the aged population is considerable and still there are only two care homes across the whole region. Little is known about older people and care for this specific age group with its relation to different lifestyles for old age persons in care homes.

The study aims are:

- To explore the life from the perspectives of older people and staff in care homes.
- To explore how residents and staff relate to each another.
- To explore what type of community exists in Kurdish care homes.
- To explore how decisions are made in Kurdish care homes.
- To explore what sort of culture exists in Kurdish care homes

Why have I been chosen?

You have been chosen because you are one of the staff working in Iraqi Kurdistan care homes. Other care home staff will also be recruited.

Do I have to take part?

It is entirely up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and you will be asked to sign a consent form then. If you decide to withdraw, you are free to do so at any time without giving a reason and your rights and any services you receive will not be affected in any way.

What will happen to me if I take part?

There are a number of different ways in which you can take part in the study. If you decide to participate you will be observed in the communal areas, or you will be interviewed, or you can agree to be observed and interviewed.

Observing will involve the researcher spending time in public areas of the care home. Whilst spending time in these areas I will be making observations of what is happening and will make some written notes. Sometimes I will join in the activities of the home. You have the right to ask me to stop making observations at any given time.

For interviewing, you will be asked to answer some questions within semi-structured in-depth interviews with me. It is expected that the interview will last approximately 45 minutes. After your permission, the interview will be audio-recorded in order to facilitate the typing up and analysing process in a later time.

What will happen if potential participants refuse to allow the researcher to observe them?

I have to respect the decision and therefore I will not be able to observe you. However, you can still give permission to be interviewed if you are interested in taking part in the study. You have the right to refuse to answer any questions or withdraw at any time without giving any reason. Also, I will assure you that participating in the study is completely voluntary, and withdrawal from the study will not influence the care provided by the homes.

In case if you feel tired during the interview, you can stop the interview and decide when to start the interview again.

What are the possible disadvantages and risks of taking part?

This study will take your time for a while and this will be appreciated. If there are any questions which make you uncomfortable, you can decide to not respond to these questions and terminate the interview any time you feel uncomfortable without having to give a reason. This will not affect your rights or your job role in the home.

What are the possible benefits of taking part?

Whilst there might be no immediate benefits to you, it is hoped that this work will help us obtain a better understanding of how communities and cultures formed in Kurdish care homes and what are the views of staff working there. This information will be used in a constructive manner and aid in improving the provision of care for residents in Iraqi Kurdistan care homes.

What if something goes wrong?

If you have any complaints in the first instance regarding your treatment by the researcher, please contact the primary supervisor Dr. Tony Ryan, School of Nursing and Midwifery, The University of Sheffield/UK. The contact details are provided at the end of this sheet.

Will my taking part in this project be kept confidential?

All the information that you provide during the research will be kept strictly confidential. You will not be able to be identified in any reports or publications.

The following strategies will be taken to ensure the privacy of personal data, audiotapes and transcripts:

- All your data will be secured in password protected computers as confidential and will be kept in a locked cabinet.
- Also all observations, interviews, audio-recordings, and fieldnotes will be anonymised and no participants original names will be written on the reports arising from the study.
- Fictitious names will be used during the analysis and present of the study findings.
- The only people who will have the ability to access to the data are the researcher and his supervisors.
- After the completion of the study, all audio recordings will be destroyed at the end of the analysis of the data. All transcriptions and observational notes will be stored in archive storage at the University of Sheffield.

What will happen to the results of the research project?

The result of the study is likely to be published following the study completion of the study in the local journal and magazines in Kurdish language. In addition, the result of the study is also likely to be published in academic journals or/and conference presentations.

Who is organising and funding the research?

This study will be organised by the primary researcher (Karwan M. M-amen) and Dr. Tony Ryan and Professor Mike Nolan are his supervisors. This study is sponsored by Kurdistan Regional Government.

Who has ethically reviewed the project?

This study has been ethically reviewed and approved by both the University of Sheffield's Research Ethics Committee and College of Nursing Ethics Committee/Hawler Medical University.

Contact for further information

In case if you wish to obtain further information about the study, you can contact the following addresses:

- The researcher: Karwan M. M-amen, College of Nursing, Hawler Medical University, Erbil/Iraq.
Mobile number: +964 750 475 3290, Email: k.amen@sheffield.ac.uk

- The supervisor: Dr. Tony Ryan, Postgraduate Research Tutor, School of Nursing and Midwifery, The University of Sheffield/UK. Barber House, 387 Glossop Road, Sheffield, S10 2HQ.
- Tel: +44 (0)114 222 2062 Email: t.ryan@sheffield.ac.uk

Thank you for reading this.

Appendix D: Consent form

Consent Form for Residents and Staff - Interview

Title of Research Project: **Exploring life in Iraqi Kurdistan care homes: A focused ethnographic study**

Name of Researcher: **Karwan M-amen**

Contact detail:

- Karwan M-amen ‘k.amen@sheffield.ac.uk’
- Tel: 0750 475 3290

Participant Identification Number for this project:

Please initial box

1. I confirm that I have read and understand the information sheet dated (/ /2014) explaining the above research project and I have had the opportunity to ask questions about the project.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and without there being any negative consequences. In addition, should I not wish to answer any particular question or questions, I am free to decline.

3. I understand that my responses will be kept strictly confidential. I give permission for members of the research team to have access to my anonymised responses. I understand that my name will not be linked with the research materials, and I will not be identified or identifiable in the report or reports that result from the research.

4. I agree to be interviewed.

5. I agree my interviews to be tape-recorded.

6. I agree to take part in the above research project.

7. I agree for the data collected from me to be used in future research.

Name of Participant

Date

Signature

Name of the researcher

Date

Signature

To be signed and dated in presence of the participant

Copies:

Once this has been signed by all parties the participant should receive a copy of the signed and dated participant consent form, the letter/pre-written script/information sheet and any other written information provided to the participants. A copy of the signed and dated consent form should be placed in the project's main record (e.g. a site file), which must be kept in a secure location.

Consent Form for Residents and Staff - Observation

Title of Research Project: **Exploring life in Iraqi Kurdistan care homes: A focused ethnographic study**

Name of Researcher: **Karwan M-amen**

Contact detail:

- Karwan M-amen "k.amen@sheffield.ac.uk"
- Tel: 0750 475 3290

Participant Identification Number for this project:

Please initial box

1. I confirm that I have read and understand the information sheet dated (/ /2014) explaining the above research project and I have had the opportunity to ask questions about the project.
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and without there being any negative consequences. In addition, should I not wish to answer any particular question or questions, I am free to decline.
3. I understand that my responses will be kept strictly confidential. I give permission for members of the research team to have access to my anonymised responses. I understand that my name will not be linked with the research materials, and I will not be identified or identifiable in the report or reports that result from the research.
4. I agree to be observed.
5. I agree to take part in the above research project.
6. I agree for the data collected from me to be used in future research.

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of the researcher	Date	Signature

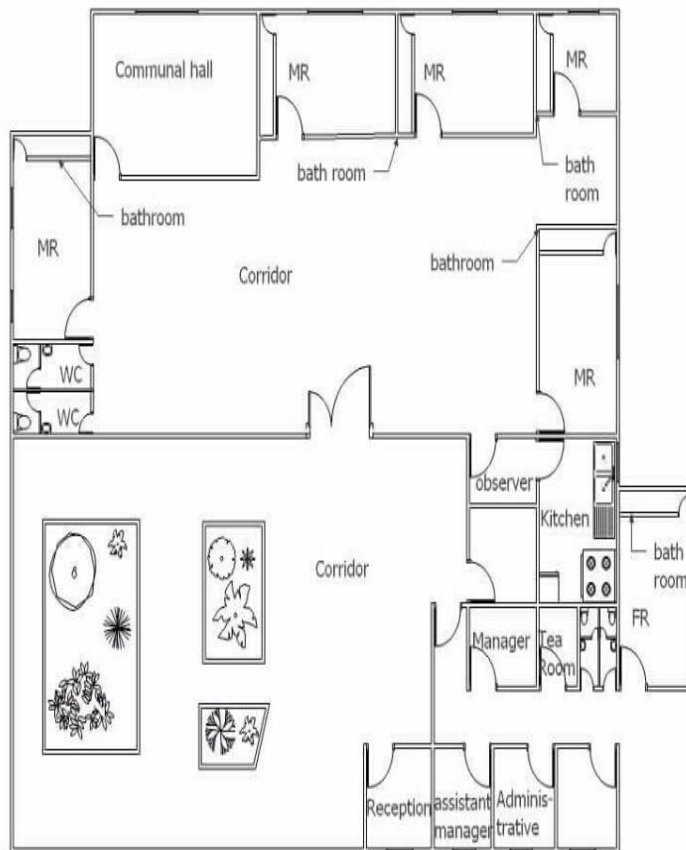
To be signed and dated in presence of the participant

Copies:

Once this has been signed by all parties the participant should receive a copy of the signed and dated participant consent form, the letter/pre-written script/information sheet and any other written information provided to the participants. A copy of the signed and dated consent form should be placed in the project's main record (e.g. a site file), which must be kept in a secure location.

Appendix E: Sketch of the care homes

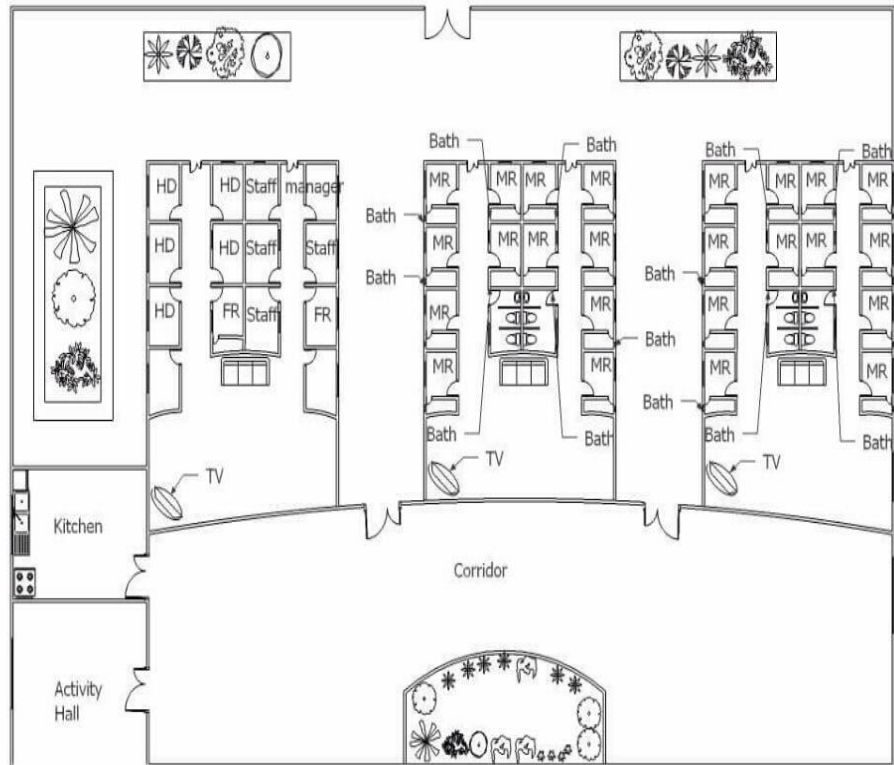
Star Care Home



* MR= Male Room/Hall

FR= Female Room/Hall

Moon Care Home



* HD= Health Department

FR= Female Room

MR= Male Room

Appendix F: Flow chart of literature searching

