

How organisational arrangements affect service provision

Organisational arrangements can shape what individual staff members do in the highly-skilled work of meeting residents' needs. This research may challenge traditional views about care quality that focus attention only on care workers

When things go wrong in the residential care of older people, individual workers may well be held responsible. This article investigates the organisational factors that are also at play, and that shape the practice of staff. Organisational factors include:

- Skill mix, training and numbers of staff
- Management and procedures
- Characteristics of the resident group
- Infrastructure of the organisation (for example, the building and its upkeep)
- Contextual factors (including organisational culture, and changes from outside the care home).

The authors reviewed the literature about abuse and neglect in institutional care of older people and then carried out qualitative research in eight different care homes in different areas in England. Older people were actively involved in the research process as peer researchers and as members of an advisory panel so that the research would stay focused on their priorities.

The authors found that although care homes faced similar pressures, demands and circumstances, these were dealt with differently in different homes. Good care can fluctuate quickly as one factor affects others. In some homes the responses of staff had helped to limit the problems caused by fluctuations. Organisational factors, however, could prevent people from providing good care. Recommendations for care homes were to pay close attention to how organisational factors could be interacting to affect care quality. Care homes should ask staff and residents for their insights to spot organisational

problems. Individual issues could be tackled and staff encouraged and supported to adapt and innovate.

Carrying out the research Research in care homes

Care homes are first and foremost the home of the residents. They are also the workplace for staff. On the one hand it is important for research to be carried out with residents and staff of care homes so that practice can improve and develop with evidence, but this must be balanced against the need for residents' privacy and a sense of home, and staff time for supporting and caring for residents.

Residents and staff should have the choice whether or not to take part in research, and for this project the authors talked individually to residents and members of staff, giving them written information about the project, explaining the implications of taking part in the research and answering any questions. All the names and care home names used are made up in order to protect the confidentiality of people and homes that took part in the research. A local NHS Research Ethics Committee reviewed the study (reference 09/110306/63).

Research methods

The research was designed to combine two approaches; comparative ethnographic case study and participatory research (Killett et al, 2012). Ethnography is a social research approach that studies what people say and do in everyday contexts (Hammersley and Atkinson, 2007). It is useful for looking at the complexities of 'real life' situations. Participatory research actively involves the people most concerned with the subject of the research, in this case, older people who are living in, or who have an interest in, residential care (Clough et al, 2006; Burns et al, 2012).

The study had three phases. In the first phase, the authors reviewed literature and inquiry reports about organisational aspects of mistreatment of older people in residential care. In the second phase, eight care settings were studied in-depth. These care settings varied in type,



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size and provider of care homes. The authors spent time in each care setting getting to know people and routines, in the week and at weekends, and overnight. A total of 294 hours of observation were carried out and 147 people were interviewed (Table 1). What was found in each care setting was compared with the findings from the other care settings.

Involving older people

People tend to see others, particularly those they do not know, in one-dimensional ways. In care homes it is easy to think of residents only as receiving care and potentially vulnerable. In society more broadly, whole groups can be treated in the media and by popular culture in stereotypical ways. Researchers of ageing, such as Gilleard and Higgs (2000), have criticised ideas of older people that do not sufficiently recognise their individuality and continuing aspirations to actively engage with their own lives and other people, even when experiencing health and memory problems, and/or living in care homes (Gilleard and Higgs, 2000).

The authors of this study trained and supported older people to be researchers and advisors. Five older people with experience (for example, as family carers) and interest in care homes became 'peer researchers'. They learned about research methods, and helped to carry out interviews, observations and analysis of data. Older people who were living in care homes, and family carers, were supported to attend a panel group that met three times through the course of the research to advise the researchers.

Developing the findings

The interviews were recorded and notes were written down during observations. These were all typed up. The researchers and the peer researchers read through the interviews and the notes, repeatedly. From this, themes were developed, these were put into groups and were used to develop findings about organisational arrangements and care experience. Below are some key points illustrated by quotations and situations that typify organisational factors at work in care homes.

Care and organisational factors

Organisational challenges

Daisy Court

In Daisy Court many staff were working hard to provide good care, but many of the residents interviewed felt negative about the home. One resident said:

'All I can think about is getting out.'

Lily, a resident at Daisy Court, is not confident that all the staff know her basic needs:

'Well some things I find difficult because I don't think they realise sometimes, some of the carers, that I can't

Table 1. Care settings that took part in the research

Care home	Type of home	Observation (hours)	Interviews with residents	Interviews with relatives	Interviews with staff
Sunny Rose	Independent	40	7	3	10
Poppyfields	Voluntary	40	12	4	16
Sunflower Place	NHS	35	0	2	14
Crocus Row	Public sector	31	1	1	11
Lily Park (part of Crocus Row)	Public sector	26	4	1	11
Iris House	Public sector	45	8	1	9
Daisy Court	Corporate	48	6	3	12
Tulip Grange	Corporate	29	0	5	14
Total		294	38	20	86

walk. You see, you know, I have to have my frame, of course, but it's difficult. Most of them are very good, but there's just the odd one or two that don't realise how helpless I am really. They think because I'm sat up and talking I'm OK.'

Meanwhile, Jane, a care assistant at the same home, feels bad that she does not know enough about the residents:

'There was a lady who fell over yesterday while she was with me. I felt awful, apparently it was her slippers. And she'd fallen over in those slippers a few days before and she should have been wearing different shoes, but because nothing has been said, but then you're always having different staff every day. So not everyone can know everything and the same person isn't going to be there and things are in the care files and stuff, but when you first come in you don't go to the care files. They're locked in the office and you have to sort of go straight to what you're doing.'

The importance of team working was emphasised by many staff participants, as this helps staff to share information and to coordinate their work with residents. In Daisy Court, however, organisational arrangements were getting in the way of team working. A pared-down staff resident ratio was achieved by 12-hour shift length without an overlap for handover, and, in addition, staff did not know until they got to work where in the home and in which team they would be working. There was a high workload and limited time for staff to communicate with each other.

Perhaps related to the workload pressure, staff turnover was a problem, including in management, and recruitment of staff was difficult. The home used agency

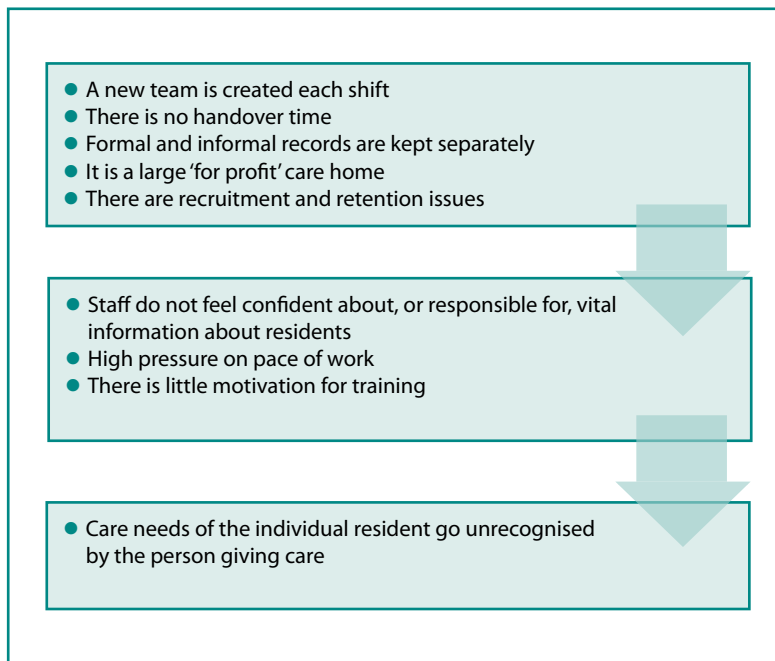


Figure 1. Organisational arrangements getting in the way of team working in Daisy Court

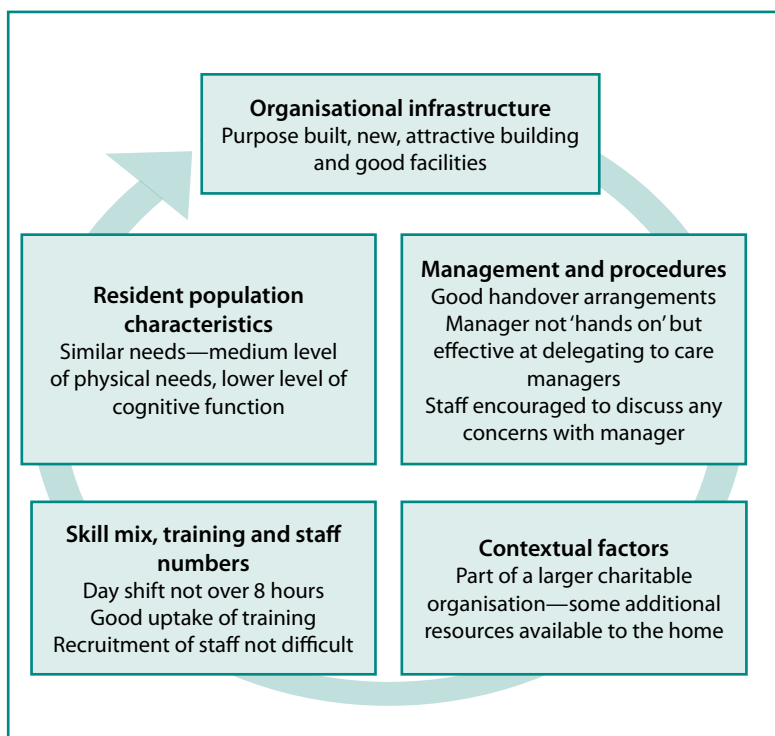


Figure 2. Interaction of organisational arrangements at Poppyfields

staff to make up shortfalls but, frequently, the whole of a shift was not covered, adding to the pressure of work. Although training was available, many staff had a negative attitude to it. The management response of penalising staff for not attending mandatory training may not have helped to develop positive attitudes (Figure 1).

Organisational arrangements at Daisy Court got in the way of teamwork and there were examples of poor care as a result. For example, Lily mentioned being washed:

'I didn't feel right. She didn't get me washed me properly and I felt dirty but most of them, they good, they'll wash your back and wash your bottom and its good, good that you know, it's loss of dignity love [sounds upset] ... And with my children coming in and my grandchildren I don't want to be smelling [sounds very upset].'

Lily also described being frightened by a carer who was 'abrupt' with her. The researcher carefully negotiated with Lily that the researcher would raise this with the manager. The manager later expressed a view that Lily's expectations were too high. Lily wanted to know what she could expect:

'I'd like to know, I'd like to have a think, well this is what they're going to do and this is, this is, adequate for me but when they come and they miss something I think—now does it matter? Should they have done that? Should I have told them about it?'

Although residents and staff like Lily and Jane could identify problems, there was vagueness and confusion about expectations of good care. The understanding of expectations of good care is not just described in policies, but by what staff know and do, and in Daisy Court the organisational issues contributed to a loss of understanding about what constitutes good care.

Poppyfields

Poppyfields provides an example where organisational arrangements supported more effective teamwork and collaboration. Agency staff were used, staff absences were covered and shifts very rarely understaffed, but mutual respect and support between permanent and agency staff was encouraged by the management. Permanent staff were given the opportunity to cover shifts, therefore, there was no competition with agency staff. Management had built up personal relationships with agency workers and these workers were offered shifts directly before management approached the agency to arrange the cover (Figure 2). These regular agency-employed workers knew individual residents and their needs, and were also valued for their experience as Zoe, a permanent care worker explains:

'Yes, they are brilliant. They do pass on their information and that is really nice and they show us how to do things well I found anyway, but they have they have actually helped me quite a lot.'

Fluctuations in care and innovative responses

The authors saw creative examples of staff, sometimes with resident input, getting around organisational obstacles. For example, in one care home, catering services were contracted out, and staff found the caterers unresponsive

to the preferences of an individual resident with dementia. The care staff got medical staff to influence the caterers by 'getting a doctor to prescribe a resident sausages'.

In Sunny Rose, a culture of learning had been established where all staff regardless of status were assumed to have valuable information about the health status of residents and their needs. This information was fed back on a daily basis and the manager would fine-tune staffing levels in line with fluctuating needs of the residents. The owner-manager of Sunny Rose had the flexibility and autonomy necessary for such decisions, and the management team developed loyalty through innovative provision of staff education and support.

However, even with the best intentions, changes in residents' needs, such as through illness, or staffing issues, can destabilise care. Some organisations are better able to adapt and minimise the impact on care, while in contrast, organisational constraints can have cumulative effects. For example, in Iris House, the resident population had changed as the organisation aimed to specialise in meeting complex physical needs. There had been some changes in the infrastructure of the care home, but there were design problems and the needs of the resident population changed more quickly than the infrastructure could be adapted. These issues led to care staff assisting with transfers of residents into and out of bed with mobile hoists that did not fit under beds. Staff complained of shoulder and back injuries due to the demands of the physical work. At the time of the research there were a number of staff on sick leave with physical injury, and staff who were covering additional shifts were becoming more tired and also more prone to injury themselves (Figure 3).

Overall, the five organisational factors provided a helpful way of understanding the differences in how care homes were able to respond and develop.

Conclusions

Care providers need to look beyond blaming care workers for failures in care and understand organisational factors that contribute to good and poor quality care. Care homes should pay close attention to organisational arrangements, and particularly the effects of changes.

Staff, residents and relatives often see organisational barriers or pinch points. Care homes should find out more from them about organisational dynamics affecting care quality. Residents, relatives and staff will be better able to contribute if they have a clear understanding of the expectations for good safe care. This information should be widely available in easy and clearly accessible ways. This may help people to voice concerns and challenge practice where needed. **NRC**

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Figure 3. Changing residents' needs and infrastructure problems at Iris House

The views expressed in this report are not necessarily the views of the Department of Health or Comic Relief.

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Key points

- Good quality care depends on a range of organisational factors, which include skill mix, training and numbers of staff; management and procedures; characteristics of the resident group; infrastructure of the organisation; contextual factors
- Organisational factors interact to enhance or obstruct the quality of care that staff can provide
- Residents, relatives and staff often have key insights about organisational problems
- Clear expectations of good care might be undermined by organisational dynamics, but can help residents, relatives and staff give their insights