DOING CARE WORK FOR OLDER PEOPLE:
WORK IDENTITIES, MOTIVATIONS AND BARRIERS TO JOB SATISFACTION

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STATEMENT OF ORIGINALITY

I certify that this thesis, presented for examination for the PhD degree in psychology, is solely my own work.

I warrant that this authorisation does not, to the best of my belief, infringe the rights of any third party.

ABSTRACT

There is an increasing care demand for care home workers have a significant role in meeting residents' care needs from the admission to a care home up to the end of life. However, there is persistent high care home worker turnover that can negatively impact the quality of care residents receive and care workers' wellbeing. This thesis aimed to explore care home workers' perceptions, experiences, and motivations of continuing their work role through the lens of self-determination theory (SDT). The first qualitative study (n=22) explored care workers' perceptions and experiences of providing care for residents from the admission to the care home up to the end of life. Thematic analysis was used to analyse the data. Participants' accounts reflected that social interaction had a significant role in facilitating the development of their work identities and encouraging them to remain employed in the care homes. The second study (quantitative, n=207) that built on the findings of study 1 investigated how care home workers' perceptions towards their work roles, psychosocial attributes, psychological needs, and motivation influence their organisational commitment and job satisfaction using structural equation modelling. The study suggested a contextual significance of satisfying care workers' psychological needs which then shapes their motivation and influences their organisational commitment and job satisfaction. The third study (qualitative, n=10) that complimented the findings of study 1 and 2 was to understand managers' perspectives on care workers' support needs and how they provide support to their care workers in the care homes using thematic analysis. Participants' accounts reflected that meeting care workers' autonomy need and enhance the effectiveness of communication between managers and care workers helped convey care home values and the meanings of care work to care workers, foster a positive work environment, and improve teamwork. This thesis contributes to the theoretical understanding of care workers' work identities and motivations of continuing their care worker role. As a career that is dominated by people and interactions with people, social interaction has a significant role in facilitating care workers to establish their work identities and implement role expectations and the meanings of care work in their care practice, satisfying their psychological needs at work, and experiencing a higher organisational commitment and job satisfaction. This thesis highlights the significance of the consistency in management practices which helps eliminate the incongruences care home workers experienced between their work identities and the real job of caring and facilitate the development and maintenance of a stable and positive care home culture. This thesis has the potential to inform or devise interventions with evidence-based information to enhance care workers' retention and wellbeing.

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CHAPTER 1
OVERVIEW OF THE THESIS

1.1 Why study care workers?

The United Kingdom population is ageing (Age UK, 2018). In 2017, 18% of the population was aged 65 and over and 2.4% of the population was aged 85 and over (Office of National Statistics, 2018). UK life expectancy has increased 2.3 years since 2006 and is anticipated to continue increasing (Office of National Statistics, 2017). It is estimated that close to a quarter of UK population (24.2%) will be aged 65 and over by 2041 (Office for National Statistics, 2018a). Older people tend to require more assistance and support for their activities of daily living (ADL) and meeting their complex care needs later in life (Age UK, 2018). Statistics showed that there were 36% of older people aged between 65 and 74 have a limiting longstanding illness whereas 47% of older people aged 75 and over suffer from chronic conditions (Age UK, 2018). There are 808,000 older people aged 65 and over living with dementia, which is a progressive illness, one of the main causes of disability and the leading cause of death for women in the UK (Office for National Statistics, 2018b). Thus, older people are more likely to suffer from chronic conditions, degenerative diseases or cognitive impairment and will require support to meet their care needs. Older people's relatives or friends often provide support and assistance to meet older people's care needs. Nevertheless, when older people are struggling to manage their ADL or their complex care needs cannot be sufficiently fulfilled by their relatives or friends, they are more likely to move to a care home (Ribbe et al., 1997).

Recent statistics showed that there were 421,100 older people aged 65 and over and 14.8% of the population aged 85 and over live in care home settings (Age UK, 2018). Moreover, between 75% and 89% of residents in care homes have a form of dementia or severe memory problems (Alzheimer's Society, 2015; Lithgow, Jackson, & Browne, 2012; Stewart et al, 2014). According to National end-of-life care intelligence Network (2017), every 1 in 5 older people aged 75 and over die in a care home setting and 38% of all those aged 75 or older at death have been cared for in a care home before death (Public Health England, 2017). A more recent government statistics stated 21.8% of deaths occurred in care home settings in England and Wales in 2016 which has increased by 5.3% since 2004 (Public Health England, 2018). Thus, it is undeniable that care home settings have an important role in meeting older people's personal care needs up to the end of life. Furthermore, the number of older people

who require personal care from care home settings is anticipated to increase. Researchers suggest that an additional 71,215 care home places in the UK will be required by 2025 in order to provide care for older people with substantial care needs (Kingston et al., 2017). In addition, estimates show that the population of older people aged 65 and over would increase 4.5 million by 2035 in England. Therefore, an additional 650,000 to 950,000 care workers will be required by 2035 in order to meet the increasing care demand (Skills for Care, 2018). It is clear that care home workers have important roles in meeting older people's personal and nursing needs up to the end of life (Bone et al., 2018; Froggatt, 2001; Teno et al., 2004).

It has been suggested that providing quality care to residents in care home settings is essential, especially where intimate personal care is provided to vulnerable older people (Badger, Thomas, & Clifford, 2007). The person-centred care approach, (Kitson, Marshall, Bassett & Zeitz, 2013) which is considered as the best care practice in delivering care, is often applied to care for residents. This approach requires care workers to have sufficient understanding and awareness of their role and self-concept, to develop effective relationships with residents, to provide care to residents while taking residents' personhood into account and encouraging residents' involvement and participation in their own care. It is worth noting that 90% of direct care in care home settings is provided by care workers (Sloane, Williams & Zimmerman, 2010). It has been suggested that care workers have a crucial role in meeting residents' personal care needs up to the end of life (Bone et al., 2018). Their role includes paying close attention to residents' care needs, meeting residents' care need (Dobbs, Baker, Carrion, Vongxaiburana & Hyer, 2014), promoting residents' personhood (Edvardsson, Fetherstonhaugh & Nay, 2010; McGilton & Boscart, 2007), autonomy, and independence (Cooney, Murphy & O'Shea, 2009), and offering social and emotional support for residents and residents' families (Brazil et al., 2004; Chan & Kayser-Jones, 2005; Gallagher & Krawczyk, 2013). In addition, researchers suggest that the stability and consistency in staffing allows the familiarity between care workers and residents and helps care workers to build the trust and relationship with residents (Edvardsson, Fetherstonhaugh & Nay, 2010; McGilton & Boscart, 2007). Care workers turnover rate and care home staffing levels have been found to have a strong association with the quality of care that residents receive in the care home settings (Castle & Engberg, 2005; Franklin, 2014; Shield et al., 2005).

However, there are long lasting issues around care workers' recruitment and retention in social care sectors as many care homes encounter high care workers turnover and understaffing (Glenn, 2000; Skills for Care, 2017). The average turnover rate in care home

settings in the UK was 33.8% and it is steadily increasing (Skills for Care, 2017). According to Skills for care (2016), 47.8% of care workers left the social care sector within one year. On the other hand, many care workers who left their job did not leave the social care sectors as 67% of recruitment in social care sectors had previous care work experience within the sectors (Skills for Care, 2018). Scholars point out that high turnover and understaffing in care home settings have negative impacts on care workers at physical, social and psychological levels (Bishop, Squillace, Meagher, Anderson & Wiener, 2009; Karsh et al. 2005; Mittal, Rosen & Leana, 2009; Pillemer et al., 2008). This can result in care workers being physically and emotionally drained and leading them to experience distress, burnout, and job dissatisfaction (Castle & Engberg, 2005; Pillemer et al., 2008). Considering the training that care homes invest in care workers, the relationship developed between care workers and residents, the care quality residents received, and care workers' wellbeing, improving care workers' retention is important in care home settings. Thus, the facilitators and motivators that encourage care workers to continue their role in the care homes is an important research area.

It is worth noting that despite the importance of the care worker role and the increasing care demand for their service, care work is often considered as an unskilled job rather than a profession (The National Association of Care and Support Workers, n.d.). Care workers working in a low-wage sector with limited monetary incentives (Skills for Care, 2018) often experience care work related stigma (Jervis, 2002; Pfefferle & Weinberg, 2008) and negative media representation (Kadri et al., 2018; Miller, Tyler & Mor, 2013), perceive their work being undervalued and underpaid in the care homes (Bjerregaard, Haslam, Mewse & Morton, 2017), and endure a heavy workload (Schnelle et al., 2004), emotional distress (Carr, 2014; Vandrevala et al., 2017), and burnout (Kokkonen et al., 2014). To tackle the issues of persistent high care worker turnover, scholars explored the contributing factors of care workers' turnover and retention (e.g. Bowers, Esmond & Jacobson, 2000; Karsh, Booske & Sainfort, 2005; Mittal, Rosen & Leana, 2009; Pillemer et al., 2008). However, scholars point out that care workers' personhood, value and identity are often overlooked and under-researched (Kadri et al., 2018; Pfefferle & Weinberg, 2008). Thus, little has been known about how care workers' expectations towards their job, work identities and values influence their job satisfaction, organisational commitment, and turnover intention.

Still, some issues remain unclear. For example: a) to what extent is each motivator or factor significant in encouraging care workers to remain in their care worker role? b) to what extent

does the social context in care home settings influence care workers' motivation? c) to what extent do care home managers influence or foster the social environment in care homes and how do their role facilitate care home workers' motivation? What are care workers' perceptions of their work role? and d) to what extent do care workers' perceptions of their role influence their motivation? Exploring these issues potentially furthers our understanding of care workers' motivation towards remaining in their work role.

1.2 Theoretical background

A number of motivation theories which have been proposed to explain individuals' work motivation and organisational behaviour in organisation contexts have been considered, including expectancy theory of motivation (Porter & Lawler, 1968; Vroom 1964), goal-setting theory (Locke & Latham, 1990), and self-determination theory (Ryan & Deci, 2000). These theories have the potential to further our understanding of care workers' experience and motivation in care home settings. Considering the characteristics of care work and the findings of previous care worker research, there are limitations shown in some of the theories that negatively affect their applicability to care home workers. For instance, expectancy theory does not take individuals' perceptions of the job or the influences of social environment into consideration (e.g. Lawler, 1981) while goal-setting theory does not explain individual motivation when they have multiple goals or discuss the role of managerial support that individuals may require (Deci, 1992; Lee, Sheldon & Turban, 2003).

Given that care workers have limited extrinsic incentives at work and their need satisfaction, close relationships with residents, and social environment in the care homes are suggested to have significant roles in their job satisfaction, care practice, and retention, self-determination theory (SDT; Deci & Ryan, 2000; Gagné & Deci, 2005) is considered the most applicable theory for this research. SDT depicts work motivation as a psychological process where individuals experience internal or external incentives at work which direct, energise and maintain their action toward a job task, role, or work performance (Deci & Ryan, 2000; Grant & Shin, 2011; Ryan & Deci, 2000; Van Knippenberg, 2000). SDT proposes that individuals have an inherent tendency for activities which leads them to experience growth, competence, self-determination and rewards. Being motivated by interests, enjoyment or values of the activities or tasks is described as intrinsic or autonomous motivation and is considered as better-quality motivation. Being motivated by external factors is depicted as extrinsic or controlled motivation and is considered as poorer quality motivation. A self-determination continuum ranking is applied to illustrate different levels of internalisation

and a higher level of internalisation leads individuals to have more autonomous motivation, to form identities, and to enhance and maintain the identity-relevant behaviours. The nutriments provided in social environment, including the satisfaction of psychological needs for autonomy, competence, and relatedness, are suggested to be essential for their internalisation. SDT also emphasises the influences of social, cultural and environmental attributes on an individual's sense of volition, motivation, well-being, functioning and performance.

The knowledge of SDT provides a comprehensive understanding of individual motivation and the influences of social and environmental attributes on motivation. SDT may help to enhance our understanding of the relationships between care workers' need satisfaction, social environment of the care homes, and other psychosocial factors, and the extent to which these factors and their relationships with others exert influences on care workers' motivation at work. Thus, SDT is considered as the adequate and applicable theoretical framework to further our understanding of care workers' work experience and motivations of remaining in their current position in care home settings.

1.3 The objectives and research aim

The aim of this thesis was to investigate care workers' perceptions, experiences, and motivations of continuing their role as a care worker. The objectives of this thesis were to further our understanding of care workers' perceptions and experiences at work, to add to the theoretical knowledge on care workers' motivations to continue working as a care worker and to contribute to the limited evidence-based information which could potentially inform future interventions and enhance retention, care practices, and care worker wellbeing. Specifically, the three research questions of this thesis were:

- What are the care workers' perceptions and experiences in providing care for residents from the admission to the care home up to the end of life?
- What are the influences or relationships between care workers' perceptions towards their work roles in the care homes, psychosocial attributes, psychological needs, and motivation, and the care workers' organisational commitment and job satisfaction?
- What are the care home managers' perceptions on the ways in which they facilitate their care workers in the care homes?

1.4 Methodologies

The researcher agrees with the constructivist perspective where knowledge is socially constructed while accepting the concept of positivism where there is objective knowledge shared by individuals within social phenomena. The constructivist epistemology informs the qualitative approach and the positivist epistemology informs quantitative approach. Taking the limitations of quantitative and quantitative approaches into consideration, the perspective of pragmatism is adopted in this thesis. The perspective of pragmatism concerns the intersubjectivity in the research process, adopts abduction reasoning, and focuses on the transferability of findings (Morgan, 2007). A mixed method involving quantitative and qualitative methods was used to explore the research questions in this thesis. The first qualitative study concerned the experiences, perceptions, feelings, and views of care workers in relation to their role, care practice, and social interaction in the care homes. The second study (quantitative) investigated the influences of the care workers' role perceptions, psychosocial attributes, psychological needs, and motivation on their job satisfaction and organisational commitment. The last qualitative study dealt with the perceptions, views and experiences of care home managers in relation to the ways in which they facilitated care workers to develop work identities and cope with the difficulties and barriers that they experience at work.

The first study was designed to explore the experience and perceptions of care workers. It is essential to discover care workers' day-to-day interactions with residents and others in the care homes, the ways in which care workers make sense of their experience, and how they construct meanings out of their role and responsibilities. Thus, conducting a qualitative study was essential to learn about care workers' subjective experiences in providing care to residents from the care home entry up to the end of life. In order to learn about the care workers' understandings, experiences, perceptions, in relation to their day-to-day work and care practice, the thematic analysis (TA; Braun & Clarke, 2006; Clarke & Braun, 2013) was used to analyse the data. The findings of the first study highlighted that the barriers care workers experienced at work and the facilitators for continuing their care worker role were associated with their perceptions towards their job. The findings also implied the significant role of care workers' work identities in relation to their self-esteem, satisfaction of psychological needs, and motivation. In order to investigate how care workers' role perceptions in the care homes, self-concept, psychological needs, and motivation influence their job satisfaction and organisational commitment, a quantitative approach was chosen for the second study. A quantitative approach permits researchers to develop an explanatory

universal pattern or law to explain the relationship between constructs (Yilmaz, 2013). In addition, the constructs concerned in the second study are not entirely independent from one another. It may be assumed that each construct may have some effects on one another. Thus, a model hypothesising the relationships between each construct was established based on previous research and self-determination theory. Using the pre-existing measures allowed the researcher to focus on certain processes of the constructs by limiting participants' options and to ensure the validity and reliability of the measures. The data were analysed using structural equation modelling (SEM) which is considered as a powerful and flexible statistical method allowing researchers to find unbiased relationships between constructs (Cohen, Cohen, West & Aiken, 2013; Iacobucci, Saldanha & Deng, 2007; Kline, 2015).

Results of the second study suggest that developing care workers' work identities is a key to positive organisational outcome. In addition, the literature review in chapter 2 and the findings of study 1 suggest care home managers have a significant role in training and supporting care workers. Learning about care home managers' experiences and perceptions in relation to care workers' support needs may enhance our understanding of the issues surrounding care workers' work identities, barriers, motivation, organisational commitment and job satisfaction. Given that each care home manager may have different experiences and care home culture and values, it was essential to enable them to express their views and experiences. Thus, a qualitative approach exploring the experience and perceptions of care home managers was applied. In order to learn about care home manager' experience and perceptions, the thematic analysis (TA; Braun & Clarke, 2006; Clarke & Braun, 2013) was used to analyse the data.

1.5 Overview of the chapters

This thesis is organised as follows. Chapter 2 and 3 present the review of the relevant literature, followed by a review of motivation theories in chapter 4. A discussion of the epistemology and methodologies of this thesis will be presented in chapter 5. Three empirical studies will be presented in chapter 6, 7 and 8. The limitations and implications of the three empirical studies and the recommendations for future studies will be discussed in each empirical study chapter as well as in chapter 9 where general discussion and conclusion will be presented.

1.5.1 Chapter 2.

In this chapter, the contextual background information of care home settings in the UK will be introduced to provide a comprehensive understanding of care work that care workers carry out and to address persistent issues in the care homes and their impact on residents, care workers, and care homes. The literature review also summarises the evidence on voluntary turnover in organisational studies and its attributes, such as organisational commitment, organisational identification and job satisfaction. The review then addresses the voluntary turnover in care home settings, including care worker motivations of continuing their roles, the influences of the psychological aspect of care home context on care worker motivation, turnover, and the attributes of turnover. A few unanswered questions emerged from the literature review which point to a need to explore care workers' experiences and perceptions towards their work role and what encourages or facilitates them to continue in their care worker role.

1.5.2 Chapter 3.

The chapter 2 literature review on care workers' motivations of continuing their work role raised a question regarding the definition of attributes. The ambiguity in defining the construct of organisational commitment and organisational identification may cause difficulties in revealing the attributes of these two constructs and interpreting the influences of these two constructs on workers' turnover intention. Thus, the literature on the construct of organisational commitment, organisational identification, and job satisfaction was reviewed in this chapter. A few unanswered questions emerged from the literature review which point to a need to explore care workers' experience and perceptions towards their work role and what motivates, encourages or facilitates them to continue in their care worker role.

1.5.3 Chapter 4.

The literature review in chapter 2 revealed that the need satisfaction of care workers, the social environment of the care homes, and other psychosocial factors may have significant roles in facilitating care workers' job-related performance and encouraging them remaining in their care worker role. However, the relationships between these factors were not illustrated and the extent to which these factors and their relationships with others exert influences on care workers' motivation at work remained unclear. Applying an adequate theory in this thesis would allow us to draw the knowledge of the theory on individuals' motivation to reach a comprehensive understanding of care home workers' experience and motivation while reflecting their need satisfaction, social environment in the care homes,

and other psychosocial factors care workers experienced at work. Therefore, three motivation theories are considered as they have the potential to enhance our understanding of care workers' experience and motivation at work. They are expectancy theory of motivation (Porter & Lawler, 1968; Vroom 1964), goal-setting theory (Locke & Latham, 1990), and self-determination theory (Ryan & Deci, 2000). Considering the strengths and limitations of each motivation theory mentioned above, self-determination theory (Deci & Ryan, 2000; Gagné & Deci, 2005) is considered as the most applicable motivation theory to further our understanding of care home workers experience and motivations of continuing their role as a care worker.

1.5.4 Chapter 5.

The epistemological assumptions of research inform the research approaches, methodologies, strategies, and methods (Dallos & Draper, 2010). The epistemological assumptions underlying the qualitative and quantitative approaches are fundamentally different. In this chapter, the reviews of the epistemological assumptions of qualitative and quantitative and the strength and limitations of qualitative and quantitative approaches were reviewed. In addition, the rationale of using mixed methods to explore care worker experiences, perceptions, and their motivations of continuing working as a care worker was discussed. The research questions developed from the findings of literature review in the chapter 2 are presented, together with the discussion of the appropriate methodology for researching these questions. The ethical issues and considerations that arose while conducting research in care home settings is addressed. Finally, the researcher's personal reflexivity is presented.

1.5.5 Chapter 6.

In this chapter, the findings of the first study are reported. This study was a qualitative study (n=22) exploring care workers' experiences in providing care to residents from entry up to the end of life. It looks at the experiences, perceptions, feelings, and views of care workers in relation to their role, care practice, and interaction with others. The interviews were transcribed verbatim and analysed using the thematic analysis (TA; Braun & Clarke, 2006; Clarke & Braun, 2013). The findings revealed that participants perceived that their work role entailed providing care to residents in accordance with residents' care needs and best interests, maintaining residents' independency and autonomy, meeting residents' emotional and social support needs and fostering a trust and close relationship with residents. Fulfilling a care worker's role required care workers to liaise with residents' families and have effective teamwork with their colleagues. The role expectations that care workers learned from the

training, other colleagues' shared work experiences, and interaction with residents informed them the meanings of being a care worker and established their work identities. Participants expressed the significance of their work experience and interaction with residents in the care homes where they examined, modified, and verified the values and meanings of care work they had learned from explicit training courses.

Participants often experienced difficulties and barriers which impeded them from meeting their care worker role. The barriers involved care workers struggling with meeting multiple role expectations, issues of emotional attachment, and difficulties in balancing between life and work. On the other hand, the positive and satisfactory experiences care workers had at work facilitated and motivated them continuing their care worker role, such as experiencing satisfaction of autonomous needs, sense of belongingness to the care home, an enhanced self-efficacy, being independent at work and valued, and reaching a sense of pride in their work. Participants' accounts reflected that their meanings of being a care worker exerted influences on the ways in which they perceived the barriers at work, their support needs, and the facilitators for carrying on their role as a care worker. The findings suggested that a care home's value and culture may heavily influence their care workers' perceptions of role expectations and identities. The compatibility between a care worker's personal values and a care home's values may be seen as an antecedent of a care worker's organisational identification. When care home values and culture empowered care workers and encouraged them to take on more shared responsibilities, care workers experienced an enhanced self-efficacy and sense of belongingness which may help them to form a stronger organisational identification, to experience a better job satisfaction, and a higher commitment to the care work in that care home. Furthermore, a care worker's satisfaction of autonomous, competence and relatedness needs seem to lead them to experience a sense of achievement and satisfaction at work.

1.5.6 Chapter 7.

In this chapter, the findings of the second study are presented. This was a quantitative study built on the findings of study 1, designed to investigate whether a care worker's perception towards their work role in a care home, psychosocial attributes, psychological needs, and motivations influence the extent to which they are more likely to stay in their job. Organisational commitment and job satisfaction have been suggested as the significant predictors of turnover intent (Lambert & Hogan, 2009) and linked to better job-related performance (Van Knippenberg & Sleebos, 2006) and care workers' wellbeing (van de Ven

et al., 2012; Zhang, Punnett, McEnany & Gore, 2016). The care workers' organisational commitment and job satisfaction were applied to understand the extent to which care workers are more likely to continue their work role. Two hundred and seven care workers working in nursing homes (N=171, 82.6%) and residential care homes (N=36, 17.4%) completed a quantitative survey study. Using self-determination theory (Gagné & Deci, 2005), the literature review in chapter 2, and the findings of the first study as the basis, a structural regression model was built and then analysed using structural equation modelling.

The findings suggested a directional linkage from care workers' organisational identification to the satisfaction of psychological needs, to intrinsic motivation and to organisational commitment and job satisfaction. The satisfaction of psychological needs and intrinsic motivation were two strong predictors of organisational commitment and job satisfaction. They were also the mediators of organisational identification in organisational commitment and job satisfaction. Unexpectedly, self-esteem was as a negative predictor of organisational commitment and job satisfaction and a negative mediator of organisational identification in organisational commitment and job satisfaction. This study implied a contextual significance in satisfying care workers' psychological needs which then shapes their motivation in carrying out their care worker role and impacts on organisational commitment and job satisfaction.

1.5.7 Chapter 8.

In this chapter, the findings of the third study are reported. This was a qualitative study (n=10) aimed at understanding care home managers' perspective on care workers' support needs and the ways in which managers provide support to their care workers in the care homes. Given that managers have an important role in creating work environment and training and supporting care workers, learning form their perspective may provide insights about which social environment or management empowers the motivators for encouraging care workers remaining their current position. The interviews were transcribed verbatim and analysed using the thematic analysis (TA; Braun & Clarke, 2006; Clarke & Braun, 2013).

The findings revealed that managers' perceptions, views, and values of the care work influenced their management practices and recruitment strategies. Participants' management practices shaped, directed, and fostered the care home culture that provided care workers with a foundation on which to carry out the care work in the care homes. Participants expected their care workers to fulfil the care responsibilities, execute care home expectations,

and offer social and emotional support to residents. At the same time, managers expected care workers to remain emotionally detached and keep emotionally distant. Managers acknowledged this dilemma for care workers and felt they needed to help their care workers navigate the boundaries and avoid the adverse effects of crossing the boundaries. The findings reveal that effective supports for care workers in continuing their role include facilitating career advancement, fulfilling their autonomous needs, fostering effective communication, enhancing their self-esteem, and promoting their self-care and wellbeing. The participants' accounts reflected that encouraging care worker involvement in managerial issues and applying reciprocal communication helped to meet care workers' autonomy needs (Baard, Deci & Ryan, 2004; De Cooman et al., 2013) as well as enhancing the effectiveness of communication between care home managers and care workers. This was viewed as significant in conveying care home values and the meanings of care work to care workers, fostering a positive work environment, avoiding misunderstanding, and improving teamwork.

1.5.8 Chapter 9.

Chapter 9 presents the key findings of this thesis. The findings contribute to furthering our understanding of care workers' work identities, barriers, and motivation at work. It also identifies self-determination theory as a valuable and comprehensive framework to understand care workers' motivation, care practice, and job satisfaction. This thesis provides evidence to understand care workers' work experience and work identities which exert influences on their care practices and motivations of continuing their care worker role.

The findings add to our understanding of a care worker's work experience and work identities and the ways in which they influence care workers' perceptions of barriers at work and facilitators for continuing to work as a care worker. Care workers establish their work identities through the explicit training and implicit learning on the job, including peer support, learning from colleagues' shared experiences and interaction with residents. The findings show that social interaction has a significant role in conveying role expectations and meanings of care work to care workers by enabling them to experience the satisfaction of psychological needs. The satisfaction subsequently facilitates care workers to internalise role expectations and the meanings of care work into their self-concept and experience intrinsic motivation at work. Care workers' internalisation then leads care workers to implement the role expectations and the meanings of care work in their care practices and experience a higher commitment and job satisfaction. Moreover, a manager's management style and management practices reflected their perceptions, views, and values of care work

that then shape, direct, foster, and maintain the care home culture and established a fundamental framework to guide care workers' care practice. In order to facilitate care workers to cope with the barriers and difficulties experienced at work and develop work identities and organisational commitment, managers may need to create a work environment which provides care workers with nutriment, such as encouraging care workers' independency in care practices and career advancement, provide consistent, positive and immediate feedback for the care practice, and foster the development of relationships between care workers, their colleagues, and residents. The findings of this thesis emphasise the importance of having the consistency in management practices which enables care workers to receive consistent feedback for their care practice, eliminates the incongruences care workers experienced between their work identities and the real job of caring, and facilitates the development and maintenance of a stable and positive care home culture. The key to having consistency in management practice is conducting management practices in accordance with the meanings and values of care work conveyed to care workers, providing feedback in accordance with the meanings and values of care work, managing the issues in a consistent, fair, and justice manner, and establishing a unified and cohesive management team.

This chapter discussed how the understandings of care workers' work identities, support needs, and work motivations presented in this thesis have the potential to inform and/or devise interventions with evidence-based information to tackle issues which may positively or negatively influence a care worker's motivation in continuing their work role. The findings of this thesis have implications for care home management, stakeholder, policymakers, and care workers and have the potential to enhance care workers' retention and wellbeing.

CHAPTER 2
LITERATURE REVIEW ON CARE WORKERS' ROLE AND TURNOVER

2.1 Introduction

The population is ageing in the United Kingdom (Age UK, 2018). Many suggest that care home settings have a significant role in meeting older people's complex care needs. Persistent high turnover of care workers in care home settings has negative impact on residents, care workers, and care homes. In this chapter, the contextual background information of care home settings in the UK will be introduced to provide a comprehensive understanding of care work that care workers carry out in these settings and to address the long-lasting issues and their impact on residents, care workers, and care homes. The literature review will also summarise the evidence on voluntary turnover and its attributes, such as organisational commitment, job satisfaction, and organisational identification while focusing on voluntary turnover in care home settings. Within this focus, the review will address care workers' motivations of carrying out their roles as care home workers, while focusing on the influences of the psychological aspect of care home context on care workers' motivation, turnover, and the attributes of turnover. This will then lead to the objectives and research questions of this thesis.

2.2 Search strategies

The aim of the literature review in this chapter was to draw on recent research to address the long-lasting issues of high turnover in care homes rather than conducting a systemic review. The literature review first focuses on the context of care work in care home settings in the UK. This includes the contextual background information of UK care homes. The following key words: 'care workers', 'care homes', 'residents', 'care practice', 'experiences', 'quality of care', and 'role' were used in combination to search the literature in five electronic databases including Social Care Online (SCIE), PsycARTICLES (Ovid), PsycINFO (Ovid), PubMed, and CINAHL Plus. The search focused on the studies published between 2000 to 2020.In addition, research conducted by charities, think tanks, or government concerning care homes was also sought. The second focus of the literature review concerned the role of care workers in providing care to residents from the admission to a care home up to the end of life. This explored care workers' role in care and the value concepts embedded in care work. The following key words: 'care worker', 'role' , 'care practices', 'value', 'personhood', 'autonomy', 'respect', 'care home', and 'nursing home' were used in combination to search the literature in five electronic databases including Social Care Online (SCIE),

PsycARTICLES (Ovid), PsycINFO (Ovid), PubMed, and CINAHL Plus. The search focused on the studies published between 2000 to 2020. Finally, the focus of the literature review moved to the long-lasting issues of high care home worker turnover and their impact on residents, care workers, and care homes. Five electronic databases including Social Care Online (SCIE), PsycARTICLES (Ovid), PsycINFO (Ovid), CINAHL Plus, and PubMed were searched. The search included the studies published from 2000 to 2020. The following key words were used in combination in searching literature, including 'care workers', 'care homes', 'turnover', 'retention', 'difficulties', and 'end-of-life care'.

The common synonyms for the terms 'care workers' were also used in searching the literatures, such as "care assistant, certified nursing assistant', 'support worker', 'care aide' and 'direct care worker'. In addition, the common synonyms for the terms 'care homes' were utilised as search terms, including "nursing home', 'residential care home', and 'long-term care facility'. The focus of this literature review was on care home settings providing care for older people. Therefore, literature focusing on homecare workers, care homes providing care for children or people with disabilities, and rehabilitation facilities were excluded. It is worth noting that the value concepts embedded in care work in care home settings were often developed in nursing or health care context and adopted and applied in the care home contexts. Thus, literature on the value concepts in health care and nursing context might be included to offer a comprehensive understanding of the significance of value concepts in care work.

2.3 What are care home settings?

Care home settings are the institutions providing long-term care in a home-like environment for older people. There are 10,722 care homes including 4,699 nursing homes and 6,023 residential care homes in the UK (Age UK, 2018). Generally speaking, there are two types of care homes: nursing home (care home with nursing care) and residential care home (care home without nursing care). Both residential care and nursing homes provide older people accommodation, social activities, and personal care to assist and support with their ADL. The main difference between residential care homes and nursing homes lies in the available levels of care. For instance, nursing homes has registered nurses (RN) on board. Therefore, residents in nursing homes receive the continuous personal care provided by care workers and nursing care from RN whereas residents in residential care homes receive nursing care from district nurses when they visit the care home.

Other types of care homes are dual-registered care homes and those that include care for dementia. The care homes with dementia care are specifically designed to provide comfort and security for older people living with dementia while dual-registered care homes are the care homes with residential care home and nursing home. Having both residential care and nursing homes in one place allows residents to receive additional nursing care once their care needs increase without having to relocate to another nursing home. Furthermore, the number of older people who would require personal care from care home settings is anticipated to increase. Researchers suggest that an additional 71,215 care home places in the UK will be required by 2025 in order to provide care for older people with substantial care needs (Kingston et al., 2017). In addition, the estimations showed that the population of older people aged 65 and over would increase 4.5 million by 2035 in England. Therefore, an additional 650,000 to 950,000 care workers will be required by 2035 in order to meet the increasing care demand (Skills for Care, 2018).

2.4 Who are the residents in care home settings?

According to Age UK (2018), 36% of older people aged between 65 and 74 have a limiting longstanding illness whereas 47% of older people aged 75 and over suffer from chronic conditions. In addition, there are 808,000 older people aged 65 and over living with dementia. Dementia is a progressive illness that is one of the main causes of disability and the leading cause of death for women in the UK (Alzheimer's Research UK, 2015). Thus, older people are more likely to suffer from chronic conditions, degenerative diseases or cognitive impairment and will require more assistance or support for their complex care needs and activities of daily living (ADL) in their later life. Older people's relatives or friends, also known as informal carers, often provide support and assistance to meet older people's care needs. Nevertheless, when older people are struggling to manage their ADL or their complex care needs cannot be sufficiently fulfilled by their informal carers, they are more likely to move to a care home (Ribbe et al., 1997).

Recent statistics showed that there were 421,100 older people aged 65 and over living in care home settings and 14.8% of the population aged 85 and over live in care homes (Age UK, 2018). Moreover, between 75% and 89% of residents in care homes have a form of dementia or severe memory problems (Alzheimer's Society, 2013; Lithgow, Jackson, & Browne, 2012; Stewart et al, 2014). Therefore, it is likely that most care home have residents living with dementia. The median period of residents' stays in a care home, from admission until their death, was around 15 months (Age UK, 2018). According to National End-of-life

Care Intelligence Network (2017), 1 in 5 people aged 75 and over died in a care home setting. A more recent government statistics stated 21.8% of deaths occurred in care home settings in England and Wales in 2016, a 5.3% increase since 2004 (Public Health England, 2018). Given that the demand for personal and nursing care and the percentage of deaths occurred in the care home settings are increasing in recent years (Public Health England, 2018), care home settings have important role in meeting older people's personal and nursing needs up to the end of life (Bone et al., 2018; Froggatt, 2001; Teno et al., 2004).

Researchers point out that older people moving into care homes often experience significant changes involving the physical environment, the routine of their daily life, and their social connections and relationships with others (Lee, Woo & Mackenzie, 2002). These changes often lead new residents to experience stress and stress-induced negative emotions during the transition period (Hodgson, Freedman, Granger & Erno, 2004; Lee, 2010). In order to eliminate the negative impact of relocation, residents may require care workers' support and a period of time for adjustment to their new living circumstances (Garity, 2006; Graneheim, Johansson & Lindgren, 2014).

2.5 What are care workers?

There are a number of job titles referring to the role of care worker in the social care sector. For instance, the term 'social service workers' is used by Scottish Social Services Council (SSSC, 2016) and 'adult social care workers' is used by the Health and Care Professions Council in England (HCPC, 2018), while 'social care worker' is used by Northern Ireland Social Care Council (NISCC, 2018) and by Social Care Wales (*Regulation and Inspection of Social Care (Wales) Act 2016*). According to the *Code of Professional Practice for Social Car*e issued by Social Care Wales (2017), social care worker is "Any paid worker contributing to the delivery of social care and support." (p. 7). Similar definition of social care workers can be found in the document *Post Registration Training and Learning (PRTL)* published by Northern Ireland Social Care Council (NISCC) (2018). In order to maintain the consistency in the use of language referring to the role of care worker in care home settings, the term 'care worker' or 'care home worker' will be used in this thesis.

2.6 Who are care workers?

According to Skills for care (2018), the majority of the social care workforce in England is female (82%) and British (83%). The mean age of care workers was 41.1 years old while 67% of care workers were aged between 25 and 54 years old and 19% of care workers were

aged 55 and over (Skills for care, 2016). Moreover, 36% of care workers had less than 2 years' care work experience and around half of senior care workers had 3 to 10 years' care work experience. Over two third of care workers achieved the Care Certificate and majority of senior care workers held the Care Certificate at level 2 or above. Care workers provide 90% of direct care to residents in care home settings (Brady, 2016; Sloane, Williams & Zimmerman, 2010) and their role is suggested as crucial in meeting residents' personal care needs up to the end of life (Bone et al., 2018; Froggatt, 2001; Teno et al., 2004) and influential in residents' wellbeing (Räikkönen, Perälä & Kahanpää, 2007; Zimmerman et al., 2005). In addition, despite the important role care workers have in providing intimate personal care to vulnerable residents and the increasing care demand for their service, care work is often considered as an unskilled job rather than a profession (The National Association of Care and Support Workers, n.d.). Scholars state that care workers often experience care work related stigma (Jervis, 2002; Pfefferle & Weinberg, 2008) and negative media representation (Kadri et al., 2018; Miller, Tyler & Mor, 2013) outside the care home while feeling their work being undervalued and underpaid in the care homes (Bjerregaard, Haslam, Mewse & Morton, 2017; Himmelweit, 2007). The median of care workers' hourly pay rate varied from £7.51 to £8.21 in England while the National Living Wage (NLW) in the United Kingdom in 2018 was £7.83 (Skills for Care, 2018). Moreover, the average hourly rate for care workers with more than 20 years' work experiences in social care sectors was £0.15 higher than the care workers with less than one year's work experience (Skills for Care, 2018). It was suggested in the report that "a challenge for employers will be continuing to reward the workers with more experience, greater responsibilities or those who are more qualified that are already paid above the NLW rate." (Skills for Care, 2018, p.75). This may be understood that the extrinsic incentives for care workers may be limited and possibly insufficient.

2.7 End-of-life care in care home settings

It is worth noting that older people who move into care homes are more likely to reach the final stage of their life and pass on in the care home as a result of being frailer and having multiple health care needs. End-of-life care in care home settings has drawn significant research attention in order to ensure the quality of care residents receive at the end of life. Nevertheless, there is no definite consensus regarding the definition of end-of-life care and the definition can differ across healthcare or social care settings and contexts (Izumi, Nagae, Sakurai, & Imamura, 2012). In general, end-of-life care is aimed at facilitating individuals who are severely ill and approaching the final stage of their life. It has been suggested that

end-of-life care should be provided to comfort the individuals and attend to their needs in accordance with their wishes (Department of Health, 2008; Kelly & Innes, 2011). In other contexts, end-of-life care can also be referred to the care provided for the individuals who are likely to die within the next 12 months (General Medical Council, 2010). While others argue that end-of-life care is the care provided for the individual in the last few hours of their life, which is often referred to as palliative care (Godwin & Waters, 2009). In care home settings, researchers suggest that end-of-life care should be considered when older people first move into a care home (Moriarty, Rutter, Ross & Holmes, 2012) and provided in an active and compassionate way for treating, comforting, supporting residents and their family members, and considering their personal, cultural and spiritual beliefs (Ross et al., 2000). The trajectory of residents' health condition may differ, and their end-of-life care needs may range from a few years to a few months or days. The definition of end-of-life care in this thesis will be conceptualised to be the care older people receive from their admission to a care home up to the final stage of their life.

2.8 Care approaches in care home settings

Ensuring the quality of care provided in care home settings is essential, especially where intimate personal care is provided to vulnerable older people (Badger, Thomas, & Clifford, 2007). Previous research points out that the care provided in care home settings should meet residents' personal care needs and attain their social, emotional and psychological needs and wellbeing (Gallagher & Krawczyk, 2013; Koren, 2010). In addition, scholars suggest there are a number of factors influencing the quality of care in care home settings including residents' autonomy and self-determination (Fetherstonhaugh, Tarzia, Bauer, Nay & Beattie, 2016; Goodman, Amador, Elmore, Machen & Mathie, 2013; Rodgers, Welford, Murphy & Frauenlob, 2012); residents' personhood (Bartlett & O'Connor, 2007; Edvardsson, Winblad & Sandman, 2008; Kim & Park, 2017; Koren, 2010); care workers providing care with dignity and respect (Kaarbø, 2011; Brazil et al., 2004); effective communications between residents, their family members, and care workers (Bailey, Murphy & Porock, 2011; Gallagher & Krawczyk, 2013; Kaarbø, 2011; Zheng & Temkin-Greener, 2010); care workers-residents ratio and staffing level (Collier & Harrington, 2008; Park & Stearns, 2009), care workers' work training and competence in providing care (Engel et al., 2006; Hasson & Arnetz, 2011; Shield et al., 2005; Smets et al., 2018; Thompson et al., 2012); care workers providing social and emotional support to residents and their families (Shield et al., 2005; Gallagher & Krawczyk, 2013); and the involvement of residents' family members in care (Levine & Zuckerman, 2000; Sudore, Casarett, Smith, Richardson & Ersek, 2014).

The majority of the factors discussed above are the key characteristics of person-centred care approach (Kitson, Marshall, Bassett & Zeitz, 2013; McCormack & McCance, 2006) and relationship centred care approach (Dewar & Nolan, 2013; Nolan, Davies, Brown, Keady, & Nolan, 2004). It is worth noting that person centred care approach is viewed by scholars and practitioners as the best practice in delivering care (Edvardsson, Fetherstonhaugh & Nay, 2010; Slater, 2006). This approach emphasises the promotion of patient's personhood in their care. McCormack and McCance (2006) proposed a four-components framework to illustrate person-centred practice comprising prerequisites, the care environment, person-centred processes, and expected outcome. The component of prerequisites refers to nurses' attributes such as their nursing competence, knowledge, communication skills, commitment, their own awareness of the role and their understanding of themselves as a person whereas the care environment focuses on the system and context of the organisation where care is provided including available facilitation for effective teamwork and shared decision-making, and organisational support. The person-centred processes are concerned with the way in which care is provided to meet patients' care needs while encouraging their involvement in their own care and ensuring their autonomy. The expected outcome is considered as the optimal results from applying person-centred nursing framework into nurses' care practices to create a therapeutic environment, relationship between nurses and patients and subsequently leads to patients' satisfaction and wellbeing in health care settings. Similarly, the significant role of effective relationship between patient and health professionals in providing person-centre care is emphasised by scholars (Kitson, Marshall, Bassett & Zeitz, 2013; McGilton & Boscart, 2007). It can be understood that care providers have an influential role in providing person-centred care to care receivers, especially care providers' awareness and understanding of their own role and self-concept at work and their relationship with care receivers have been emphasised in research on person-centred care (Edvardsson, Fetherstonhaugh & Nay, 2010; Kitson, Marshall, Bassett & Zeitz, 2013; McCormack & McCance, 2006).

The concept of person-centeredness is often applied in delivering health care (Carr & Higginson, 2001) and is adopted to provide social care to older people, especially for those living with dementia in care homes (Chenoweth et a., 2009; Edvardsson, Fetherstonhaugh & Nay, 2010; Kitwood & Bredin, 1992; Kitwood, 1997; McKeown, Clarke, Ingleton, Ryan, & Repper, 2010). It is worth noting that the environment in care home settings is significantly different from healthcare settings, especially when comparing their longevity and feature of institutionalisation. The relationships between care home workers and residents have been

described as complex and influential to both care home workers and residents personally and professionally (McGilton & Boscart, 2007). Person-centred care in care home settings often emphasise the promotion of residents' personhood, including knowing the person, providing a personalised environment, and applying flexibility and continuity in their care provision (Edvardsson, Fetherstonhaugh & Nay, 2010). It is suggested that the consistency in staffing allows the familiarity between care workers and residents which is particularly important for care workers when they utilise their knowledge and understanding about residents into their care practices (Edvardsson, Fetherstonhaugh & Nay, 2010). Stable staffing also helps care workers to build the trust and relationship with residents with dementia which is of importance in delivering person-centred care (Edvardsson, Fetherstonhaugh & Nay, 2010; McGilton & Boscart, 2007). Based on the significance of personhood in person-centred care, it is suggested that the care practices in care home settings should involves taking residents' subjective experience, social-cultural values, beliefs, and norms into consideration while creating an interactional environment for residents (Department of Health, 2001; Edvardsson, Fetherstonhaugh & Nay, 2010). It is worth noting that a person-centred care approach in care homes rarely addresses the attributes of care workers such as their awareness of the work role and their perceptions of themselves as a person in care work (Kadri et al., 2018; Pfefferle & Weinberg, 2008). It seems that McCormack and McCance's framework for person-centred care (2006) is implemented incompletely in care home settings.

To summarise, good care practices in care home settings requires care workers to have sufficient understanding and awareness of their work role and self-concept, to develop effective relationship with residents, to provide care to residents while taking residents' personhood into account and encouraging residents' involvement and participation in their own care.

2.9 Values in care practices in care homes

As previously discussed, person-centred care is considered the best care practice in meeting residents' care, emotional, and social needs. It is worth noting that there are a number of ethical values embedded in a person-centred care approach that are not explicitly addressed in the previous section including respect, dignity, autonomy, and personhood (O'Connor et al., 2007; Gallagher, Curtis, Dunn & Baillie, 2017; Kong, Fang & Lou, 2017). These values are often explored in the research of care practices and perceived as significant indicators of the quality of care in care homes and healthcare settings (Fetherstonhaugh, Tarzia, Bauer, Nay, & Beattie, 2016; Gallagher, Curtis, Dunn & Baillie, 2017; Heggestad, Nortvedt &

Slettebø, 2015; Koskenniemi, Leino-Kilpi & Suhonen, 2015; Milte et al., 2016; Nord, 2016; Tranvåg, Petersen, & Nåden, 2015). These values have also been included in the code of conduct guiding care practice in care home settings (e.g. Social Care Wales, 2017; SSSC, 2016). Notably, researchers point out that these value are often multifaceted and complex (Buron, 2008; Lohne et al., 2017) and the meanings of these concepts in care may not always be fully grasped by social and health care professionals (Gallagher, 2011; Rejnö, Ternestedt, Nordenfelt, Silfverberg & Godskesen, 2019; van Thiel & van Delden, 2001). In this section, the discussion will focus on these value concepts and their significance in care work.

According to Kitwood, personhood is defined as "a standing or a status that is bestowed on one human being, by another in the context of relationship and social being" (Kitwood 1997, p. 8). The concept of personhood has been applied to move the focus of dementia care from a biomedical approach to a person-centred care approach where the individuality of each individual with dementia is valued (Cleary & Doody, 2017; Scales, Bailey, Middleton & Schneider, 2017). Personhood can be understood as many different characteristics in relation to being an individual (Buron, 2008), such as 'reason, consciousness, self-awareness and communication, and the capability to value one's own existence.' (Gallagher, 2007, p.363). When care incorporates the concept of personhood, it is not only focusing on meeting an individual's physical needs but also concerning the individual's autonomy, empowerment, respect, and dignity (Buron, 2008; Scales, Bailey, Middleton & Schneider, 2017). In care home settings, embedding the concept of personhood is suggested as a means of moving the care practices away from routinised and task-oriented approach (Scales, Bailey, Middleton & Schneider, 2017). O'Connor and colleagues (2007) stress that research on understanding or supporting personhood in dementia care often focuses on the subjective experiences of people with dementia, their interactional environment, and/or the social-cultural context. They also point out a need to explore the ways in which the concepts of usefulness, autonomy and independence are constructed in dementia care and how these concepts influence the subjective experience of people with dementia (O'Connor et al., 2007).

Autonomy may have been perceived as interchangeable with self-determination (Ekelund, Dahlin-Ivanoff, & Eklund, 2014). However, researchers point out that there are differences between autonomy and self-determination (Schenell, Ozanne, Strang & Henoch, 2019). Self-determination is defined as "a process in which the person has control, legal and ethical rights, knowledge, and the ability to make a decision based on free choice." (Ekelund, Dahlin-Ivanoff & Eklund, 2014, p.122). Whereas autonomy refers to "the capacity of a

person to choose and act on the basis of their own preferences regarding their life and their own body." (Rejnö et al., 2019, p105). In other words, autonomy may be considered as the right to exercise self-determination where an individual's informed decision is respected (Cahill, McLoughlin, O'Connor, Stolberg & Wetherall, 2017; Sims-Gould, McKay, Feldman, Scott, & Robinovitch, 2014). Moreover, autonomy is perceived as a human right and a universal need of individuals (Boyle, 2008). However, researchers point out that older people with deteriorated mental capacity and/or physical mobility who rely on the support of others may not be able to make their own decision. Thus, their autonomy or independence may be compromised or threaten due to the limitations caused by their illness or dependence (Boyle, 2008; Hillcoat-Nallétamby, 2014; Knight, Haslam & Haslam, 2010; Schenell, Ozanne, Strang & Henoch, 2019; Wikström & Emilsson, 2014). In care homes, the significance of respecting residents' autonomy has been recognised (Heggestad, Høy et al., 2015; Sims-Gould et al., 2014) and the strategies have been devised to promote residents' autonomy (Knight, Haslam & Haslam, 2010). It is worth noting that researchers point out that the attitude of care workers and the organisational structure of care homes could have positive of negative impact on residents' autonomy (Hillcoat-Nallétamby, 2014; Oosterveld-Vlug et al., 2013; Schenell, Ozanne, Strang & Henoch, 2019) and the negative impacts can then affect or threaten residents' dignity (Hall, Longhurst & Higginson, 2009; Heggestad, Høy et al., 2015).

Despite researchers' criticism over the value of the concept of dignity (e.g. Macklin, 2003; Pinker, 2008), dignity is a significant concept in social and health care settings (Gallagher, Curtis, Dunn & Baillie, 2017; Heggestad, Høy et al., 2015; Tranvåg, Petersen & Nåden, 2015) and one of the core values of caring (Lohne et al., 2017). According to Baillie, Gallagher & Wainwright, (2008), "dignity is concerned with how people feel, think and behave in relation to the worth or value of themselves and others. To treat someone with dignity is to treat them as being of worth, in a way that is respectful of them as valued individuals." (p.8). It may be understood that an individual's experience of dignity is through the interaction between that individual and others. Tranvåg, Petersen and Nåden (2015) point out that the dignity experience of people with dementia is influenced by the interactions with others including their family, friends, and healthcare professionals. Dignity-preserving interactions include people with dementia experiencing love, affection, support, and appreciation from their family, experiencing friendship and social inclusion form their social network, and experiencing warmth, understanding, gentle, empowered and caring and being treated "as an equal human being" from healthcare professionals (Tranvåg, Petersen & Nåden, 2015).

Their findings are consonant with other research findings. For instance, Baillie, Gallagher and Wainwright (2008) stress that individuals would have a sense of being in control, valued, contented, and autonomy when experiencing dignity. Whereas individuals are likely to experience humiliation, embarrassment and discomfort when dignity is not present (Baillie, Gallagher &Wainwright, 2008). In care home context, researchers stress that good care practices involve listening to residents, paying them attention, giving them time, preserving their dignity by respecting their individuality and values (Oosterveld-Vlug et al., 2014; Thompson, McArthur, & Doupe, 2016). Given that care workers provide most of the direct and personal care to residents, they may have an important role in preserving residents' dignity by respecting residents' autonomy and personhood.

Furthermore, the value concept of respect has been applied in health care settings (Gallagher, 2007; Koskenniemi, Leino-Kilpi & Suhonen, 2013), government (Home Office, 2006), and social care settings (van Thiel & van Delden, 2001). The concept of respect seems to be closely related to the concept of autonomy, personhood, and dignity. Considering the findings of the previous research discussed above, respect may be viewed as a means of promoting residents' personhood, autonomy, and preserving residents' dignity. However, the definition of respect is not clearly stated in health or social care settings (Gallagher, 2007; van Thiel & van Delden, 2001). For instance, van Thiel and van Delden (2001) explore the concept of respect in a care home context through focusing on care workers' moral judgement in relation to the respect for autonomy. Researchers suggest that care workers' understanding of respect is multidimensional and care workers' views on whether a resident's autonomy is respected may be altered depending on the circumstances. Researchers also point out that incorporating the concept of respect for autonomy into care practices requires care workers' awareness and understanding of the value of autonomy, their caring attitude, and their engagement in building up relationship with residents (van Thiel & van Delden, 2001). Their findings imply that respect can be practised through care workers' engagement with residents and in a mutual and trusting basis. Moreover, Gallagher (2007) conceptualises the concept of respect in a nursing context as "an active value and can be conceptualized within the context of virtue ethics as a hybrid virtue having both intellectual and ethical components" (p. 360). Furthermore, Koskenniemi, Leino-Kilpi and Suhonen (2013) investigate the definition of respect from the perspectives of patients and their relatives in a Finnish acute hospital. Their findings suggest contributing factors leading patients feeling respected. These factors include positive actions and attitudes from patients'

relatives and nurses toward patients, care environment-related factors such as organisational management, nursing culture, and a thorough flow of information.

There are a number of similarities within the research findings discussed above. In regard to incorporating respect into nursing/care practices, all three studies discuss the significance of a care provider's attitude, engagement and interaction with a care recipient (Gallagher, 2007; Koskenniemi, Leino-Kilpi & Suhonen, 2013; van Thiel & van Delden, 2001). Gallagher (2007) and Leino-Kilpi and Suhonen's (2013) research focus on the ways in which nurses can incorporate the concept of respect into their nursing practices. On the other hand, van Thiel and van Delden (2001) discuss mutual respect in care home settings. It is worth noting that researchers point out that care home workers may experience a sense of being 'devalued, disrespected and disempowered' (Gray et al., 2016, p.205; Kemper et al., 2008). Researchers suggest that these feelings in care workers' may be caused by the organisational or interpersonal factors (Cooke, 2018; Cox & Mainiero, 2017; Gray et al., 2016; Pfefferle & Weinberg, 2008). However, it is unclear whether care workers' sense of being disrespected would influence their care practices, and relationship with residents or impede them from incorporating the value concepts into their care practices. Future studies may explore the influences of care workers' sense of being disrespected on the ways in which care workers incorporate the concept of respect into their care practices.

The values, including personhood, autonomy, respect, and dignity are essential qualities and indicators of the quality of care in care homes. To ensure the care quality residents received, these value concepts are required to be embedded in care provided to residents and to guide care workers' care practices. Thus, care workers may be required to understand the meanings, conceptual connections, and implications of these value concepts and to provide care to residents with respect and dignity while concerning residents' autonomy and personhood.

It is clear that care workers have a significant role in incorporating these values into the care provided to the residents. On the other hand, researchers have pointed out that care providers in care homes may encounter ethical issues or challenges when implementing value concepts into their care practices (Bollig, Schmidt, Rosland & Heller, 2015; Preshaw, Brazil, McLaughlin & Frolic, 2016; Teeri, Välimäki, Katajisto & Leino-Kilpi, 2008; van der Dam, Molewijk, Widdershoven & Abma, 2014). Researchers stress that the occurrence of an ethical challenge or issue is when a care provider might be uncertain, disagreeing or questioning whether their practice might be morally correct or good (Hem, Molewijk,

Gjerberg, Lillemoen, & Pedersen, 2018; Muldrew, Kaasalainen, McLaughlin & Brazil, 2018; Teeri et al., 2008). When care providers identified with the ethical issue and were satisfied with the outcome of the issue, they are likely to experience a sense of moral comfort. However, when care providers were dissatisfied with the outcome of the ethical issue and cannot alter or modify the outcome, they are likely to experience moral distress (Hem et al., 2018; Muldrew et al., 2018). Researchers stress that healthcare professionals working in nursing homes frequently experience ethical challenges when providing care to residents (Muldrew, Kaasalainen, McLaughlin & Brazil, 2018; Preshaw, Brazil, McLaughlin & Frolic, 2016). A number of studies have been conducted to explore the ethical challenges in nursing homes (Bollig et al., 2015; Gjerberg, Førde, Pedersen & Bollig, 2010; Hosseinabadi et al., 2019; Preshaw et al., 2016; Teeri et al., 2008; Tønnessen et al., 2016). These studies indicate that nursing home staff frequently experience the clashing of ethical principles (Gjerberg, Førde, Pedersen & Bollig, 2010; Preshaw, Brazil, McLaughlin & Frolic, 2016; Tønnessen et al., 2016).

The ethical principles may be understood as guidance for care providers to implement ethical values into their practices. Researchers suggest that these principles include care providers' duty to respect the care recipients' own decisions (autonomy), providing similar level of care to care recipients with similar needs (justice), avoiding negative outcomes or harm to care recipients (non-maleficence), and ensuring the best interests of the care recipients (beneficence) (Bollig et al., 2015; Hosseinabadi et al., 2019; Preshaw, Brazil, McLaughlin & Frolic, 2016; Tønnessen, Solvoll & Brinchmann, 2016). Preshaw et al. (2016) reviewed previous research on nursing home staff's experiences of ethical issues and suggested that many nursing home staff have experienced their ethical principles 'clashing with each other or with institutional policy' (p.4). For instance, care providers may experience difficulties in upholding residents' autonomy, especially when residents have limited or deteriorating cognition capacity to understand, retain, or use the information to make their own decisions (Bollig, Schmidt, Rosland & Heller, 2015; Muldrew, Kaasalainen, McLaughlin, & Brazil, 2018; Solum, Slettebø & Hauge, 2008). In some cases, respecting residents' autonomy may lead to undermining the residents' best interests and thus conflicting with care providers' duty of care (Preshaw, Brazil, McLaughlin & Frolic, 2016). A number of studies also reveal that nursing home staff can experience ethical issues relating to interacting and communicating with residents' next of kin (Bollig et al., 2015; Muldrew et al., 2018; Tønnessen, Solvoll & Brinchmann, 2016). Such ethical issues may be particularly prominent for nursing home staff when planning for and providing residents' end-of-life care. Bollig et

al. (2015) point out that care providers tend to reach a balance between ensuring residents' best interests and avoiding harm to residents when experiencing the clash of ethical principles. However, reaching an appropriate balance can be challenging and more complicated when a resident's next of kin interferes with the care and takes control of the resident's autonomy (Bollig et al., 2015; Tønnessen et al., 2016). Researchers stress that experiencing the conflict of ethical principles can lead care providers experiencing a higher level of burden and distress (Bollig et al., 2015; Hem et al., 2018; Muldrew et al., 2018).

Care providers working with older people in long-term care facilities can experience ethical challenges and subsequently a higher level of burden and distress. In order to better facilitate care providers to manage the ethical issues, researchers suggest that the support should be provided at the individual level (Gjerberg, Førde, Pedersen & Bollig, 2010) and at the organisational level (Bollig et al., 2015; Brodtkorb, Skisland, Slettebø & Skaar, 2017; van der Dam, Molewijk, Widdershoven & Abma, 2014). At the individual level, researchers suggest that staff need to have sufficient knowledge and understanding of the ethical challenges, be allowed time to reflect on the ethical challenges (Bollig et al., 2015; Gjerberg et al., 2010; Teeri et al., 2008), and receive support from their fellow staff who have the experience of managing the ethical challenges (Gjerberg et al., 2010). Organisational level support for staff may involve nursing homes introducing systematic ethics work to facilitate staff in managing ethical issues (Bollig et al., 2015; Brodtkorb et al., 2017; van der Dam et al., 2014), allocating time for staff's ethics discussion (Bollig et al., 2015; Gjerberg et al., 2010; Teeri et al., 2008), implementing openness in communication, and establishing routines for information sharing between care providers, residents, and relatives (Teeri et al., 2008; Tønnessen et al., 2016; van der Dam et al., 2014). It is worth noting that most of the research discussed above in relation to ethical issues in care homes were conducted in Europe and Canada and focused on the experience of nurses in care home contexts. Considering that the similarities of the care home contexts in the UK and other countries, the findings discussed above may facilitate the understanding of the ethical issues that care workers experience in UK care homes.

However, it is crucial to acknowledge the differences between nurses and care workers in terms of their level of training and the processes of their work socialisation. According to the findings of Muldrew et al. (2018), registered practical nurses (RPNs) who had relatively less training on managing ethical issues and lower position in the hierarchical structure in nursing homes seemed to experience more frequent ethical issues than registered nurses

(RNs). Their findings imply that the levels of ethical issues related training may influence the ways in which care providers manage ethical issues and subsequently impact on care providers' level of distress at work. It is worth noting that care workers often experience ethical issues in care practices and that there is no significant difference between the frequencies of ethical issues experienced by care workers and RNs (Muldrew et al., 2019). Considering that care home workers have less training than RNs, it follows that care home workers are likely to experience more difficulty in managing ethical issues. Note that in 2016, researchers were encouraging more research to be conducted to explore ethical issues experienced in nursing homes (Preshaw et al. 2016). Many of the existing studies combine both nurses and care workers (e.g. Bollig et al., 2015; Muldrew et al., 2019) or focus on nurses (e.g. Brodtkorb et al., 2017; Tønnessen et al., 2016). Thus, the findings of previous research on ethical issues experienced in nursing homes may not able to provide a comprehensive account for care home workers' experiences and support needs for managing ethical issues. Given that care home workers in the UK provide most of the direct care to residents, there may be a need to explore the ethical issues care home workers experienced, the impact of experiencing ethical issues on care home workers, and the ways in which care home workers manage the ethical issues.

2.10 Care worker's role in providing care up to the end of life

Research illustrates care workers' role in care home settings from a number of aspects, such as: facilitating residents' adjustment to the care home (Hodgson, Freedman, Granger & Erno, 2004; Lee, 2010; Lee, Woo & Mackenzie, 2002); promoting residents' personhood and continuation of self (Edvardsson, Fetherstonhaugh & Nay, 2010; McGilton & Boscart, 2007; O'Connor et al., 2007); promoting residents' autonomy and the best interests (Abrahamson, Fox, Roundtree & Farris, 2020; Cooney, Murphy & O'Shea, 2009); and providing social and emotional support for residents and their family (Brazil et al., 2004; Chan et al., 2005; Gallagher & Krawczyk, 2013; Shield et al., 2005).

Care workers who provide care for residents in a daily basis are more likely to detect residents' changing health condition and inform health professionals about residents' changes (Dobbs, Baker, Carrion, Vongxaiburana & Hyer, 2014; Holloway & McConigley, 2009) or to pick up residents' unspoken or unmet needs (Bradshaw, Playford & Riazi, 2012; Hancock, Woods, Challis & Orrell, 2006). Additionally, residents' self-determination and autonomy have significant influence on the quality of care from their entry to a care home up to the end of life (Cleary & Doody, 2017; Cooney, Murphy & O'Shea, 2009; Murphy,

Cooney & Casey, 2014; Preshaw, Brazil, McLaughlin & Frolic, 2016; Rodgers, Welford, Murphy & Frauenlob, 2012). Research points out that care workers often feel that it is their roles and responsibilities to promote the residents' autonomy (Abrahamson, Fox, Roundtree & Farris, 2020; Brownie & Nancarrow, 2013; Murphy, Cooney & Casey, 2014). Especially where dementia is an issue, care workers tend to use various methods to encourage residents to exercise their autonomy in their everyday care (Fetherstonhaugh, et al., 2016; Hancock, Woods, Challis & Orrell, 2006). It is worth noting that residents with dementia may make decisions that may be considered by some not to be in their best interests. Care workers view their role as helping residents' decision-making by providing simple and limited options in order to reach the balance between residents' autonomy and best interests (Fetherstonhaugh, et al., 2016; Smebye, Kirkevold & Engedal, 2012).

The care workers' role also involves providing the physical care for residents and offering social and emotional support for residents and their families (Bowers, Esmond & Jacobson, 2000; Bradshaw, Playford & Riazi, 2012; Shield et al., 2005; Gallagher & Krawczyk, 2013). Previous research suggests the developed relationship between care workers and residents has a positive impact on residents' quality of life, quality of care (Bradshaw, Playford & Riazi, 2012; Cooney, Murphy & O'Shea, 2009), and care workers' job satisfaction (Ball, Lepore, Perkins, Hollingsworth & Sweatman, 2009). Ball et al. (2009) point out that there is a reciprocal interaction between the care outcomes and the relationship between residents and care workers. This developed relationship influences residents' perception of care outcomes (Ball et al., 2009; Bradshaw, Playford & Riazi, 2012; Cooney, Murphy & O'Shea, 2009). It is important to note that the relationship between resident and care worker not only has an impact on the care outcome but also affects care worker's perception in terms of their work identity, their value of care, and their job satisfaction (Ball et al., 2009).

Many of the studies discussed above were conducted to explore the perspective of residents and their family on the issues of care quality, care approach, satisfaction toward the care received while fewer studies focus on care home workers' perceptions and experiences of care practice. The care workers' role is frequently indicated as important in providing person-centre care and quality care to residents. However, a care home worker's role in the person-centred care approach tend to be perceived as a facilitator or an instrument to produce person-centred care for residents, leaving the care worker's intrinsic values and contributions overlooked and/or unnoticed (Cooke, 2018; Kadri et al., 2018). Some researchers have explored the ways in which care home workers perceive and make sense of their work role

(e.g. Abrahamson, Fox, Roundtree & Farris, 2020; Gray et al., 2016; Pfefferle & Weinberg, 2008). Researchers point out that care workers perceive their role as significant and pivotal in meeting residents' care needs (Abrahamson, Fox, Roundtree & Farris, 2020; Cooke, 2018; Gray et al., 2016). Researchers suggest that care workers' perceptions regarding their role in care homes indicate that a significant part of care work is constructed through care workers' social interaction and engagement with residents (Abrahamson, Fox, Roundtree & Farris, 2020; Gray et al., 2016). On the other hand, research findings reveal that care workers often experience a sense of being devalued and unrecognised at work by their managers, residents, and/or their colleagues (Cooke, 2018; Cox & Mainiero, 2017). A study points out that care workers' personhood, value and identity are often overlooked and suggests that care workers' intrinsic value and experiences in providing person-centred care should be recognised (Kadri et al., 2018). The lack of recognition can have a negative impact of care workers' self-esteem, stress level, and wellbeing which may subsequently affect the quality of care or impede them from providing person-centre care.

To summarise, the literature on care approaches in care homes and values embedded in care work suggests that care provision is not merely meeting residents' personal care needs. Good care practice in care homes require care workers to develop effective relationships with residents and to provide care with respect and dignity while taking residents' personhood and autonomy into account. Given that care workers provide most of the direct care to residents, it may be understood that care workers have a significant role in meeting residents' care needs, promoting residents' personhood, autonomy, and independence, and offering social and emotional support for residents and residents' family. Nevertheless, the intrinsic value of care workers' roles, their personhood, and identities were often overlooked. Thus, the ways in which care workers perceive their role and how such perceptions affect their care practices remain unclear. In order to promote person-centred care and enhance care quality in care home settings, there is a need to learn about care workers' experiences and perceptions in relation to their care practices and care work.

Furthermore, there are long lasting issues of care workers' recruitment and retention in social care sectors (Glenn, 2000; Zúñiga et al., 2019). Researchers suggest that high turnover in care homes can negatively impact on care workers and care quality (e.g. Cooper et al., 2018; Woodhead, Northrop & Edelstein, 2016). In the following section, the literature review will focus on the high turnover rate in care home settings.

2.11 Turnover and its impact on care home settings

The turnover rate in care home settings in the UK ranges from 3% to 120% with the average turnover being 24% in 2016 and increasing to 33.8% in 2017 (Skills for Care, 2016; Skills for Care, 2018). According to Skills for Care (2016), 47.8% of novices left the social care sector within one year. On the other hand, many care workers who left their jobs did not leave the social care sectors as 67% of recruitment in social care sectors had previous care work experience within the sectors (Skills for Care, 2018). Considering the training that care homes invested in care workers and the relationship developed between care workers and residents, improving care workers' retention in the care home is essential. Furthermore, the average workforce vacancy rate in social care sectors in England was 7.8%, equivalent to 122,000 vacancies (Skills for care, 2019). Researchers point out that many care homes encounter high care workers turnover and understaffing (Castle, 2007; Castle & Engberg, 2006; Glenn, 2000; Pillemer et al., 2008; Skills for Care, 2017). High care workers turnover and care home understaffing have been found to have a negative impact on (a) care workers (Bishop, Squillace, Meagher, Anderson & Wiener, 2009; Dhain et al., 2016); (b) quality of care residents received (Cooper et al., 2018; Suhonen, Charalambous, Stolt, Katajisto & Puro, 2013; Woodhead, Northrop & Edelstein, 2016; Zúñiga et al., 2015); and (c) economic costs for care homes (Bishop, Squillace, Meagher, Anderson & Wiener, 2009).

New care workers working in a care home with a high turnover rate may have a limited understanding of residents' preferences and routine. This could have a negative impact on the provision of person-centred care (Edvardsson, Fetherstonhaugh & Nay, 2010; McGilton & Boscart, 2007). Moreover, researchers point out that sufficient staffing would facilitate care workers to build the relationship with residents and subsequently enhance the care outcome (Cooney, Murphy & O'Shea, 2009; Räikkönen, Perälä & Kahanpää, 2007). In contrast, when care workers work under staff shortages, they have insufficient time to meet residents' care needs and to develop the meaningful bond. This undermines the quality of care that residents received (Cooper et al., 2018; Mittal, Rosen & Leana, 2009; Woodhead, Northrop & Edelstein, 2016) and negatively impacts on care workers' stress level and wellbeing (Daly & Szebehely, 2012; Elstad & Vabø, 2008). Furthermore, poor staff retention can lead the serious financial problems to care homes (Hillman & Foster, 2011; Pillemer et al., 2008). High care worker turnover rate resulted in insufficient staffing in care home settings. In order to provide quality care for residents, care home management is required to provide an adequate staff-resident ratio and prepare new care workers with appropriate knowledge and skills to look after residents. Therefore, when a care home has a high turnover,

the management is forced to spend a higher amount of their budget in recruitment and training (Castle & Engberg 2005; Mittal, Rosen & Leana, 2009; Pillemer et al., 2008). When human resource budgets are fixed, an increased spending on recruitment and initial training can affect the available budget for continuous training and improvement for the quality of care provision (Mittal, Rosen & Leana, 2009). Care workers' workload tends to increase when working in a care home with high turnover which, in turn, can reduce their efficiency, increase their stress level and experience higher job burnout (Castle & Engberg, 2005; Pillemer et al., 2008). Care workers under severe pressure and burnout are more likely to leave their current position in the care homes (Pillemer et al., 2008).

2.12 What we know about turnover in care home settings

A number of studies have been conducted to explore the contributing factors of care home workers' turnover and retention (e.g. Clausen, Hogh, Carneiro & Borg, 2013; Costello, Cooper, Marston & Livingston, 2020; Mittal, Rosen & Leana, 2009; Pillemer et al., 2008). The potential contributing factors or antecedents include job satisfaction (Chamberlain et al., 2017; Karsh, Booske & Sainfort, 2005), burnout (Costello et al., 2020; Yasin, Razak, Hasbollah & Mohammad, 2018), stress (Elstad & Vabø, 2008; Hasson & Arnetz, 2008; Rajamohan, Porock & Chang, 2019), care home management (Berta et al., 2018; Hurtado, Berkman, Buxton & Okechukwu, 2016; Manthorpe, 2014), care workers' psychological wellbeing (Clausen, Hogh, Carneiro & Borg, 2013), and organisational commitment (Gaudenz, De Geest, Schwendimann & Zúñiga, 2019; Grødal, Innstrand, Haugan & André, 2019). Care home worker turnover is complex and multifactorial issue (Mittal, Rosen & Leana, 2009) and tackling the issue of care worker turnover cannot only focus on one construct. Researchers have developed various models to investigate the relationships between care workers turnover and its predictors or antecedents (e.g. Gaudenz, De Geest, Schwendimann & Zúñiga, 2019; Grødal, Innstrand, Haugan & André, 2019; Karsh, Booske & Sainfort, 2005; Ravenswood, Douglas & Haar, 2017; Yasin, Razak, Hasbollah & Mohammad, 2018).

For instance, Karsh, Booske and Sainfort (2005) develop a model named 'General model of nursing staff turnover' based on the Price and Mueller model (1981) and other empirical studies. Their model includes care work characteristics and work environment, care workers' involvement of quality improvement and care workers' subjective perception of how caring the organisation is towards their workers to predict care workers' organisational commitment, job satisfaction, and turnover intention. Their findings show that care workers' turnover

intention is attributed to organisational commitment and job satisfaction (Karsh, Booske & Sainfort, 2005). Such findings are also supported by other researchers (Bishop, Squillace, Meagher, Anderson & Wiener, 2009). In addition, scholars point out that job satisfaction and organisational commitment are strongly related to better care practices and quality of care (Hasson & Arnetz, 2008). However, there are a few issues within Karsh, Booske and Sainfort's model (2005) which may impact on its ability to predict care workers' organisational commitment and the understanding of care workers' motivations at work. First, they were originally examining the relationship between job satisfaction, organisational commitment, and turnover intention. However, they replaced the organisational commitment with organisational identification in their model after analysing the data and claimed that organisational identification is equivalent to affective commitment. This raises a question regarding the definition of attributes and endogenous variables in the model and other research on employees' organisational commitment, organisational identification, and job satisfaction. For instance, Karsh, Booske and Sainfort (2005) adopt Cook and Wall's (1980) view on the concept of organisational commitment which is comprised of three distinguishable components, namely identification, involvement, and loyalty. Karsh, Booske and Sainfort (2005) initially used the measure of involvement and identification to reflect organisational commitment but removed the construct of involvement afterwards due to its poor reliability. They further stated that the measure of organisation identification reflects the concept of affective commitment addressed in Allen and Meyer's work (1990). This raises another question of the relationship between organisation identification and affective commitment, whether they are the same constructs or related. If so, what is the reason for using organisational identification rather than affective commitment in Karsh, Booske and Sainfort's model (2005)? It is worth noting that many scholars agree that organisational commitment and organisational identification both reflect individuals' psychological relationship with the organisation they work for. Nevertheless, these two constructs are different but related (Stinglhamber et al., 2015; Van Knippenberg & Sleebos, 2006). Stinglhamber et al. (2015) demonstrate that affective commitment mediates the relationship between employees' organisational identification and turnover. Thus, Karsh, Booske and Sainfort's model (2005) may have offered an insightful account for the attributes of care workers' job satisfaction and its relationship with turnover intention. However, the ambiguity in defining the construct of organisational commitment and organisational identification may cause the difficulties in revealing the attributes of organisational commitment and to interpret its role in relation to care workers' turnover intention.

Secondly, Karsh, Booske and Sainfort's model (2005) largely focuses on demographic characteristics, job characteristics, and organisational factors. They also focus on how certain aspects of care work influences care workers' organisational commitment, job satisfaction, and turnover intention, such as quality improvement, able to do job independently, role conflict, and role ambiguity. It is worth noting that listing specific tasks may help care workers to reflect the constructs and allow them to express an evaluation of their job in certain aspect. However, this may also exclude other aspects of the care work rather than provide a universal perspective of their work experience. Moreover, many attributes in their model may be explained using the concept of satisfaction of psychological needs, such as need for autonomy, competence, and relatedness (Deci & Ryan, 2000; Huyghebaert, Gillet, Fernet, Lahiani & Fouquereau, 2018). For instance, 'able to do job independently' may refer to care workers' autonomy at work whereas 'perceived caring of the facility' may refer to their need of relatedness. Therefore, it may be worth examining the effects of care workers' universal psychological needs on their organisational commitment and job satisfaction. Lastly, in recent years, there is more research attention drawn to explore the influences of care workers' psychosocial factors on predicting organisational commitment, job satisfaction, and turnover intention. Some researchers view the psychosocial factors as the attributes of care workers' job satisfaction and organisational commitment (e.g. Bishop et al., 2009). Karsh, Booske and Sainfort (2005) also suggest that the psychosocial factors may have important role in predicting care workers' job satisfaction, organisational commitment, and turnover intention. However, the psychosocial factors were not included in their model. Thus, the extent to which care workers' psychosocial factors attribute to their organisational commitment, job satisfaction, and turnover intention remained unclear and require further investigation. Despite the issues regarding Karsh, Booske & Sainfort's model (2005) discussed above, their findings provide evidence to identify the effective predictors of care workers' job satisfaction and organisational commitment. Their findings may point to the motivators for care home workers carrying on their work role.

Moreover, a number of researchers have adopted the job demands-resources (JD-R) model (Bakker & Demerouti, 2007) to investigate the issues relating to care home worker turnover and care work performance (e.g. Grødal, Innstrand, Haugan & André, 2019; Ravenswood, Douglas & Haar, 2017; Yasin, Razak, Hasbollah & Mohammad, 2018). For instance, Yasin, Razak, Hasbollah and Mohammad (2018) build a model encompassing job demands, social support, and burnout to predict nursing home staff's turnover intention. Bakker and Demerouti (2007) adopt the notion of self-determination theory (SDT) (Deci & Ryan, 2000)

to build the job demands-resources (JD-R) model with dual processes. The JD-R model includes job demands and job resources as the contributing factors of stress and motivation respectively which influence employees' organisational outcomes and performances. It is suggested that job resources would moderate the development of job strain caused by job demands while job demands could impede the motivation engendered by job resources. In JD-R model (Bakker & Demerouti, 2007), job demands are defined as 'those physical, psychological, social, or organizational aspects of the job that require sustained physical and /or psychological (cognitive and emotional) effort or skills' (p. 312). Bakker and Demerouti (2007) conceptualise job demands as role stressors which are induced by the expectations or duties of the role employees undertake (Cooper, Dewe & O'Driscoll, 2001; LeRouge, Nelson & Blanton, 2006; Manning & Preston, 2003). Bakker and Demerouti, (2007) argue that job demands may not be negative. However, job demands can have serious impacts on employees when it is perceived as unmanageable or exceedingly high (LeRouge, Nelson & Blanton, 2006). On the other hand, job resources refer to the 'physical, psychological, social, or organizational aspects of the job' that facilitates employees to achieve their work goals, to minimise the impact of job demands, and to advance in personal growth and career (Bakker & Demerouti, 2007). This includes support, autonomy, relatedness, feedback, learning, and work environment. The JD-R model provides insightful accounts for the interaction and relationships between job demands, job resources, work strain, motivation, and organisational outcomes. However, there are a number of issues in relation to the JD-R model.

First, despite Bakker and Demerouti (2007) adopting the notion of SDT in the JD-R model, the conceptualisation of the constructs in the model relating to SDT is different from SDT. For instance, Bakker and Demerouti (2007) conceptualise job resource as having both intrinsic and extrinsic motivational potential, facilitating employees to experience the satisfaction of basic human needs, and motivating employees' engagement and commitment. It is worth noting that SDT suggests the satisfaction of psychological needs as the nutriment for individuals to internalise the external values and regulations and to experience more intrinsic or autonomous motivation. However, in the JD-R model, the satisfaction of psychological needs seems to be conceptualised as a motivator which encourages employees' engagement and commitment. Moreover, SDT suggests that individuals have intrinsic or extrinsic motivation which energises and directs individuals to maintain a behaviour or to engage in activities, tasks or performance. SDT also argues that there is a distinction between intrinsic and extrinsic motivation where intrinsic motivation is considered better-quality

motivation in comparison to extrinsic motivation (Ryan & Deci, 2000). However, motivation in the JD-R model refers to employees' engagement and commitment which then leads to positive organisational outcomes and performances while the quality of motivation was not addressed or discussed. Considering the nature of extrinsic motivation, employees are more likely to withdraw from the tasks or become passive in the absence of external motivator or incentives (Ryan & Deci, 2000; Ryan & Deci, 2003). However, the JD-R model may not be able to explain the level of adherence of employees' engagement and commitment.

Second, the important assumption of the JD-R model is that 'every occupation may have its own specific risk factors associated with job stress, these factors can be classified in two general categories (i.e. job demands and job resources)' (Bakker & Demerouti, 2007, p.312). This may be understood that the categories of job demands and job resources are independent from one another. However, it is possible that the differences between job demands and job resources may result from the extent of a certain factor. For instance, in the care home context, a close relationship between a care worker and a resident may be classified into the category of job resources because such relationship may satisfy the care worker' relatedness need. However, such close relationships may lead the care worker to encounter the ethical issues in relation to attachment or justice. In this case, such close relationship may be classified into the category of job demands. However, the JD-R model did not address the issues in relation to identifying which factors in what extend should be classified into the category of job demands or job resources.

Furthermore, the JD-R model has been adopted in studies investigating care workers' turnover and care work performances (e.g. Grødal, Innstrand, Haugan & André, 2019; Ravenswood, Douglas & Haar, 2017; Yasin, Razak, Hasbollah & Mohammad, 2018). In the research of Grødal et al., (2019), Ravenswood et al. (2017) and Yasin et al. (2018), they develop models using the concept of job demands and job resources but investigate different aspects of job demands. For instance, both Grødal et al., (2019) and Ravenswood et al. (2017) investigate the impact of emotional demands on care workers. However, Ravenswood et al. (2017) focus on more specific aspect of emotional demands including the physical or verbal abuse, and racial discrimination that care workers may have experienced, whereas Grødal et al., (2019) look at care workers' emotional demands in a more general sense. In addition, Yasin et al. (2018) explore the quantitative demand referring to time pressure, work conflict, and excessive workload, and attention demand including job monitoring. Moreover, these three studies include different aspects of job resources, such as autonomy, supervisor support

and social community at work (Grødal et al., 2019), social support (Yasin et al., 2018), and training (Ravenswood et al., 2017). The findings of these three studies demonstrate the applicability of the JD-R model in care home contexts, despite the fact they examine different aspects of job demands and job resources. Their findings (Grødal et al., 2019; Ravenswood et al., 2017; Yasin et al., 2018) demonstrate that the JD-R model provides a framework with flexibility allowing researchers to explore relevant risk factors in care home contexts and emphasise the significance of providing sufficient job resources to care workers to eliminate the negative impact of excessive job demands. It is worth noting that their models did not indicate the most prominent job demands or most effective job resources because specific aspects of job demands and job resources have been included in their model. Although these three studies provide evidence to explain the impact of different types of job demands and job resources on care workers' turnover and care practices, the findings of individual study may not be able to provide a comprehensive account for care workers' support needs.

To sum up, research has been conducted to explore the predictors and/or antecedents of care workers' turnover and retention in order to tackle the issues of high care work turnover and understaffing. A number of models have been developed to explore the relationships between care workers turnover and its predictors and/or antecedents as well as to provide evidence for developing interventions for enhancing care home workers' retention. The strength and limitations of the previous models have been discussed above (e.g. Bakker & Demerouti, 2007; Grødal et al., 2019; Karsh et al., 2005; Ravenswood et al., 2017; Yasin et al., 2018). Considering the limitations of these models, a qualitative study exploring care workers' work experiences and support needs may be required in order to develop a theory-based new model incorporating care workers' psychosocial factors to further our understanding of care workers' motivations in continuing their role as a care worker.

2.13 Care home workers' motivations of carrying on their role

In a care home context, scholars explored the potential motivators or significant attributes which encourage care workers to continue in their role as a care worker. Their findings suggest the significant influences of care workers' retention include extrinsic incentives and reward (Wiener, Squillace, Anderson & Khatutsky, 2009) and psychosocial factors, such as care workers' sense of being valued and respected (Bishop et al., 2009; Bowers, Esmond & Jacobson, 2000; Coogle, Head & Parham, 2006; Mittal, Rosen & Leana, 2009; Sikorska-Simmons, 2005) and work strain (Ravenswood, Douglas & Haar, 2017; Yasin et al., 2018),

adequate management and training (Coogle, Head & Parham, 2006; Menne, Ejaz, Noelker & Jones, 2007), organisational support (McGilton, Hall, Wodchis & Petroz, 2007), effective working relationship (Decker, Harris-Kojetin & Bercovitz, 2009) care workers' self-esteem (Coogle, Parham & Young, 2007), and job satisfaction (Decker, Harris-Kojetin & Bercovitz, 2009; Hasson & Arnetz, 2008; Karsh, Booske & Sainfort, 2005; Pitfield, Shahriyarmolki, & Livingston, 2011).

These findings contribute to the understanding of care workers' retention in three different aspects. Firstly, care workers' turnover and retention may be seen as a consequence of a dynamic system or process where different factors may interact with one another to motivate or demotivate care workers at work. For instance, care workers' turnover intention may be increased when they experience being undervalued (Bowers, Esmond & Jacobson, 2000; Mittal, Rosen & Leana, 2009) and decreased if they experience positive work morale or have close relationships with colleagues and residents (Mittal, Rosen & Leana, 2009; Robison & Pillemer, 2007). Given that care workers may experience being undervalued and have close relationships with colleagues and residents at the same time, investigating the effective motivators or influential factors for care home workers' retention may be required.

Secondly, many factors mentioned above reflect the psychological perspective of care home workers' needs at work. For instance, the influence of care workers being valued suggests a need for recognition and appreciation whereas effective working relationship points to a need for meaningful bond and connection with residents, colleagues, and managers. Thus, these psychological factors may indicate care workers' particular needs which may be explained by three basic psychological needs: need for autonomy, competence and relatedness (Deci & Ryan, 2000; Huyghebaert, Gillet, Fernet, Lahiani & Fouquereau, 2018). Some researchers assume that individuals' needs generate a motivating force which directs individuals' behaviour (e.g. Herzberg, 1968; McClelland, 1987), whereas self-determination theory suggests that the satisfaction of three basic psychological needs within the social environment functions is a nutriment which facilitates individuals to internalise the external regulations and actualise intrinsic motivation (Gagné & Deci, 2005). Thus, the research findings discussed above may also imply that the social contexts in care homes plays an important role in shaping care workers' motivation in staying in their current position in the care home. However, to what extent care workers' needs and the social context in care homes associate with or mediate other attributes in predicting retention or turnover remain unclear. In addition, many studies imply care home managers may have a significant role in attending

to care workers' needs at work. In organisational studies, scholars point out that managers have an important role in creating, developing, and shaping organisational culture (Carney, 2006; Kane-Urrabazo, 2006; Martins & Terblanche, 2003) and implementing organisational goals (Huhtala, Feldt, Hyvönen & Mauno, 2013). Thus, it may point to a need to explore the way in which care home managers support their staff, attend staff's needs, and achieve the care home's goals.

Lastly, many of the studies mentioned above point to the role the care workers' expectations have towards their job. For instance, care workers may expect certain levels of organisational support at work. When the support care workers received from managers did not meet their expectation, they might perceive it as a lack of organisational support. It is worth noting that care workers' expectation towards the job may involve their personal beliefs, values, and perceived meaning of care work. However, scholars have pointed out that care home workers' perceptions of their work role, meaning-making, identity and personhood are often overlooked and under-researched (Kadri et al., 2018; Pfefferle & Weinberg, 2008). Thus, exploring care workers' perceptions of their role may help to understand their expectation and to further our understanding of their job satisfaction, organisational commitment, and turnover intention.

To sum up, good care practice in care home settings requires stable staffing and care workers' involvement and participation. However, care work is recognised as a job with low pay, limited material incentive and, quite often, care workers experience negative media representation and care work related stigma. The long-lasting issues of high turnover and understaffing undermine the care quality, negatively impact residents, care workers and care homes. Previous research has suggested a number of psychosocial factors contributing to care workers' retention. Based on those findings, a few research gaps emerge: to what extent is each motivator or factor important or significant in encouraging care workers to remain in their work role? To what extent does the social context in care home settings influence care workers' motivation? To what extent care home managers can influence or foster the social environment in care homes and how their role facilitates care home workers' motivation? What is care workers' perceptions of their work role? To what extent do care workers' perceptions of their role influence their motivation? Filling these research gaps potentially furthers our understanding of care workers' motivation towards remaining in their work role.

It is worth noting that the literature concerning care workers' work roles, care practices, and motivations of retention implies the care home manager plays a significant role in supporting care workers at work. The next section will focus on what is known about the role of care home managers in previous research.

2.14 The role of care home management

As mentioned previously, care workers may experience difficulties or challenges at work which can impede their good care practice or negatively influence their psychological and physical wellbeing. Researchers stress the importance of having supportive supervisors and adequate management to help care workers deal with the difficulties associated with working in a care home (Berta et al., 2018; Hurtado, Berkman, Buxton & Okechukwu, 2016; Dhaini et al., 2016; Manthorpe, 2014; Virdo & Daly, 2019). Moreover, unlike other healthcare professionals, the majority of care workers learn about the relevant knowledge, skills, role, responsibilities and norm after they have started working in a care home (Cohen-Scali, 2003; Zarshenas et al., 2014). Thus, care workers' experience and perceptions of care work are likely to be influenced by the care home training, value and culture. In addition, a number of studies investigate the effectiveness of the interventions on care workers' training (Coogle, Head & Parham, 2006; Harrisson, Loiselle, Duquette & Semenic, 2002; Lawrence, Fossey, Ballard, Moniz-Cook & Murray, 2012; Stolee et al., 2005). These findings point to the significant role of care home management in facilitating and implementing care workers training in their care practice. Moreover, research findings suggest that care workers who receive adequate training are likely to experience better job satisfaction which can subsequently facilitate the reduction in turnover (Coogle, Head & Parham, 2006; Kim, Wehbi, DelliFraine & Brannon, 2014; Menne, Ejaz, Noelker & Jones, 2007). This suggests care workers who are equipped with adequate knowledge and skills will be better able to deliver quality care and also find work easier and more reassuring. In some cases, scholars point out that care workers' confidence was enhanced through the process of empowering staff at work (Yeatts, Shen, Yeatts, Solakoglu & Seckin, 2016) and taking shared responsibilities (Barry, Brannon & Mor, 2005; Colón-Emeric et al., 2006; Corazzini et al., 2014).

Furthermore, many researchers state that care home managers act as the foundation of the quality of care because they have the power to foster a positive care home culture (André, Sjøvold, Rannestad & Ringdal, 2014; Jeon, Merlyn & Chenoweth, 2010; Toles & Anderson, 2011), support their staff to make sense of their work experience (Gittell, Weinberg, Pfefferle

& Bishop, 2008), to provide a positive work environment (Berta et al., 2018; Chamberlain, Hoben, Squires & Estabrooks, 2016; Dhaini et al., 2016; Gaudenz, De Geest, Schwendimann & Zúñiga, 2019; Grødal, Innstrand, Haugan & André, 2019), and transmit the tacit and explicit values of the care work in the care home (Lopez, 2006; Pfefferle & Weinberg, 2008).

It is worth noting that care home managers' style can influence the extent to which their care workers perceive independence and autonomy in their care practices (Bowers, Esmond & Jacobson, 2000; Kemeny & Mabry, 2017; Kjøs, Botten, Gjevjon & Romøren, 2010; Leutz, Bishop & Dodson, 2009). Other researchers point out that a top-down or punitive management style has an adverse effect on the relationship between care home managers and care workers and the quality of care (Colón-Emeric et al., 2006; Scott-Cawiezell et al., 2006; Swagerty, Lee, Smith & Taunton, 2005). Kim, Wehbi, DelliFraine & Brannon (2014) further suggest that the organisational structure of a care home influences the care workers' level of job satisfaction and intent to leave. They investigate the relationships between care workers' job satisfaction and intent to leave and different organisational structures of care homes. Their findings stress that care workers are more likely to experience higher job satisfaction and have lower intent to leave if they work in a care home with a decentralised and less formalized organisational structure, while receiving a high level of training and being encouraged to communicate with their fellow care workers and management. This suggests that care homes with a decentralised and less formalized organisational structure enables care workers' autonomy at work while empowering them by providing a high level of training and providing support through effective communication. Furthermore, Gaudenz, De Geest, Schwendimann and Zúñiga, (2019) adapted Cohen-Mansfield's circular model of decision to leave (1997) and investigated the influences of the work environment (e.g. leadership, staffing and resources), work stressors (e.g. stress, workload, lack of preparation), and care worker outcome (e.g. emotional exhaustion, health problem, and affective organisational commitment) on care worker turnover intention. Their findings point out that the leadership practices in nursing homes influences staff turnover. Specifically, where nursing home management facilitated their staff in decision making, encouraged staff to learn and improve care practices from the mistakes staff made, acknowledged staff's efforts and hard work, empowered staff to develop meaningful relationship with residents, their care workers had lower turnover intention (Gaudenz et al., 2019).

Toles and Anderson (2011) suggest care workers' effective interdependence is important for providing quality care for residents in care home settings. In care home contexts, effective

interdependence refers to care workers' abilities to adjust their care practices to the situation and other's work in order to enhance group effectiveness. Such effective interdependence is suggested as a reciprocal adjustment among care workers and effective communication and teamwork are essential for achieving effective interdependence (Toles & Anderson, 2011). The importance of having effective communication between care workers and the care home management have been widely proposed (Hughes & Lapane, 2006; Scott-Cawiezell et al., 2006; Zheng & Temkin-Greener, 2010). However, some researchers point out that care home management and care workers may have different perceptions about the efficiency of the communication between them (Forbes-Thompson, Gajewski, Scott-Cawiezell & Dunton, 2006; Scott-Cawiezell et al., 2004) which can cause negative impact on care quality (Berta et al., 2010; Bowers, Esmond & Jacobson, 2000; Scott-Cawiezell et al., 2006; Zheng & Temkin-Greener, 2010). Researchers indicate that there is a need for care home management to establish a close relationship with care workers in order to enhance their communication, empower care workers in decision-making, and foster social interaction in the care home (André, Sjøvold, Rannestad & Ringdal 2014; Toles & Anderson, 2011).

To sum up, most of the previous research discussed in this section often focuses on the relationship between care workers' care practices and care home management. However, less focus has been placed on care home managers' perceptions and values of care work and this may be a contributing factor of care home management. For example, while researchers such as Gaudenz and colleagues (2019) and Kim and colleagues (2013) have discussed the significance of managers empowering care workers, less attention has been placed on the extent to which care home managers perceive care workers' support needs and expectations of career advancement. Thus, whether managers' perceptions of care workers' support needs and expectations would influence their managerial practices and care workers' job satisfaction and care practices remains unclear. Given that researchers have suggested that care home managers have a significant role in supporting care workers, investigating managers' values of care work and perceptions of care workers' needs may have the potential to further our understanding of care workers' experiences, care practices, and motivations of staying employed.

2.15 Conclusion

Care work is considered as a job with low pay and limited material incentive. Nonetheless, care workers have important role in meeting residents' complex care need up to the end of life. In this chapter, care workers' role and the influences of their work difficulties have been

discussed. The long-lasting issues of high turnover and understaffing undermine the care quality, negatively impact residents, care workers and care homes. The literature reviews imply that there is a need to explore care workers' experience and perceptions towards their work role and what motivates, encourages or facilitates them to continue in their role.

CHAPTER 3
LITERATURE REVIEW ON ATTRIBUTES RELATING TO TURNOVER

3.1 Introduction

A number of organisational studies have demonstrated that organisational commitment and job satisfaction are two strong predictors of turnover intention (e.g. Lambert, & Hogan, 2009; Kim, Price, Mueller & Watson, 1996; Mor Barak, Nissly & Levin, 2001). Whereas other constructs have also been suggested as antecedences of turnover intention, job satisfaction and organisational commitment, such as self-esteem (Johnson, Morgeson, Ilgen, Meyer & Lloyd, 2006; Van Knippenberg & Van Schie, 2000), self-efficacy (Vignoles, Regalia, Manzi, Golledge & Scabini, 2006), and identification (Smith, Amiot, Callan, Terry & Smith, 2012; Van Dick et al., 2004). Given that research on care home settings has suggested the influence of care workers' job satisfaction and organisational commitment on care quality and care workers' wellbeing (Hasson & Arnetz, 2008). It can be assumed that the constructs of organisational commitment and job satisfaction are appropriate to be the indicators of care home workers' motivation of remaining in their current position in care homes. Thus, in this thesis, care workers' organisational commitment and job satisfaction are conceptualised as the indicators for whether they are being motivated to continue in their care worker role.

The literature review on care worker turnover in chapter 2 points to a need to clarify the definition of constructs relating to or predicting turnover intention prior to studying the subject of motivating care home workers to continue their work role. For instance, what indicators can be effectively used to distinguish whether care home workers are being motivated to remain in care work and how are those indicators defined and measured? Applying an unclear or ambiguous definition of the constructs may lead to difficulties in interpreting their roles in relation to care worker turnover intention or furthering our understandings of care workers' motivation in remaining employed. In this chapter, the definition of job satisfaction, organisational identification, and organisational commitment will be presented and clarified. The antecedences or predictors of these three constructs, their relationships with one another, and the comparisons between them will also be discussed.

3.2 Search strategies

In this chapter, the literature review focuses on the concepts and definitions of job satisfaction, organisational identification, and organisational commitment. The five electronic databases searched were Social Care Online (SCIE), PsycARTICLES (Ovid),

PsycINFO (Ovid), CINAHL Plus, and PubMed. The search included studies published from 2000 to 2020. In order to grasp a full understanding of the definition of aforementioned concepts, literature published before 2000 were also included in this chapter. The following key words were used in combination in searching literature, including 'job satisfaction', 'organisational commitment', 'organisational identification', 'identity', 'identification', 'self-esteem', 'self-efficacy', 'care work', 'care work', 'retention', and 'turnover'.

3.3 What is job satisfaction?

Care workers' job satisfaction has been acknowledged as an important factor in the quality of care for older people in care home settings (Hasson & Arnetz, 2008; Karsh, Booske & Sainfort, 2005 Suhonen, Charalambous, Stolt, Katajisto & Puro, 2013). Care workers with greater job satisfaction were likely to experience less work stress and burnout (Castle & Engberg, 2005; Pillemer et al., 2008) and more likely to stay in the current position (Coogle, Head & Parham, 2006; Menne, Ejaz, Noelker & Jones, 2007). However, previous research often treats the concept of job satisfaction as a well-known construct with a widely agreed definition. In fact, scholars define job satisfaction from the perspective of affective reaction (Cranny, Smith & Stone, 1992) while others view job satisfaction as individuals' attitude toward their job (Brief, 1998; Miner, 1992; Weiss, 2002). According to Cranny, Smith, and Stone (1992), job satisfaction is defined as ''an affective (that is, emotional) reaction to one's job, resulting from the incumbent's comparison of actual outcomes with those that are desired (expected, deserved, and so on.)'' (p. 1). Thus, job satisfaction involves individuals' affective reaction in relation to the congruency between the expectation at work and received outcome. This affective reaction can be positive or negative. This may imply that an individual's negative affective reaction leads low job satisfaction. On the other hand, Locke (1969) conceptualised job satisfaction and dissatisfaction with a dual definition: ''pleasurable emotional state resulting from the appraisal of one's job as achieving or facilitating one's job values. Job dissatisfaction is the unpleasurable emotional state resulting from the appraisal of one's job as frustrating or blocking the attainment of one's values'' (p. 317). Locke's definition involves individuals' attitude achievement at work, personal values and feelings and implies that the lack of job satisfaction is not equivalent to job dissatisfaction.

Many scholars view job satisfaction as an attitude and define it as a positive or negative evaluative judgement that an individual has toward their job or the situation at work (Brief, 1998; Miner, 1992; Weiss, 2002). It is worth noting that some claim that an attitude is

equivalent to affective reaction when referring to job satisfaction (Hulin, 1991; Locke, 1976). However, some other researchers argue that an attitude is not affective reaction (Crites et al., 1994; Eagly & Chaiken, 1993; Weiss, 2002). An attitude, which refers to a conclusive evaluation of an object (e.g. a person, organisation, an issue, or a situation), is often directed by individuals' beliefs towards the object. Whereas individuals' affective reaction may be influenced by the situation or behavioural consequences at the time (Weiss, 2002). In the concept of job satisfaction, an attitude refers to individuals' judgement or evaluation towards their job which may be directed by their beliefs. Such judgement or evaluation may arouse individuals' emotional reaction while in some cases, individuals' affective reaction s can have a long-term influence on their evaluative judgement toward their job. Thus, the conceptualisation of job satisfaction can be seen as comprising individuals' personal beliefs, evaluative judgement, and affective reaction. Weiss (2002) suggests that it is important to distinguish these three constructs when measuring job satisfaction. In this thesis, the definition of job satisfaction is adopted from Weiss (2002) where it is conceptualised as an attitude involving individuals' judgement or evaluation towards their job which may be directed by their beliefs.

Many studies on job satisfaction use various measures to reflect employees' job satisfaction, such as the Minnesota Satisfaction Questionnaire (MSQ; Weiss, 1967), Job Descriptive Index (JDI; Smith, Kendall & Hulin, 1969), and the nursing home certified nurse assistant job satisfaction questionnaire (NH-CNA-JSQ; Castle, 2007) For instance, MSQ (Weiss, Dawis & England, 1967), which comprises 20 facets of job satisfaction, is used to measure intrinsic and extrinsic job satisfaction. MSQ has been used in the research on care workers (Coogle, Parham & Young, 2007; Karsh, Booske & Sainfort, 2005), human resource (Buitendach & Rothmann, 2009; Edgar & Geare, 2005), restaurant staff (Hancer & George, 2003), and teachers (Reyes & Shin, 1995). It is worth noting that some researchers argue that some existing measures of job satisfaction applied in care home context did not yield satisfactory performance (Castle, Engberg & Anderson, 2007). According to Castle (2007), this may result from the lack of care work characteristics in these existing job satisfaction measures.

There is a considerable amount of research focusing on care workers' job satisfaction in care home contexts. For instance, researchers stress that care workers' low job satisfaction has a negative impact on the provision of person-centred care (Suhonen, Charalambous, Stolt, Katajisto & Puro, 2013). In order to enhance care workers' job satisfaction, researchers have

investigated care workers' demographic characteristics and personal attributes (e.g. age, gender, and marital status; Hebson, Rubery & Grimshaw, 2015; Karsh, Booske & Sainfort, 2005), organisational factors (e.g. job demand, benefit, care staff resident ratio, task control, and supervision; Bishop et al., 2009; Chamberlain, Hoben, Squires & Estabrooks, 2016; Decker, Harris-Kojetin & Bercovitz, 2009; Kim, Wehbi, DelliFraine & Brannon, 2014), working condition (King, Wei & Howe, 2013); physical and verbal abuse (Ravenswood, Douglas & Haar, 2017), extrinsic incentive (Bishop et al., 2008; Decker, Harris-Kojetin & Bercovitz, 2009), the wider economic and cultural environment (Hebson, Rubery & Grimshaw, 2015), work strain (Hasson & Arnetz, 2008), and training (Coogle, Parham & Young, 2007; Ravenswood et al., 2017). Moreover, researchers identify a number of constructs associated with care workers' job satisfaction, such as work identity (Hebson, Rubery & Grimshaw, 2015; Morrow et al., 2011), motivations (Deci & Ryan, 2000; Ravenswood, Douglas & Haar, 2017), organisational commitment (Pitfield, Shahriyarmolki, & Livingston, 2011), and value congruence (Verquer, Beehr, & Wagner, 2003).

For instance, Karsh, Booske and Sainfort (2005) emphasise how the care home environment and organisational characteristics influence the care workers' job satisfaction and argue that care home management has an important role in facilitating care workers job satisfaction. Moreover, Bishop, Squillace, Meagher, Anderson and Wiener (2009) suggest that care workers' extrinsic incentives and workload influence their job satisfaction. Their findings also point out that care workers with good relationships with their supervisors and management experience greater job satisfaction. Their findings are also supported by other scholars (Castle, 2007; McGilton, Hall, Wodchis & Petroz, 2007; Suhonen, Charalambous, Stolt, Katajisto & Puro, 2013). Furthermore, Hebson, Rubery and Grimshaw (2015) explore care workers' high job satisfaction in a low pay work sector through three aspects: the gendered norm of women, intrinsic value of care work, and the wider economic and cultural environment of care workers. They acknowledge the significant role of the intrinsic value of care work in contributing care workers' high job satisfaction and point out the importance of taking into consideration the influence of the wider economic and cultural environment in which the care workers are located when researching care worker job satisfaction. Their findings provide a valuable insight in understanding female care workers' acceptance of many of the negative aspects of care work. In addition, the researchers stress the role of work experiences in facilitating care workers to establish relationships and attachment with care recipients and to form 'the positive identity of being a care worker' (Hebson et al., 2015, p.327). Thus, care workers' pre-existing perceptions or understanding of care work may be

influenced by their own work experience after started working as a care worker. It may be assumed that care workers' positive work experience or relationship with residents may contribute to forming a positive identity of being a care worker and subsequently experience a higher job satisfaction.

3.4 What is organisational commitment?

Organisational commitment has been suggested as a significant predictor of a number of job-related outcomes, such as employees' turnover (Meyer & Allen, 1991; Rusbult & Farrell, 1983; Van Knippenberg & Sleebos, 2006), job satisfaction (Karsh, Booske & Sainfort, 2005; Testa, 2001; Tett & Meyer, 1993; Trimble, 2006), job motivation, and job performance (Podsakoff, MacKenzie, Paine & Bachrach, 2000; Van Knippenberg & Sleebos, 2006). Although there is a lack of consensus regarding the definition of organisational commitment (Meyer & Allen, 1991; Reichers, 1985), it has been generally viewed as a psychological relationship between individuals and the organisation (Allen & Meyer, 1996; Reichers, 1985; Van Knippenberg & Sleebos, 2006) and a multidimensional construct (Meyer & Allen, 1991; Meyer, Allen & Smith, 1993; Mowday, Steers & Porter, 1979; Reichers, 1985). Some scholars conceptualise organisational commitment as a function of incentives, also known as side-bets, which help individuals assume the membership of the organisation (Becker, 1960; Reichers, 1985; Rusbult & Farrell, 1983). Becker (1960) proposed that individuals who feel that they have strongly invested in their job and worry that they may lose this investment through a job change are more likely to have greater commitment. It is worth noting that Becker's side-bets theory has been criticised for its 'penalty-producing arrangement' (Griffin & Hepburn, 2005, p.612)

In contrast to the side-bets theory, Angle and Perry (1983) explore employees' commitment from the perspective of the reciprocity effect where the organisational support received by the employees enhances their willingness to commit to the organisation. Researchers further elaborate that when a desirable treatment offered by the organisation is identified as the organisation meeting their obligation of reciprocity, such treatment may lead employees to perceive a positive relationship with the organisation that increases their sense of obligation to the organisation (Eisenberger, Armeli, Rexwinkel, Lynch, & Rhoades, 2001). Such sense of obligation encourages employees to take the organisational welfare into account and put in efforts to achieve organisational goals and objectives (Dabos & Rousseau, 2004; Eisenberger et al., 2001). Notably, when employees' perceived injustice at work, this may be seen as the organisation failing to fulfil their obligation of reciprocity (Griffin & Hepburn,

2005; Mathieu & Zajac, 1990). It is worth noting that reciprocity emphasises the importance of satisfaction of employees' psychological needs (Dabos & Rousseau, 2004). Thus, some researchers address the perspective of the reciprocity effect as an affective attachment (Allen & Meyer, 1990), whereas others view it as affective commitment (Eisenberger et al., 2001; Griffin & Hepburn, 2005).

It is worth noting that research on organisational commitment often focuses on the attitudinal and behavioural perspectives of organisational commitment by investigating individuals' commitment related behaviour or attitude (Allen & Meyer, 1996; Meyer, Allen & Smith, 1993; Meyer, Stanley, Herscovitch & Topolnytsky, 2002; Mowday, Steers & Porter, 1979). Attitude-related commitment refers to individuals' views regarding the compatibility between their personal and organisational values. On the other hand, behaviour-related commitment involves the employees' engagement in the organisation, their performance meeting and/or exceeding the organisational expectations, and their willingness of dealing with the issues encountered in the organisation (Allen & Meyer, 1990; Mowday, Steers & Porter, 1979; O'Reilly & Chatman, 1986).

Meyer and Allen (1991) propose a three-component model of commitment (TCM), based on Becker's (1960) side-bet approach, whereas Mowday, Steers and Porter's (1979) idea is to explore the multidimensional nature of organisational commitment. In TCM, Allen and Meyer (1990) purpose three components of commitment including affective, continuance, and normative commitment (Allen & Meyer, 1990; Allen & Meyer, 1996; Meyer, Stanley, Herscovitch & Topolnytsky, 2002). Allen and Meyer (1990) emphasise that they do not propose three different types of organisational commitment but reveal the three components within the organisational commitment. Affective commitment, which has been claimed as the essence of the organisational commitment (Mercurio, 2015; Solinger, Van Olffen & Roe, 2008), refers to individuals' emotional attachment to the organisation (Allen & Meyer, 1990; Allen & Grisaffe, 2001; Meyer & Herscovitch, 2001). Notably, researchers suggest that affective commitment is developed through: a) individuals' perceptions of the compatibility of their own values with the organisational values (Allen & Grisaffe, 2001), b) the identification with the organisation (Meyer & Herscovitch, 2001), and c) the engagement in the organisation (Meyer, Stanley, Herscovitch & Topolnytsky, 2002). Thus, individuals with stronger organisational identification and higher engagement, and sharing the same values with the organisation are more likely to have higher affective commitment towards the organisation.

Normative commitment refers to the scenario where individuals remain in an organisation due to a sense of obligation. This sense of obligation may lead individuals to feel that loyalty to the organisation is necessary and dedication should be made to support the organisation (Allen & Grisaffe, 2001; Meyer & Herscovitch, 2001; Meyer, Stanley, Herscovitch & Topolnytsky, 2002). The difference between affective and normative commitment is that individuals with affective commitment stay with the organisation because they want to do so, whereas individuals with normative commitment feel staying with the organisation is what they have to (Meyer & Herscovitch, 2001). Continuance commitment refers to the cost individuals feel they will incur when they leave the organisation. The cost may be the close relationship with others at work, the benefits offered by the organisation and career investments. Therefore, individuals may decide to stay with the organisation in order to avoid the perceived cost (Allen & Meyer, 1990; Allen & Grisaffe, 2001). It is important to note that the TCM has been criticised for its concept (Cohen, 2007; Ko, Price & Mueller, 1997), the inconsistent results in empirical research (Solinger, Van Olffen & Roe, 2008; Vandenberg & Self, 1993), and a lack of precise definition for each component of commitment (Ko, Price & Mueller, 1997; Solinger, Van Olffen & Roe, 2008). Moreover, some researchers argue that affective commitment is the only component in TCM that accounts for individuals' general organisational commitment, whereas normative and continuance commitment seem to address individuals' attitude regarding certain behaviours, such as intent to leave or stay (Solinger, Van Olffen & Roe, 2008; Vandenberg & Self, 1993). Furthermore, Solinger and colleagues (2008) argue that the TCM may be used to account for individuals' turnover and intent to stay, yet it does not explain individuals' organisational commitment or behaviour.

In contrast to Allen and Meyer's (1990) TCM, Mowday, Steers and Porter (1979) focus on the attitudinal perspective of organisational commitment and suggest that it can be understood from three aspects: individuals' belief and acceptance regarding the organisational values and interests, individuals' willingness of devoting their efforts in support of the organisation, and whether individuals are keen to affirm the membership of the organisation. Thus, individuals have a higher organisational commitment because they experience value congruency with the organisation, are endeavouring to help the organisation, and are keen to maintain their membership and stay with the organisation. Based on those three aspects, the organisational commitment questionnaire (OCQ) was developed to reflect the attitudinal perspective of commitment (Mowday, Steers & Porter, 1979). In addition, attitudinal commitment has been suggested as involving the process

where individuals reflect on their relationship with the organisation (Cohen, 2007; Dutton, Dukerich, Harquail, 1994; Mowday, Steers & Porter, 1979).

Considering the limitation and critiques of the TCM, it may not be able to reflect care workers' attitude towards the care homes. Therefore, in this thesis, the definition of organisational commitment is adopted from Mowday, Steers and Porter (1979) where it is conceptualised as individuals' attitude toward the organisation they work for and this attitude is attributed by their belief and acceptance of the organisational goal, values and interests, their willingness of devoting efforts in supporting the organisation, and their keenness to maintain the membership of the organisation. Research on care workers' organisational commitment suggests that a higher organisational commitment is associated with lower stress at work, better quality of care, (McCormack et al., 2010; Redfern, Hannan, Norman & Martin, 2002), and better job satisfaction (Karsh, Booske & Sainfort, 2005; Sikorska-Simmons, 2005). It is worth noting that in organisational studies organisational commitment and job satisfaction have been viewed as two significant constructs associating positive job performance and retention (Podsakoff, MacKenzie, Paine & Bachrach, 2000; Van Knippenberg & Sleebos, 2006). Nevertheless, there is limited research on care workers' organisational commitment comparing to research on job satisfaction in care home settings (Sikorska-Simmons, 2005). The relationship between organisational commitment and job satisfaction has frequently been reported in organisational studies even though controversy continues over their causal relationship. In the next section, the relationship between organisational commitment and job satisfaction will be discussed.

3.4.1 Relationship between organisational commitment and job satisfaction.

In organisational studies, a number of constructs are suggested as the antecedences or predictors of both organisational commitment and job satisfaction, such as organisational identification (Smith, Amiot, Callan, Terry & Smith, 2012; Van Dick et al., 2004), self-esteem (Johnson, Morgeson, Ilgen, Meyer & Lloyd, 2006), self-efficacy (Vignoles, Regalia, Manzi, Golledge & Scabini, 2006), the satisfaction of basic psychological needs and intrinsic motivation (Gagné & Deci, 2005; Gray & Wilson, 2008). Despite both constructs involving individuals' personal beliefs and sharing some attributes, researchers argue that organisational commitment and job satisfaction are two distinguishable but related constructs (Mowday, Steers & Porter, 1979; Porter, Steers, Mowday & Boulian, 1974). Scholars state that organisational commitment concerns employees' psychological relationship with the organisation which includes social exchange between employees and

their organisation (Van Knippenberg & Sleebos, 2006), whereas job satisfaction emphasises employees' emotional responses and evaluation towards the job they are doing in the organisation. Some argue that organisational commitment is considered as more stable and consistent comparing to job satisfaction in predicting turnover (Porter, Steers, Mowday & Boulian, 1974).

In addition, it is possible that employees may be keen to devote and maintain their membership with the organisation (high organisational commitment) but dissatisfied with their specific job in the organisation (low job satisfaction) (Mowday, Steers & Porter, 1979). Furthermore, some researchers suggest that job satisfaction is a significant predictor of organisational commitment (Mowday, Porter & Steers, 1979; Mueller & Price, 1990; Price & Mueller, 1986) whereas other researchers point out that organisational commitment affects employees' job satisfaction (Freund, 2005). It is worth noting that Tett and Meyer (1993) conduct research using meta-analysis to investigate the relationship between organisational commitment and job satisfaction and demonstrate that these two constructs independently predict employees' turnover intention. Therefore, while organisational commitment and job satisfaction may be related due to the shared attributes, they are not the same constructs in predicting employees' turnover intention.

3.5 What is organisational identification?

To obtain a comprehensive understanding of the concept of organisational identification, it is important to clarify the concepts between self, identity and identification. Identity theory (IT; Stryker, 2007; Stryker & Burke, 2000) and social identity theory (SIT; Ashforth & Mael, 1989; Hogg, Terry & White, 1995) are two theories established to explain the concept of self. These two theories have the same view on the concept of self, but different views regarding the ways in which an individual acquires an identity (Stets & Burke, 2000). SIT views an individual's identity as an autonomous psychological entity (Hogg, Terry & White, 1995), whereas IT emphasises that an individual acquires their identity through social interaction in a social structure. SIT is more effective in exploring individuals' intergroup behaviour, whereas IT offers a more comprehensive account of identity involving interpersonal social interaction in a given social structure. Nevertheless, both theories suggest that an individual's self is formed or developed within social construct and composed of multiple identities and consider identity as individuals' cognitive schema and one's behaviour is influenced by the social construct (Hogg, Terry & White, 1995; Stets & Burke, 2000).

According to IT (Stryker, 2007; Stryker & Burke, 2000), self is conceptualised as reflexive and suggested as being formed or developed within social construct. Self is constituted by the congeries of identities which are organised in a hierarchical fashion in accordance to their salience (Stryker, 1997). Self also functions as an active agent in performing social behaviour without conscious thought. An individual's self-concept tends to have as many identities as the positions they occupy in different social structures. For instance, an individual could be a parent, a care worker, a friend, a son or daughter, and a volunteer at the same time. Many have suggested that "self reflects society" (Stryker, 1997; Stryker & Burke, 2000). The term society refers to the social structures which are seen as an abstract idea related to the expectations of individuals' behaviour or interaction in a given social structure. For instance, social structure can be understood as an organisation, a company, a school, a family, or in this case, a care home. Positions individuals hold in a social structure can be understood as roles. Stryker (2008) adopted the concept of role theory (Turner, 1962) that proposes that individuals have multiple roles and those roles are the basis of individuals' identities and self. The term 'role' refers to the expectations attached to a social position in society, for instance, the role for care home workers may be providing person-centred care for residents, being patient, and offering emotional and social support for residents. Moreover, Stryker and Burke (2000) conceptualise an identity as individuals internalised the meanings attached to the social structure they are in through the processes of social interaction. Identities, on the other hand, represent the meanings of the position they occupy, for instance, the meaning for being a parent, a care worker, a friend, or a student (Stryker & Burke, 2000). Therefore, identities are not roles, but emerge from meanings arising from roles (Stryker, 2008).

On the other hand, a role identity can be understood as a set of internalised meanings attached to the role, for instance, a care worker always communicating with residents when providing care for them and always asking for permission before providing personal care. Burke (2003) states that "identities are the meanings that individuals hold for themselves, what it means to be who they are. These identities have bases in being members of groups (social identity), having certain roles (role identities) or being the unique biological entities that they are (personal identities)." (p.196). Therefore, identities can be seen as a cognitive schema which is developed through learning meanings and interacting with others in a given social structure (Hogg, Terry & White, 1995; Stets & Burke, 2000). In different positions, individuals interact and develop a relationship with others. The interaction and relationship help individuals to learn the appropriateness of actions or behaviour, the meanings of the

patterned regulation in the given social structure, and boundaries of networks or social structure. Identities are conceptualised as social products which are formed through social processes. In other words, individuals' identities are formed through a) occupying a role in a given social structure, b) learning the meanings of the role and a set of role expectations, c) interacting with others in the given social structure (Burke & Stets, 2009; Stryker, 2007; Stryker & Burke, 2000). Through process of internalising the expectations of a social role attached within the social relationship, an identity is used to represent one of many selves an individual occupies. Therefore, an identity can be understood as a framework which provides meanings to guide individuals' behaviour and to fulfil the expectations. Alvesson, Ashcraft, and Thomas (2008) state that identity is a key construct in understanding the implicit, complicated and dynamic employee-organisation relationship. In care home context, when an individual is recruited to be a care worker, being a care worker in a care home is their role. After learning the meanings of being a care worker through training and interacting with others in the care home, this individual as a care worker would develop a care work-based identity.

Work identity, which also alludes to professional, vocational, occupational, and career identity (Caza & Creary, 2016; Skorikov & Vondracek, 2011), is defined as individuals' perceptions of their self-concept within their work role regarding the attributes, beliefs, values, motivations, and working experiences (Aguilar, Stupans, Scutter & King, 2012; Bothma, Lloyd & Khapova, 2015; Ibarra, 1999; Pratt, 1998; Skorikov & Vondracek, 2011; Slay & Smith, 2011). In this thesis, work identity is used to refer the identity that care workers assume working as a care worker. Work identity is associated with individuals' work status and, therefore, guides individuals' behaviour at work (Cennamo, & Gardner, 2008; Geijsel & Meijers, 2005; Kleijnen, Dolmans, Muijtjens, Willems & Van Hout, 2009; Stryker & Burke, 2000) and enhance commitment (Bartels, Peters, de Jong, Pruyn & van der Molen, 2010; Podnar, 2011), and job satisfaction (Feather & Rauter, 2004). Sutherland, Howard and Markauskaite (2010) state that work identity is commonly understood to have four features: a) an identity is flexible and is purposefully developed through individuals' continuously interpreting their experience; b) an identity is formed through the negotiation and adjustment of individuals' personal knowledge and understanding with the social environment (Stryker & Burke, 2000); c) individuals start to form the work identity when they perceived being or are perceived in the profession; and d) work identity involves internalisation where individuals' other identities, beliefs and values are used to make sense of their experience and lead individuals' work identity to being unique. Furthermore, Stryker and Burke (2000)

illustrate the influences of the identity being perceived by individuals as valuable and important which will increase the likelihood that individuals become more active in executing and fulfilling their role expectations and affirming the identity across different situations (Ashforth, Harrison, & Corley, 2008; Burke & Reitzes, 1991; Burke & Stets, 2009; Stets & Burke, 2000; Stryker & Burke, 2000).

It is worth noting work identity of teachers has been better studied (Sutherland, Howard & Markauskaite, 2010), nurses (Johnson, Cowin, Wilson & Young, 2012; Walker et al., 2014) and other healthcare professional (Swick, 2000) than care workers in the care home settings. Thus, care workers' perceptions of their role, meaning-making, identity and personhood at work remain unclear (Kadri et al., 2018; Pfefferle & Weinberg, 2008). Given that work identity is associated with employees' enhanced behaviour, engagement and performance, commitment and job satisfaction, there is a need to investigate care workers' perceptions of their role and work identity.

Furthermore, the concept of identity and identification are often addressed when exploring employees' behaviour, performance, commitment, and job satisfaction (e.g. Bothma & Roodt, 2012; Bothma, Lloyd & Khapova, 2015; Lloyd, Roodt, & Odendaal, 2011; Miscenko & Day, 2016). Researchers conceptulaise identity as an individual's cognitive schema or the conceptual framework which they use to occupy a position in a social structure. Whereas identification is conceptualised as a process (Bothma & Roodt, 2012; Kreiner, Hollensbe & Sheep, 2006) where individuals accept the influences of the social identity "in order to engage in a satisfying role-relationship with another person or group (Steers & Porter, 1991, p. 214). Therefore, identification refers to the extent to which an individual identifies themselves in terms of the subject of the identity, such as organisation, nation, or gender (Brown, 2015; Dutton et al. 1994). It is worth noting that researchers further expand the definition of identification to suggest that it can be seen as a form of attachment to the role or identity of individuals (Ashforth, Harrison, & Corley, 2008; Jones & Volpe, 2011; Miscenko & Day, 2016). Thus, identification may also be seen as the extent to which individuals feel belonging in their position in the social structure (Alvesson, Ashcraft & Thomas, 2008; Ashforth, Harrison, & Corley, 2008; Miscenko & Day, 2016). For instance, care workers may acquire the work identity of care worker when they work in care homes while their work identification refers the extent to which care workers identify themselves as a care worker. Therefore, in order to learn about care workers' work identity, identification may be an adequate construct to explore.

According to social identity theory, a group or category is defined as a cognitive construct which provides information and knowledge for individuals within it. Such knowledge provides individuals with a standard to evaluate the attributes and the distinctiveness of the category which helps individuals to distinguish between in-group and out-group (Hogg & Abrams, 1988). In other words, social categories provide meaning for individuals to define themselves and others in a social environment. For instance, a care worker who uses their profession to identify themselves will categorise other care workers as in-group members. Whereas a care worker who identifies themselves in terms of the care home will categorise other care workers in other care homes as out-group members. Tajfel (1981) suggests that individuals are more likely to have positive emotions towards their in-group member. On the other hand, Hogg and Abrams (1988) state that individuals are more likely to show positive emotions towards the out-group members when the out-group is considered as more powerful, possessing a higher status and/or a better reputation in comparison to individuals' own group. Furthermore, there is guidance to direct individuals' behaviour to meet the appropriateness based on the norm and values within the group or social category. When individuals perceive their membership of the group or social category as meaningful or important, they are more likely to act in accordance with what is considered as appropriate in the group (Tajfel, 1981). Notably, researchers suggest that the meanings within a social group can have an impact on individuals' self-image (Ashforth & Mael, 1989; Bergami & Bagozzi, 2000; Tajfel, 1981). When individuals perceived a positive social identity from their own social group, they will have a stronger sense of belongingness with the social group.

Researchers argue that employees tend to identify themselves in terms of the work as well as the organisation where they work (Bartels, Peters, de Jong, Pruyn, & van der Molen, 2010; Hekman, Steensma, Bigley & Hereford, 2009). Work identification can be understood as the extent to which an individual would define themselves using their profession or the distinct character within the profession (Mael & Ashforth, 1992). According to Mael and Ashforth (1992), organisational identification is defined as "the perception of oneness with or belongingness to an organisation, where the individual defines him or herself in terms of the organisation(s) in which he or she is a member" (p. 104). Thus, organisational identification refers the degree to which individuals identify themselves in terms of the organisation (Ashforth, Harrison & Corley, 2008; Bartels, Peters, de Jong, Pruyn, & van der Molen, 2010; Jones & Volpe, 2011) and reach the sense of psychological attachment to the organisation (Dutton, Dukerich, & Harquail, 1994; Jones & Volpe, 2011). It is important to note that the research on employees' behaviour, commitment, and turnover often focuses on the work and

organisational identification (Ashforth, Harrison & Corley, 2008; Hekman, Steensma, Bigley & Hereford, 2009; Jones & Volpe, 2011; Miscenko & Day, 2016). Scholars are interested in the differences and associations between professional and organisational identification as well as the effectiveness of these constructs on individuals' professional behaviour (Bartels, Peters, de Jong, Pruyn, & van der Molen, 2010). Scholars state that individuals with a particular profession, such as physician, nurses, and accountants, presented a stronger identification with their profession rather than with the organisation (Apker & Fox, 2002; Apker, Ford & Fox, 2003; Bamber & Iyer, 2002; Bartels, Peters, de Jong, Pruyn, & van der Molen, 2010). Other researchers point out that the extent to which employees are more likely to identify with a profession or organisation can be influenced by employees' position in the organisation (Bartels, Pruyn, De Jong, & Joustra, 2007).

The concepts of professional and organisational identification have been categorised into a hierarchical structure where they are considered as lower- and higher-order identities respectively (Ashforth & Johnson, 2001; Bartels, Peters, de Jong, Pruyn, & van der Molen, 2010; Bartels, Pruyn, De Jong, & Joustra, 2007; Meisenbach & Kramer, 2014). Ashforth and Johnson (2001) indicate that different identities relating to organisational settings may overlap and nest within each other. It is suggested that nested identities result from the salience of a social identity where individuals perceive how the centrality and relevance of the identity are in the given social situation (Ashforth & Johnson; 2001; Stryker & Burke, 2000). Ashforth and Johnson (2001) further elaborate on the concept of nested identities using lower and higher order identities. Lower order identities, such as work identity, refer to the identities that are a) more exclusive due to the restrictiveness of the membership, b) sufficiently and directly influencing individuals' behaviour, and c) associated with more specific behaviour or performance. On the other hand, higher order identities, such as organisational identity, refers to the identities that a) comprise the lower order identities, b) are more inclusive and less restricted, and c) have relatively indirect or delayed impact on individuals' behaviour. Notably, Ashforth, Rogers and Corley (2011) suggest that nested identities are somehow linked to each other especially in an organisation where individuals' professional and organisational identities are "relatively isomorphic" because achieving organisational goals "require some internal coherence" (p.1).

Riketta and van Dick (2005) conducted a meta-analysis investigating the influences of professional and organisation identification on employees' professional behaviour. Their findings suggest that professional identification was significantly related to satisfaction with

colleagues or supervisors, and altruistic behaviour, while organisational identification was closely associated with the satisfaction with the organisation, commitment, and intent to leave. Previous research on organisational identification indicates that employees with a stronger organisational identification would experience greater job satisfaction and more likely to work cooperatively with their colleagues (Morrow et al., 2011). This subsequently might contribute to low absenteeism and staff turnover rate in the organisation (Bartel, 2001; Riketta, 2005; Smith, Amiot, Callan, Terry & Smith, 2012; Van Dick et al., 2004). In care home contexts, there is limited research on care workers' organisational or work identification and their impact on care workers' job-related performance. It may be assumed that when care workers identify themselves as a care worker in a particular care home and perceive such identity as important and valuable, they would be more likely to behave in line with the care home expectations and endeavour to affirm the identity. Given that previous research demonstrates the effects of professional and organisational identification on an individual's professional behaviour, there is a need to explore to what extent care workers' job-related performance may be enhanced by a stronger professional and organisational identification.

3.5.1 Relationship between organisational identification and self-evaluation processes.

Previous research on organisations suggests that organisational identification is closely associated with self-concept (Sluss & Ashforth, 2008; Stets & Burke, 2000), values (Edwards & Cable, 2009; Slay & Smith, 2011), motivation (Van Knippenberg & Van Schie, 2000) and commitment (Burke & Reitzes, 1991; Van Knippenberg & Sleebos, 2006). Self-concept refers to an individual's understanding and knowledge about themselves (Cooper & Thatcher, 2010), incorporates both cognitive and affective responses toward the self and influences or directs one's thoughts, behaviours, feelings and achievement (Leary & Tangney, 2003; van Knippenberg, van Knippenberg, De Cremer, & Hogg, 2004).

Sluss and Ashforth (2008) suggest that organisational identification is not only referring to an individual's membership in an organisation, but also indicating the extent to which they integrate the organisational attributes and values into their self-concept. It has been argued that individuals have different roles within different social structures (Stryker & Burke, 2000). Stryker and Serpe (1994) point out that individuals organise their multiple identities using a hierarchy and the salient identity which is of greater importance or value is more likely invoked across different situations and events. Researchers emphasise the influences of social interaction on forming individuals' organisational identification and their self-

concept (Ibarra, 1999; Slay & Smith, 2011; Sluss & Ashforth, 2007; Stets & Burke, 2000; Stryker & Burke, 2000; van Knippenberg, van Knippenberg, De Cremer, & Hogg, 2004; Vignoles, Regalia, Manzi, Golledge & Scabini, 2006). Moreover, researchers exploring the influences of social interaction at the organisational level indicate that individuals are more likely to be motivated to adopt the identity of the social group where they are based so that they can reduce the sense of uncertainty about their place in that group (Pratt, 1998; Pratt, Rockmann & Kaufmann, 2006). The process of developing organisation identification is suggested as individuals adopting and integrating the organisational attributes, beliefs, and values with their personal ones (Ashforth, Harrison & Corley, 2008; Ibarra, 1999; Pratt, Rockmann & Kaufmann, 2006; Slay & Smith, 2011). Hence, organisational expectations, which are attached to the position where individuals occupy within an organisation, are incorporated into ones' self. Scholars suggest that integrated meanings, values, and attributes influence individuals' thoughts, behaviours and emotions and subsequently modify their self-concept (Ashforth, Harrison & Corley, 2008; Ibarra, 1999; Slay & Smith, 2011).

Moreover, the constructs of self-esteem and self-efficacy are often applied to study organisational identification in organisational studies (e.g. Dutton, Dukerich & Harquail, 1994; van Knippenberg, van Knippenberg, De Cremer, & Hogg, 2004). Self-esteem and self-efficacy are viewed as self-evaluation processes and distinguishable from self-concept. Self-efficacy refers to one's evaluation regarding their capability or competency in completing a task (Chen, Gully & Eden, 2001), whereas self-esteem suggests the knowledge of individuals' emotional judgement or attitude toward their own worth (Rosenberg, 1965). It is worth noting that individuals identifying with the organisation are prone to integrate more organisational values and attributes into their self-concept (Sluss & Ashforth, 2008; Stinglhamber et al., 2015; Van Knippenberg & Sleebos, 2006). This may provide meanings to individuals and enhance their self-esteem (Ashforth & Mael, 1989; Smidts, Pruyn & Van Riel, 2001) and self-efficacy (Vignoles, Regalia, Manzi, Golledge & Scabini, 2006). In the case of care workers in care home settings, it may be assumed that care workers' self-esteem and self-efficacy is significantly influenced by the social interaction they experience at work, such as the feedback from the residents regarding their care provision, their cooperation with other colleagues in care provision, and their interaction with residents, residents' family, colleagues and managers (Dutton, Dukerich, & Harquail, 1994; Field, Duffy & Huggins, 2013).

Dutton, Dukerich and Harquail (1994) discuss the concept of perceived external prestige in relation to organisational identification and commitment. Perceived external prestige (PEP), which is also known as constructed external image, refers to individuals' perceptions regarding the thoughts that outsiders have toward the organisation. Thus, PEP considers individuals' understanding of the reputation of the organisation (Dutton & Dukerich, 1991; Dutton, Dukerich & Harquail, 1994). Research on organisations suggests that individuals are more likely to see themselves as affiliated with the organisation while the external organisational reputation is more likely to influence their perceptions of their own organisational performance (Carmeli, Gilat & Weisberg, 2006; Podnar, 2011). Therefore, individuals working in an organisation with considerable prestige may evaluate their own worth positively (Bartel, Dutton, Hogg & Terry, 2001; Dutton, Dukerich, & Harquail, 1994). Furthermore, research on PEP points out that the affiliation with an organisation with greater reputation encourages individuals to develop organisation identification which then enhances their self-esteem and commitment in the organisation (Carmeli, Gilat & Weisberg, 2006; Fuller et al., 2006; Riketta, 2005; Smidts, Pruyn & Van Riel, 2001). Hence, employees' PEP has an influential role in the development of organisation identification. Findings also suggest a directional relationship between organisational identification, self-esteem, and commitment (Riketta, 2005; Smidts, Pruyn & Van Riel, 2001). In other words, individuals' self-esteem can be influenced by the organisational identification and the prestige of the organisation which then results in the extent to which they are willing to commit to their role in the organisation.

McCall and Simmons (1978, cited in Stets & Burke, 2000) indicate that work identity is developed based on individuals' self-concept regarding their work together with the meanings or interpretations of the work role within the social construction. On the other hand, research on education emphasises the contribution of self-esteem and self-efficacy in the development of identification (Burke & Reitzes, 1991; Canrinus, Helms-Lorenz, Beijaard, Buitink & Hofman, 2012; Kelchtermans, 2009; Rots, Aelterman, Vlerick & Vermeulen, 2007). It is worth noting that Kelchtermans (2009) avoids the term 'identity' (Canrinus, Helms-Lorenz, Beijaard, Buitink & Hofman, 2012), but uses the term 'self-understanding' to describe an interpretative framework which reflects on a teacher's work, and explains their sense-making and commitment in teaching. Kelchtermans (2009) states that individuals' self-understanding is influenced by self-image, self-esteem, job motivation, task perception, and future perspective. Thus, it may be understood that individuals' self-concept attributes to the development of identification.

To sum up, the findings from the aforementioned studies indicate that individuals develop the organisational identification based on their self-concept. Through the process of developing organisational identification, individuals embed the organisational meanings, attributes, values and prestige into their self-concept that then modify their thoughts, behaviours, self-concept and self-evaluation processes. Thus, a dynamic nature of the reciprocal relationship between organisational identification and self-evaluation processes, including self-esteem and self-efficacy, may be implied. However, it is important to note that the relationship between care workers' organisational identification, self-esteem and self-efficacy in care home settings is under-researched. Thus, their relationships remain unclear. Exploring the relationships between care workers' organisational identification, self-esteem, and self-efficacy may provide valuable insights into the development and maintenance of care workers' organisational identification.

3.5.2 Relationship between organisational identification and values congruence.

The concept of value has been frequently discussed in relation to organisational identification (Ibarra, 1999; Pratt, 1998; Slay & Smith, 2011), work motivations (Cennamo, & Gardner, 2008), organisational performance (Ostroff & Judge, 2007), and commitment (Edwards & Cable, 2009; Verquer, Beehr, & Wagner, 2003). Shamir (1990 cited in Gecas, 2000) suggests that values refer to an individuals' concepts or beliefs that can influence their decision-making, behaviour and judgement across different situations or scenarios based on the importance of the incidents. Individuals' personal values are suggested as a guide to their work performance and promoting their work motivations (Cennamo, & Gardner, 2008; Rosete, 2006). Notably, such a guide is found to be consistent across different situations or scenarios. (McCarty & Shrum, 1994; Murphy & Davey, 2002). It is suggested that the changes in an individual's personal values are associated with the changes in their behaviour (Bissett, 2014).

On the other hand, organisational values have been considered as essential in organisations (Kleijnen, Dolmans, Muijtjens, Willems & Van Hout, 2009). Previous research suggests that organisational values provide an account for justifying organisational decision and action and direct the organisational problem-solving strategies and the coordination within the organisation to ensure stability (Enz, Dollinger & Daily, 1990; Newton & Jimmieson, 2008). Moreover, Rosete (2006) indicates that organisational values shape and direct employees' behaviour in order to achieve the organisational goals. Sullivan, Sullivan and Buffton (2001) indicate that values-led organisations have better growth in revenue, job creation, profit

performance and lower turnover rate compared to non-values-led organisations. Notably, researchers suggest that when there is a difference between the espoused organizational values and the actual enactment of the management in the organisation, the employees tend to have an indifferent attitude towards the espoused organisational values (Murphy & Davey, 2002).

Furthermore, when Ravlin and Meglino (1987) explored the values in the workplace they found three different components within work values including employees' personal values, organisational values, and the person-organisation values fit. Previous research showed that employees perceiving a congruence between their personal values and organisational values are more likely to experience higher job satisfaction and a sense of belongingness within the organisation, a commitment in the employment relationship, and remain in their position within the organisation (Edwards & Cable, 2009; Verquer, Beehr, & Wagner, 2003). Ren (2010) suggests that value congruency may be perceived by employees as a form of intrinsic motivation which facilitates them to achieve organisational goals. It is worth noting that the benefit of person-organisation values fit is not only for employees but also for the organisations. Researchers point out that the compatibility between organisational and personal values has a positive influence on organisational performance and outcome (Dobni, Ritchie & Zerbe, 2000; Ostroff & Judge, 2007) as well as employees' job satisfaction and commitment (Meglino, Ravlin & Adkins, 1989; Ren, 2013; O'Reilly III, Chatman & Caldwell, 1991; Rosete, 2006).

Researchers exploring the association between value congruency and job attitude of nurses in nursing homes conclude that job attitude is not influenced by nurses' value congruency. Nevertheless, nurses' value congruency is positively associated with organisational commitment and job satisfaction, and negatively related to the staff's intent to leave (Ren, 2013; Ren & Hamann, 2015). Despite the differences between nurses and care workers in care home context in respect of training and responsibilities, it may be assumed that care workers might experience value congruency positively influencing their job satisfaction and organisational commitment, especially when care workers learn about organisational values through social interaction and socialisation in care homes. Experiencing value congruency may facilitate care workers' performance to achieving their organisational goal. This may subsequently lead care workers to experience better job satisfaction and higher willingness to commit to the care home. Perceiving incongruence between the organizational values and the enactment of management may result in care workers being indifferent toward

organisational values creating a negative impact on organisational performance and outcome.

To sum up, value congruency involves individuals' comparing their own personal values with organisational values. Experiencing a higher value congruency may facilitate individuals to internalise the organisational values and focus on pursuing organisational goal. Thus, investigating care workers' value congruency may provide insightful information for the development of effective intervention for enhancing their organisational identification, job satisfaction, and organisational commitment.

3.5.3 Relationship between organisational commitment and organisational identification.

Organisational commitment and organisational identification can be used to reflect individuals' psychological relationship with the organisation. Organisational identification reflects employees' 'self-definitional' perspective of the relationship with the organisation (Van Knippenberg & Sleebos, 2006). On the other hand, organisational commitment is related to individuals' salient identity, where individuals perceive the identity as important and are willing to behave in accord with the role expectations of the identity across different situations (Burke & Reitzes, 1991; Stryker & Burke, 2000; Stryker & Serpe, 1994). In addition, Burke and Reitzes (1991) suggested that commitment functions as a link between individuals' identity and other job-related outcomes such as: performance meeting organisational expectations (Becker, 1960), a reciprocal bond with the organisation (Kanter, 1968), and assuming the role and developing a firm relationship with others in the organisation. Thus, organisational commitment involves the social exchange between employees and their organisation (Coopey, 1995). Some researchers view organisational identification as equivalent to affective commitment (Cook & Wall, 1980; Karsh, Booske & Sainfort, 2005). Nevertheless, other scholars argue that these two constructs are related but different (Stinglhamber et al., 2015; Van Knippenberg & Sleebos, 2006). In the work of Stinglhamber et al. (2015), they conduct three studies including two cross-sectional studies and one longitudinal study to demonstrate that the positive effect of an employee's positive work experience on their affective commitment works through their organisational identification. Their findings also suggest that affective commitment mediates the effect of organisational identification on employee turnover. Stinglhamber et al. (2015) provide valuable insights into the relationships between organisational identification, affective commitment, and turnover.

It is worth noting that the definition of organisational commitment in this thesis is adopted from Mowday, Steers and Porter (1979), whereas the concept of affective commitment in the work of Stinglhamber et al. (2015) is adopted from Allen and Meyer's (1990) TCM. Previous research suggests that organisational identification and organisational commitment are two different but related constructs (Stinglhamber et al., 2015; Van Knippenberg & Sleebos, 2006) and the organisational commitment questionnaire developed by Mowday, Steers and Porter (1979) has been used to validate the measures of Allen and Meyer's TCM (1990). However, the relationship between a care worker's organisational commitment and organisational identification is unclear. The understanding of this relationship may potentially further our understanding of care workers' motivations in continuing working as a care worker.

3.6 Conclusion

To tackle the issue of high turnover in care home settings, a number of constructs in relation to motivating care home workers have been discussed in this chapter with respect to their definition, their relationship with one another, and their influences on job satisfaction, organisational commitment and turnover intention.

CHAPTER 4
REVIEW OF MOTIVATION THEORIES

4.1 Introduction

The previous chapter outlined the persistent issue of high turnover in care home settings and its impact on care quality and care practice. The contextual background information of care home settings provided in chapter 2 points out that the extrinsic incentives for care workers may be limited and possibly insufficient (see chapter 2 section 2.4). The literature review revealed the difficulties that care home workers often experience including demanding work schedule, heavy workload, stress, burnout, care work related stigma and negative media representation. On the other hand, the significance of establishing close relationships with residents has frequently been emphasised in the research on care workers' job satisfaction, care practice, and retention intention. It has been suggested that social environment of the care homes, and other psychosocial factors (e.g. the sense of being valued and respected, self-esteem, effective working relationship and organisational support) may facilitate care worker's job-related performance and encouraging their retention. In other words, these factors may be key to furthering our understanding of care home workers' experiences and motivation. It may also imply a significant role played by intrinsic motivation and social environment in care workers' retention. However, there are a few questions which are not answered by previous research. For instance, the relationships between these factors are not illustrated and the extent to which these factors and their relationships with others exert influences on care workers' motivation at work remains unclear.

It is suggested that applying an adequate theory in research allows scholars to grasp the understanding of the subject matter, to further develop the theory, and to deliver their findings to practitioners regarding the potential intervention and practice based on a mutual understanding of the theory (Miner, 2005). Researchers suggest that selecting an adequate theory to apply in research involves initially considering a range of theories which may have the potential to inform the question in the subject matter and then identifying the most applicable theory among the prospective theories (Davis, Campbell, Hildon, Hobbs & Michie, 2015). In this thesis, the question for the selection of applicable theory will be to select a theory which could be of value to enhancing our understanding of care workers' motivations of continuing their care worker role while reflecting the need satisfaction of care workers, social environment in the care homes, and other psychosocial factors care workers experience.

It is worth noting that motivation has been extensively explored in different fields related to human behaviour, such as health behaviour change (Gorin, Powers, Koestner, Wing & Raynor, 2014), education (Aelterman, Vansteenkiste, Van Keer & Haerens, 2016), and organisational studies (Gagné & Deci, 2005; Miner, 2005; Van Knippenberg & Van Schie, 2000). Scholars indicate that theories inform previous research on the subject area and provide the concentrated and accumulated knowledge of mechanisms in the subject matter (Davis, Campbell, Hildon, Hobbs & Michie, 2015; Miner, 2005). In organisation contexts, various theories have been proposed to explain individuals' motivation at work and organisational behaviour (Eisenberger & Cameron, 1996; Miner, 2005). Therefore, applying an adequate theory in this thesis allows us to draw the knowledge of the theory on individuals' motivated behaviour phenomenon to reach a comprehensive understanding of care workers' experience and motivation in care home settings. This chapter will begin with a short section on the concept of motivation. The focus will subsequently move onto different motivation theories in organisational contexts and their adequacy and applicability for research on care workers' motivation in care home settings.

4.2 What is motivation?

Scholars suggest that motivation is a construct with multiple dimensions (Ryan & Deci, 2000) and many defined it as a force which prompts individuals to behave in certain ways or help them to develop a tendency for certain behaviour (Grant & Shin, 2011; Pinder, 1998; Ryan & Deci, 2000). Ryan and Deci (2000) state that motivation can influence the extent to which individuals are likely to engage in an action, to adhere to the behaviour or to maintain a changed behaviour. In organisational contexts, motivation, which is often referred to as work motivation, is defined as "a set of energetic forces that originate both within as well as beyond an individual's being, to initiate work-related behaviour, and to determine its form, direction, intensity, and duration" (Pinder, 1998, p. 11). On the other hand, work motivation is also depicted as a psychological process where individuals experience internal or external incentives at work which direct, energise and maintain their action toward a job task, role, or work performance (Grant & Shin, 2011; Ryan & Deci, 2000; Van Knippenberg, 2000). Thus, the set of energetic forces or incentives may be viewed as motivators and individuals' motivation may involve multiple internal or external motivators. It is worth noting that a motivator does not directly lead to an individual's work-related behaviour, action or performance but rather establish individuals' motivation which may then lead to the motivated outcome.

4.3 Motivation theories

Many theories have been proposed to explain individuals' motivation in organisational contexts. Given that care workers have limited extrinsic incentives at work and their need satisfaction, close relationships with residents, and social environment in the care homes are suggested to have significant roles in their job satisfaction, care practice, and retention, five motivation theories are considered as prospective because they have the potential to enhance our understanding of care workers' experience and motivation at work. They are behavioural approaches (Eisenberger & Cameron, 1996), motivation-hygiene theory (Herzberg, 1971), expectancy theory of motivation (Porter & Lawler, 1968; Vroom 1964), goal-setting theory (Locke & Latham, 1990), and self-determination theory (Ryan & Deci, 2000).

Behavioural approaches emphasise the role of extrinsic incentives in shaping individuals' behaviour, whereas motivation-hygiene theory concerns individuals' motivation from the perspective of human need for continuous psychological growth and avoiding negative outcomes. Expectancy theory suggests that individuals' behaviour is influenced by their expectations towards the outcomes of the behaviour. Goal-setting theory refer to the effects of specific and challenging goals on individuals' organisational performance and behaviour. Self-determination theory, which is considered as the most applicable theory to enhancing our understanding of care workers' motivations of carrying on their role as a care worker, suggests that individuals' motivation is influenced by their inherent growth tendencies, psychological needs, and social-environmental determinants.

It is worth noting that behavioural approaches (Eisenberger & Cameron, 1996) have been criticised for overlooking individuals' cognitions and attitudes in motivations and its short-term effects on individuals' behaviours while motivation-hygiene theory (Herzberg, 1971) has been criticised for having little empirical evidence to support the theory. Thus, these two motivation theories will not be reviewed with detail. In the following section, expectancy theory and goal-setting theory will be reviewed to illustrate the way in which motivation is defined and conceptualised in these theories, as well as explore their implications in individuals' organisational behaviour and their applicability in this thesis. After this, the theoretical overview of self-determination theory will be provided to demonstrate its applicability to enhance the understanding of care workers' motivations of carrying on their role as a care worker.

4.3.1 Expectancy theory.

Expectancy theory suggests that individuals evaluate their potential behaviour or action in a given situation based on whether the potential outcome would be preferable prior to their actual behaviour or action (Porter & Lawler, 1968; Vroom 1964). According to expectancy theory, individuals' evaluation is based on three factors: valence, instrumentality and expectancy. Individuals are expected to experience satisfaction after their goal or preferred outcome has been achieved or obtained. Vroom (1964) uses the term of valence to refer to individuals' feelings toward a specific outcome. Perceiving positive valence suggests that an individual prefers to achieve the outcome whereas perceiving negative valence refers to individuals' preference of not obtaining the outcome. For instance, receiving training may lead care workers to have better care practices and potential career advancement. When a care worker has positive feelings towards better care practices and potential career advancement, this is described as positive valence. On the other hand, manually moving a bedridden resident may be considered by care workers to cause physical harm to the resident or lead to punishment to the care workers for not following regulations and procedure. When a care worker views causing harm to residents or being punished as undesired and prefers not to obtain them, this is described as negative valence. It is worth noting that an outcome may have its own valence or have a part of accumulated valence of a secondary outcome which may provide individuals with a greater feeling of satisfaction. For instance, care workers completing training courses may have its own valence where care workers may experience a sense of achievement or satisfaction after the completion of the course. This can also be a part of accumulated valence of a secondary outcome where completing training courses may be the antecedence for care workers to advance their career. Thus, a secondary outcome for care workers in this instance may be the career advancement which may lead them to experience a higher level of satisfaction.

Instrumentality refers to individuals' belief that they will obtain the preferred outcome after conducting the performance or action and this preferred outcome will lead them to achieve the secondary outcome. For instance, care workers have been told that after completing the training course they will be promoted to a senior-level role. Such information will strengthen care workers' beliefs that they will receive the promotion after the completion of the training course. Moving into a more senior role may also mean that care workers will receive a pay rise. In this instance, the promotion is viewed as the preferred outcome after conducting the action (completing the training course) and a pay rise is considered as the secondary outcome. Instrumentality refers to care workers' beliefs regarding the future promotion. Moreover, the

promotion may lead care workers to receive a pay rise and instrumentality also refers to care workers' beliefs regarding the future pay rise after being promoted. Thus, instrumentality is also conceptualised as a link between two outcomes (Vroom, 1964).

Expectancy, which concerns the link between efforts and outcome, refers to the probability or degree of certainty that individuals developed to evaluate whether their efforts lead to the preferred performance. In other words, individuals will evaluate whether the input efforts will result in fulfilment of their preferred or desired performance. Such evaluation is often based on individuals' previous experience, self-efficacy, perceived difficulties of the performance, and perceived control. For instance, care workers may evaluate the amount of effort they have to exert to complete a training course prior to the enrolment. If care workers believe that the training course is difficult, they do not have sufficient skill or knowledge to complete the course, or they may not receive future promotion, this will most likely lead to low expectancy and subsequently low motivation to complete the training course. Vroom (1964) uses the term 'force' to describe the combination of expectancies and total valence. The function of the force is to arouse individuals' motivation to act or exert efforts in order to achieve the preferred outcome (Vroom, 1964). In other words, the occurrence of individuals' behaviour is based on their evaluation on whether the outcome is preferable and how likely they will obtain the preferred outcome.

Porter and Lawler (1968) develop their initial model based on Vroom's expectancy theory of work and motivation (1964) and include six additional factors into their model such as effort-reward probability, abilities and traits of individuals, role perceptions, performance, reward, and perceived equitable rewards. In this model, Porter and Lawler (1968) suggest that individuals may have intrinsic or extrinsic outcomes. The former comes from within an individual that can be a sense of achievement, fulfilment, or volition whereas the latter comes from others which can be a line manager, colleagues, or the organisation. It is proposed that intrinsic outcomes are more likely to lead to a better performance. Porter and Lawler (1968) state that an intrinsic outcome comes from individuals themselves whereas an extrinsic outcome replies on others to provide. Thus, the expectancy of an intrinsic outcome is more likely to be higher than an extrinsic outcome. In other words, the distinction between intrinsic and extrinsic outcomes in motivating individuals' behaviour is the probability of receiving the preferred outcome.

Porter and Lawler' model (1968) was then modified by Lawler (1981). In the portrayal of the basic expectancy theory model (Lawler, 1981), a motivational chain is used to illustrate the effects of individuals' valence, instrumentality and expectancy on their motivation. The chain starts at motivation, and goes to job effort, to job performance, to first-level outcomes, to second-level outcomes, and finally arriving at satisfaction. The effects of expectancy are denoted between job effort and job performance, job performance and first-level outcomes, and first-level outcomes and second-level outcome. The concept of effort-to-performance expectancy refers to individuals' evaluation of whether the performance will be successfully conducted if they exerted the efforts. The concept of performance-to-outcome expectancy is used to describe individuals' evaluation on whether the desired outcome will be obtained if they successfully conducted the performance. It is worth noting that effort-to-performance expectancy and performance-to-outcome expectancy only work for individuals when they have perceived the valence of the outcome as preferable and desirable.

Expectancy theory has been suggested to be one of the most influential motivation theories. Unlike motivation-hygiene theory, expectancy theory has ample of empirical evidence supporting it (e.g. Sanchez, Truxillo & Bauer 2000; Van Eerde &Thierry, 1996; Wanous, Keon & Latack, 1983). Nevertheless, expectancy theory does not place significant attention on the influence of the social environment within the organisation on individuals' motivation, job performance or job efforts. Nor, does it emphasise the role of individuals' perception towards their job (after Lawler's modification of the model, the role perception was removed from the model). Expectancy theory found its applicability in research on occupation or organisation choice (Wanous, Keon, & Latack 1983). This may provide insights around care workers' decision in relation to their turnover or retention in the care homes. However, the criterion for the applicability of theory is whether the theory could further our understanding of care workers' motivations of carrying on their work role and explain the influences of care workers' need satisfaction, close relationships with residents, and social environment on their job satisfaction, care practice, and retention. Considering the limitations of expectancy theory, it may not be the most applicable theory for this thesis.

4.3.2 Goal-setting theory.

Goal-settings theory is considered as a motivational technique and has been widely applied in management to enhance and sustain employees' performance (DuBrin, 2012). This theory is concerned with the association between the level of the intended achievement and actual level of achievement and suggests that a higher level of intended achievement will attribute

to a higher level of actual achievement (Locke & Bryan, 1966). Goal-setting theory hypothesises that individuals are more likely to actually achieve a goal when they have a clear and specific goal in comparison to a general or unclear goal. In goal-setting theory, a goal is defined as what an individual consciously attempts to achieve (Lunenburg, 2011). The effects of specific goals are then extended to conducting tasks. Locke and Bryan (1967) suggest that "working toward a determinate goal would lead to a higher level of task interest than would be the case with an abstract goal such as do your best" (p.121). In other word, individuals with a specific goal are likely to experience less boredom at work. Locke and Latham (1990) suggest that individuals are more likely to have higher level of performance if they were given a specific and challenging goal rather than a vague one. For instance, a care worker having a clear goal (e.g. assisting five residents to get dressed, have breakfast and participate in the activities in accordance with their preferences) is more likely to have a higher level of care practice than being given a vague goal (e.g. doing your best to provide care).

Moreover, Bryan and Locke (1967) suggest that goal setting mediates the process between individuals perceiving tasks and their actual performance of the tasks. Thus, individuals are likely to adjust their efforts and performance based on the tasks they perceive. Bryan and Locke (1967) state that "adjustment requires first that the subject perceive the task, that he be conscious of the fact that there is a task to be performed, and that he have some idea or knowledge of what the task requires of him. Then, depending upon the situation and the individual's perception of it in relation to his own values, he will set himself a goal or standard in terms of which he will regulate and evaluate his performance" (p.206). Bryan and Locke (1967) further illustrate that individuals may go through the goal-setting process consciously, subconsciously, explicitly or implicitly and they would adjust their efforts and performance in order to achieve the goal. In addition, Latham (2003) points out antecedences of the mediating effect of goals on individuals' performance including their sufficient ability to perform and achieve the goals, their acceptance of the goals, and receiving the performance-related feedback. When individuals were given an exceedingly difficult goal, they may not accept the goal. The unacceptance of the goal may result in an invalid hypothesis of goal-setting theory and individuals may not have a higher level of performance even when they are given a specific and challenging goal.

Locke and Latham (1990) introduce the high-performance cycle model where specific and challenging goals and individuals' self-efficacy influence the way in which individuals

mediate their efforts, persistence, direction and strategies towards the goal which then lead to a higher performance. Locke and Latham (1990) suggest the moderating factors between individuals' intention and performance including goal commitment, performance feedback, task complexity, situation, and constraints. After conducting high level of performance, individuals may receive contingent or non-contingent rewards which influence whether they experience satisfaction or anticipated satisfaction. Furthermore, individuals' sense of satisfaction lead to positive consequences or outcomes such as accepting organisational goals, enhancing organisational commitment, and willingness to accept future challenges. The positive consequences feed back to the specific and challenging goals and moderating factors. It appears that this model emphasises the significance of individuals' self-efficacy, rewards, commitment in the goal-related performance. It is worth noting that this model has not been fully supported by empirical studies (Latham & Locke, 2007). Some studies have provided evidence to support some parts of the high-performance cycle model (e.g. Bipp & Kleingeld, 2011; Selden & Brewer, 2000).

Latham (2003) presents a general model of goal-setting theory to illustrate the significance of values and intentions (goals) in individuals' behaviour. This model is simplified version of high-performance cycle model and does not include individuals' self-efficacy, reward, moderating factors, or organisational commitment. In this model, individuals' values create their emotional reaction and desires which then lead to individuals' intentions or goals. Such goals or intentions then have different mechanisms to motivate individuals' performance or behaviour. For instance, goals will direct individuals' attention and motivate them to develop strategies towards the goal-related tasks, while challenging goals will mobilise individuals' higher level of efforts. Those mechanisms then have effects on individuals' behaviour and performance and achieve the goal-related outcomes. It is worth noting that when individuals accomplish the goal, such experience can feed satisfaction and further motivation back into their values. However, failing to achieve the goals can lead individuals to experience frustration and lower motivation which then influence their values. It seems that Latham's (2011) general model is aimed to emphasise the relationship between goals, performance, outcome, and the role of the feedback. It is clear that applying goal-setting theory to enhance employees' performance requires the goals to be specific, challenging, attainable, and accepted. In addition, the outcome related feedback is required to be offered to the employees as it can be a motivator to encourage their better performance.

Goal-setting theory has been criticised for considering the concept of motivation as unitary (e.g. Deci, 1992). In other words, despite goal-setting theory identifying the different performance between a simple goal and a challenging goal, it does not provide account for the reason why there is such difference. Ryan and Deci (2000) point out that there are different quality of motivations and intrinsic motivation is considered as better-quality motivation than extrinsic motivation. Given that the literature review in chapter 2 revealed that care workers' lack extrinsic incentives and the significance of intrinsic motivation in their job satisfaction, care practice, and retention, goal-setting theory may be considered inadequate to explain care workers' different quality of motivations and their influences on care workers' care practices and retention. Moreover, the role of the performance-related feedback has been emphasised in this theory as a motivator for better performance. However, it seems that goal-setting theory does not take employees' potential support needs into consideration as the managerial support is not included in the model. As emphasised in chapter 2, employees may experience difficulties in performing their daily tasks. Without managerial support, it can affect employees' physical and psychological wellbeing and subsequently worsen the productivity at work (Baker-McClearn, Greasley, Dale & Griffith, 2010; Bierla, Huver & Richard, 2011; Eisenberger & Stinglhamber, 2011). Failing to acknowledge the role of employees' support needs in an organisational context may have limited goal-setting theory to inform the issues of care workers' support needs and their influences on care workers' job satisfaction, care practice, and retention. In addition, scholars argue that goal-setting theory should include individual difference and personality factors into the model, especially as it has been demonstrated that personality traits are an important predictor of the goal-related strategies (Lee, Sheldon & Turban, 2003). Finally, goal-setting theory does not provide explanation for employees' performance or intention when they have been given more than one goal or task. Thus, it is unclear whether employees' performance remains the same as if they have only one goal. Likewise, this theory does not address that whether employees would go through evaluation or decision-making process to prioritise one of the tasks they have. On the other hand, the extent to which employees are allowed to prioritise one task and the relationship between their autonomy and goal-related performance remains unexplained. While goal-setting theory may be a useful technique to enhance care workers' performance, its limitations show that it may not be applicable to enhance the understanding of care workers' motivation in carrying on their role as a care worker.

To summarise, two most influential motivation theories in organisational contexts, including expectancy theory and goal-setting theory, have been described the ways in which they

define motivation and their applicability for research on care home workers. Expectancy theory suggests that individuals are likely to exert efforts when they evaluate the potential outcome as preferable and achievable. Whereas goal-setting theory emphasises the pervasive influence of goals on individuals' behaviour and performance. Nevertheless, expectancy theory does not take individuals' perceptions of the job or the influences of social environment into consideration, while goal-setting theory does not explain individuals' motivation when they have multiple goals or discuss the role of managerial support individuals may require. The aforementioned limitations of those motivation theories suggest that they are not the most applicable theory for research on care home workers' motivation in carrying on their role as a care worker.

On the other hand, self-determination theory (Deci & Ryan, 2000) has been widely applied in education (Kaplan, 2018), healthcare (Russell & Bray, 2010) and human resource (Rigby & Ryan, 2018). The following section will briefly describe the theory and consider its applicability as a theoretical framework to further our understanding of care home workers' experiences and motivations of carrying on their role as a care worker.

4.4 Self-determination theory (SDT)

Self-determination theory (Deci & Ryan, 2000; Ryan & Deci, 2000) is a theory emphasising the contribution of motivations, personality and the social environment on individuals' self-regulated behaviour. The term 'self-determination' was originally used to refer the right of a nation to self-governance. This term also refers to enabling and allowing control and choice for individuals (Sands & Wehmeyer, 1996). In the social movement for disability rights, self-determination is often used interchangeably with the term 'empowerment' to emphasise the right for people with disabilities to have control in their own lives (Sands & Wehmeyer, 1996). Self-determination in SDT is viewed as a construct of motivation differentiating from individualism and independence (Chirkov, Ryan, Kim & Kaplan, 2003). Deci and Ryan (1985) in their early work conceptualise self-determination as a need rather than the capacity to have choices and control. They stress that 'self-determination is more than a capacity; it is also a need. We have posited a basic, innate propensity to be self-determining that leads organisms to engage in interesting behaviors' (Deci & Ryan, p.38). Thus, self-determination in SDT is conceptualised as an individual's internal need which contributes or motivates their performance or behaviour. Unlike the motivation theories mentioned earlier, SDT proposes that individuals' motivation and behaviour are significantly influenced by their personal and social-environmental determinants. SDT is also concerned with the ways in

which social and cultural attributes can positively or negatively influence individuals' motivation, well-being, sense of volition, functioning and performance. Furthermore, the central assumption of SDT is that individuals are active organisms that "have natural, innate, and constructive tendencies to develop an ever more elaborated and unified sense of self" (Deci & Ryan, 2002; p.5). In other words, individuals have an inclination towards a positive psychological growth, overcoming challenges, and integrating new identification into their self. Deci and Ryan (2002) point out that individuals' inherent tendency towards integration includes their own autonomy (psychological level) and homonomy with others (interpersonal level). Autonomy refers to individuals' tendency to integrate regulation, identification, and values into their self, whereas homonomy refers to individuals' willingness to fit the self with others in a given social environment. It has been suggested that a healthy development or growth entails both aspects of autonomy and homonomy in the integration (Deci & Ryan, 2002). It appears that SDT is not only concerned about individuals' personal growth but also their development in social contexts. Furthermore, SDT provides accounts for individuals' acquisition and maintenance of identity in a social environment. In order to provide a clear theoretical overview of SDT, it is important to begin with how motivation is conceptualised in SDT.

4.4.1 Nature of motivation.

According to SDT, motivation, which is viewed as a construct with multiple dimensions, is conceptualised as what energises and directs individuals to maintain a behaviour or to engage in activities, behaviour, tasks, or performance. Thus, individuals' motivations influence the extent to which individuals may engage in or adhere to a behaviour. Motivation is also viewed as offering the reason for "why" individuals conduct a behaviour (Ryan & Deci, 2000). SDT proposes that individuals have an inner desire or tendency for activities which leads them to experience growth, competence, self-determination and rewards. Individuals' need for self-determination refers to the need for a sense of being able to make a choice rather than being controlled. Individuals' sense of being autonomous and being controlled are suggested to have significant influences on the motivation and performance. On the other hand, many scholars suggest that individuals' behaviour reflects their interests, values or external influential factors (Deci & Ryan, 2000). Hence, the quality of motivation may be shown in individuals' behaviour. According to SDT, being motivated by the interests, enjoyment or values of the activities is considered as better-quality motivation whereas being motivated by external factors is considered as poorer quality motivation. Based on the

different quality of motivations, SDT argues that there is a distinction between intrinsic and extrinsic motivation within human motivations (Ryan & Deci, 2000).

4.4.2 Intrinsic motivation.

Intrinsic motivation as an example of autonomous motivation refers to individuals performing an activity in accordance with their interest or their satisfaction from the activity (Gagné & Deci, 2005). Hence, when individuals' behaviour or engagement are regulated by their interests, enjoyment, values and satisfaction, it is described as intrinsic or autonomous motivation. For instance, a care worker who enjoys providing care to residents or reach a sense of satisfaction form doing care work is intrinsically motivated. Scholars have demonstrated that individuals who are intrinsically motivated are more likely to experience positive psychological outcomes and have better performance at work (Kuvaas, 2009; Kuvaas, Buch, Weibel, Dysvik & Nerstad, 2017), higher organisational commitment (Gagné, Chemolli, Forest, & Koestner, 2008), higher confidence and self-esteem, and greater general well-being (Deci & Ryan, 2000; Hodgins, Brown & Carver, 2007). It is worth noting that interesting activities are relevant to individuals' selections. For instance, when an individual does not choose to focus on interests or values of an activity, the intrinsic motivation becomes less relevant to their performance. Despite the positivity and significance of intrinsic motivation on individuals' behaviour, researchers argue that intrinsic motivation may not be the most advantageous motivating force for individuals' persistence on voting behaviour (Koestner, Losier, Vallerand & Carducci, 1996) and educational transition (Koestner & Losier, 2002). It has been suggested that the maintenance of individuals' intrinsically motivated behaviours and performances requires positive social and environmental support (Ryan & Deci, 2003). In care home contexts, it may be assumed that a care worker who is intrinsically motivated to be a care worker requires social and environmental support to maintain their intrinsically motivated behaviours and care practice.

4.4.3 Extrinsic motivation.

When the activities are not perceived as interesting or enjoyable by individuals, they require tangible rewards or extrinsic motivation to regulate individuals' performance or engagement. Extrinsic motivation as an example of controlled motivation states that individuals act in response to the anticipated consequences of the activity. It is suggested that the anticipated consequences can be positive or negative. Therefore, individuals may be extrinsically motivated to conduct a performance in order to receive anticipated rewards or to avoid punishments. Due to the nature of extrinsic motivation, some researchers suggest that

individuals are more likely to withdraw from the activity or become passive when the anticipated consequences are removed (Ryan & Deci, 2000; Ryan & Deci, 2003). Moreover, SDT proposes that rewards can be perceived as controlling and informational. The former involves offering pressure to regulate individuals to receive reward whereas the latter refers to the feedback for individuals to evaluate their performance (Deci & Ryan, 2002). On the other hand, SDT suggests that extrinsic rewards have an undermining effect on intrinsic motivation (Deci, Koestner & Ryan, 1999; Gagné & Deci, 2005). This effect has been argued as controversial in organisational contexts (Rynes, Gerhart & Parks, 2005) A recent study points out that the occurrence of the undermining effect is associated with individuals' perception of verbal reward salience and the difficulties of the tasks (Hewett & Conway, 2016). Thus, it may be assumed that the undermining effect of external rewards on autonomous motivation may be valid or irrelevant depending on the nature of the rewards and tasks and whether employees perceived the rewards as salient.

4.4.4 Self-determination continuum of motivation.

It is worth noting that individuals being controlled by external regulations is considered as opposite their natural inner tendency. Interestingly, it has been found that in some cases, individuals perceived some external regulations as less controlling (Ryan & Deci, 2000). It is assumed that individuals have a natural tendency to assimilate or internalise the external regulations into the self. Internalising the external regulations leads individuals to experience the regulations as less controlling and relatively autonomous. SDT points out that the extent to which individuals perceive the external regulations as more autonomous is influenced by the level of internalisation. In other words, a higher level of internalisation leads to more autonomous perception of the external regulations. Based on the different level of internalisation, a self-determination continuum of motivation is proposed to illustrate the motivations with different regulatory style (see figure 3.1). The continuum can be viewed as a spectrum from non-self-determination to self-determination. Intrinsic motivation, which is at the right end of the spectrum, regulates individuals' behaviour intrinsically. Amotivation is at the left end of the spectrum, which is described as non-regulation, impersonal, or completely lack of motivation (Howard, Gagné, Morin & Forest, 2016). Individuals with amotivation are more likely to feel detached from or lacking control over the behaviour or performance (Gagné et al., 2015).

Moreover, scholars suggest that amotivation can lead to a number of negative organisational outcomes, such as lower job performance, job satisfaction, and organisational commitment

and higher burnout, turnover intention and emotional distress (Gagné et al., 2015; Tremblay, Blanchard, Taylor, Pelletier, & Villeneuve, 2009). Extrinsic motivation, which is located between amotivation and intrinsic motivation in the spectrum, has four different types of regulatory style: external, introjected, identified, and integrated regulation. According to SDT, different types of extrinsic motivation are attributed by individuals' inherent tendency to take the external regulations into the self (Ryan & Deci, 2002). Thus, these motivations differ based on the processes where individuals internalise the extrinsic values and regulations (Gagné & Deci, 2005; Hagger et al., 2014). Thus, introjected, identified, and integrated regulations represent the different extent to which individuals internalise the extrinsic values and regulations into their self (Gagné & Deci, 2005; Hagger et al., 2014). The more external values and regulations individuals internalise, the more volition and autonomous motivation they experience. Scholars also demonstrate that the more autonomous forms of extrinsic motivation, such as identified regulation and integrated regulation, would lead to individuals' better organisational performance and outcomes (Howard, Gagné, Morin & Van den Broeck, 2016).

4.4.4.1 Introjected regulation.

Introjected regulation describes the external regulations which have been internalised by individuals but not accepted as their own motivation. Thus, individuals may perceive this type of regulation as more controlling. In other words, individuals may feel that they were controlled by the regulation and act in accordance with regulation to avoid guilt or to gain approval. Introjected regulation can be contingent self-esteem, ego-involvement, internal rewards, and punishment (Ryan & Deci, 2000). For instance, individuals may work because the work provides them with a sense of self-worth (Gagné & Deci, 2005).

4.4.4.2 Identified regulation.

Identified regulation refers to the external regulations which individuals identify the values of the regulations as being compatible with their own goals or reflecting a part of their own identities and then internalise. It is also described as regulation through identification. It is worth noting that the concept of identification in SDT is similar to the identification discussed in chapter two. According to Ryan and Deci (2000), "identification reflects a conscious valuing of a behavioral goal or regulation, such that the action is accepted or owned as personally important" (p.72). When individuals identify with a role or activity, they consciously accept or approve the values and importance of that role or activity (Ryan & Deci, 2003). Therefore, individuals with identified regulations will experience more

freedom and volition because the identified regulations are consistent with their goals and identities. Hence, identified regulations can be of personal importance and conscious valuing (Ryan & Deci, 2000). For instance, care workers may strongly value residents' autonomy and involvement in their own care. When care workers are asked to obtain residents' consents for every personal care task, they are more likely to experience relatively autonomous despite the fact that obtaining consents may not be considered interesting or enjoyable.

4.4.4.3 Integrated regulation.

Integrated regulation refers to the extrinsic regulations which are fully internalised, entirely accepted by individuals, and assimilated to the self. SDT views individuals' self as a combination identifications, interests, and values (Gagné & Deci, 2005). Thus, integrated regulation involves individuals identifying themselves with the external regulation and assimilating the identification with the self. Individuals with integrated regulation feel that their regulated behaviour represents who they are, and experience greater autonomy, volition and self-determination. Hence, integrated regulation can be congruence, awareness, and synthesis with self (Ryan & Deci, 2000). For instance, when care workers integrate the external regulations to the self, they are not only identifying with the importance of promoting residents' autonomy in their own care but also integrating such regulations with other aspects of the care work and their lives. It is worth noting that despite integrated regulation representing the most autonomous form of extrinsic motivation and has some similar qualities to intrinsic motivation, it does not make integrated regulation equivalent to intrinsic motivation. To sum up, it is clear that different types of extrinsic motivation result from individuals' different levels of internalisation. A higher level of internalisation leads individuals experiencing more autonomous motivation. It may be understood that internalisation is a key for individuals to experience more autonomy, volition and self-determination when they are regulated externally.

4.4.5 Internalisation.

Scholars suggest that internalisation, which is conceptualised as a process, is essential for individuals initiating and maintaining a behaviour change (Deci & Vansteenkiste, 2004; Ryan & Deci, 2003). According to Gagné and Deci (2005), internalisation has been defined as "taking in values, attitudes, or regulatory structures, such that the external regulation of a behavior is transformed into an internal regulation and thus no longer requires the presence of an external contingency" (p.334). Moreover, Ryan and Deci (2003) state that the concept of internalisation is associated with socialisation in a given social environment because

socialisation has been conceptualised as the process of fostering internalisation. For instance, care workers go through the process of work socialisation in the care home to learn about the regulation, values, norm and work attitudes of the care home. It may be expected that the ways in which care workers are facilitated with the socialisation influences the extent to which care home value, regulation, and norm are internalised by care workers. According to SDT, the term "self" represents the concept of integration where individuals internalise, adapt, and endorse what they experience regarding the fulfilment of basic psychological needs and their interaction with the social environment (Deci & Ryan, 2000). Ryan and Deci (2003) indicate that individuals may assume or "wear" an identity for various reasons and the internalisation allows not only the formation of an identity, but also the enactment of the identity-relevant behaviours. Furthermore, SDT indicates that the process of internalisation can be facilitated and enhanced by receiving the nutriment within the social environment (Deci & Ryan, 2000).

4.4.6 Satisfaction of psychological needs.

Nutriment has been conceptualised as the fulfilment of basic psychological needs for autonomy, competence, and relatedness. Researchers demonstrate that nutriments are essential for internalising the extrinsic values and regulation, enhancing individuals' intrinsic motivation (Deci & Ryan, 2000), individuals' optimal functioning and integrity (Gagné & Deci, 2005), social development and well-being (Gagné & Deci, 2005; Ntoumanis, 2005; Reis, Sheldon, Gable, Roscoe & Ryan, 2000), and preventing ill-being (Deci & Ryan, 2011; Ryan, Sheldon, Kasser & Deci, 1996). In contrast, lack of satisfaction with these needs would thwart the positive processes and outcomes and lead to individuals' maladaptive functioning, passivity and ill-being (Deci & Vansteenkiste, 2004; Huyghebaert et al., 2018; Vansteenkiste & Ryan, 2013). Thus, it may be understood that the nutriment individuals receive in a social environment is required to be provided consistently. These three basic psychological needs are suggested as universal necessities for individuals, regardless of their cultural background (Chirkov, Ryan, Kim & Kaplan, 2003; Kaplan & Madjar, 2017; Li et al., 2019; Martela & Riekki, 2018; Vierling, Standage & Treasure, 2007), and socioeconomic status (SES) (González, Niemiec & Williams, 2014; González, Swanson, Lynch & Williams, 2016) and how they evaluate their basic psychological needs (Gagné & Deci, 2005). In other words, all individuals have a need to experience the fulfilment of basic psychological needs.

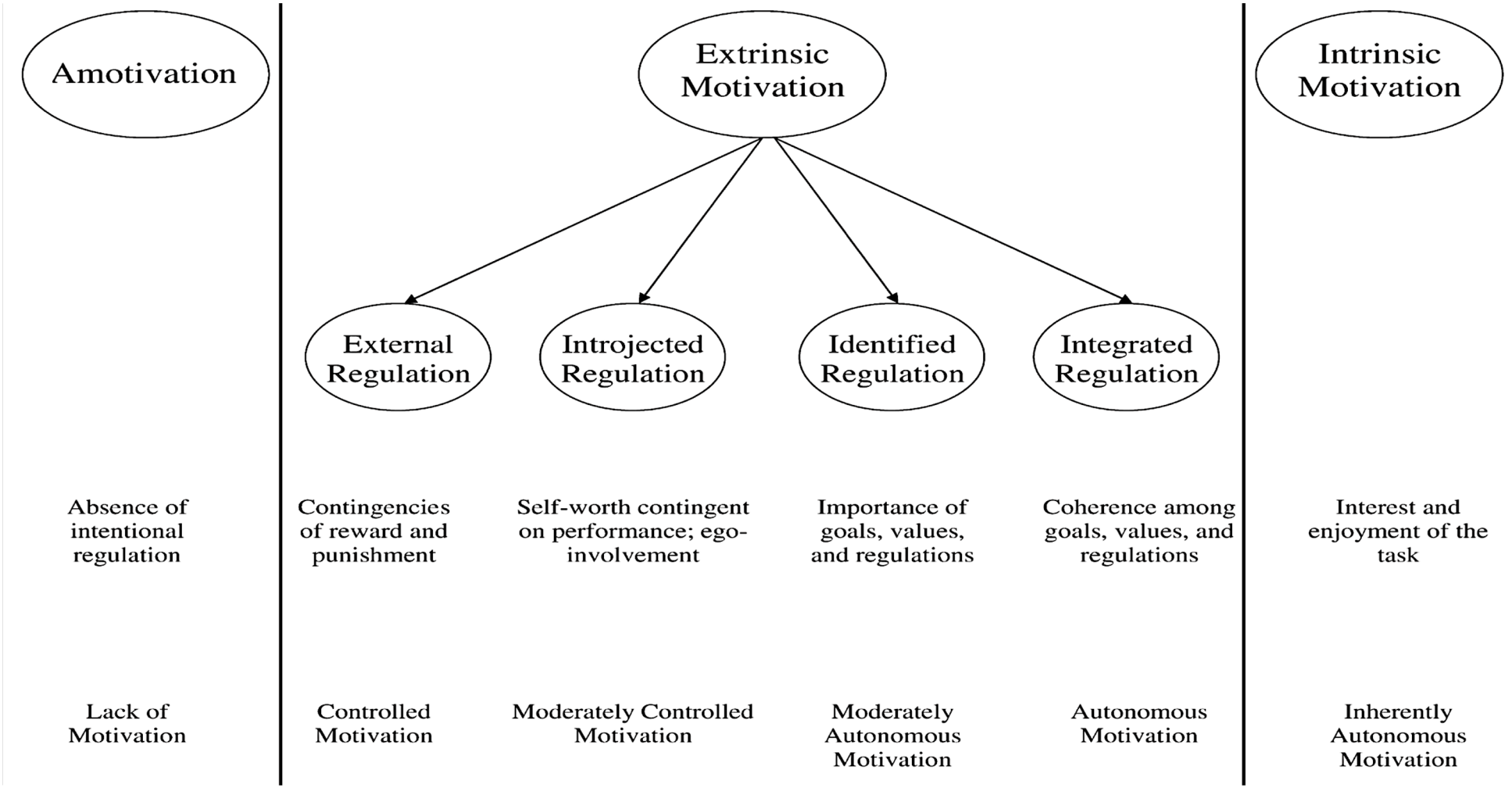

Figure 4. 1 The self-determination continuum
Source: Adapted from (Gagné and Deci, 2005, p336

In recent years, researchers suggest that SES is an important determinant of an individual's health status where individuals with lower socioeconomic status or working in lower-status occupations are more likely to experience poorer health outcomes than those with higher socioeconomic status or working in higher-status occupations (González, Niemiec & Williams, 2014; González, Swanson, Lynch & Williams, 2016; Marmot, 2006; Rouse et al., 2019). Researchers who investigate the influences of SES on individuals' physical and mental health and wellbeing from the perspective of SDT demonstrate that the satisfaction of psychological needs mediates the negative effects of SES on individuals' health (Di Domenico & Fournier, 2014; González, Niemiec & Williams, 2014; González, Swanson, Lynch & Williams, 2016). According to the findings of González et al. (2016), employees with higher SES reported better satisfaction of basic psychological needs and more positive mental and physical health outcomes whereas other employees in the same organisation with lower SES reported less satisfaction of psychological needs and more negative mental and physical health outcomes. González et al. (2016) point out that the positive relationship between SES and satisfaction of psychological needs may be influenced by the degree to which managers support their subordinates' need satisfaction and self-determination. The impacts of lack of satisfaction of psychological needs on employees' mental and physical health (González et al., 2016) were later confirmed by the study of Rouse et al. (2019) focusing on firelighters' wellbeing and psychological functioning. It is clear that the satisfaction of psychological needs is essential for individuals to experience not only intrinsic motivation, but also positive physical and psychological health regardless their SES and cultural background.

On the other hand, recent studies concerning psychological need satisfaction discuss the individual difference in need strength where individuals may perceive a psychological need as particularly more important than others (Chen et al., 2015; Hofer & Busch, 2011). It seems that some research attention in SDT has moved from focusing on the consequences of need satisfaction to the strength of three basic psychological needs.

4.4.6.1 Need for autonomy.

Need for autonomy refers to individuals' needs for having a sense of volition, freedom, willingness to make decisions while performing an activity. In other words, individuals need to have a sense of taking the ownership of their behaviour in the action. Individuals' need for autonomy is not equivalent to the need of working independently. For instance, a care worker may be asked to do an additional task independently. When this care worker makes

a volitional decision to do that task, the autonomous need is fulfilled. However, when the care worker does not want to do so but feels being forced to do that task, the autonomous needs is thwarted or frustrated, in spite of the fact that the need of working independently is satisfied. Previous research suggests that individuals with the satisfaction of autonomous needs experience a higher level of intrinsic motivation and better performance (Baard, Deci & Ryan, 2004; De Cooman, Stynen, Van den Broeck, Sels & De Witte, 2013). Furthermore, researchers point out that individuals' performance would reach optimal attainment and development when they are in an autonomy-supportive social context because they tend to internalise and integrate the external regulations of the performance (Deci & Vansteenkiste, 2004; Gagné & Deci, 2005).

4.4.6.2 Need for competence.

The need for competence suggests that individuals make inherent attempts to have a sense of effectance when dealing with the environment. Effectance refers to a state where individuals act as a causal effect on an object. Therefore, when individuals are capable of dealing with the surrounding environment and mastering it, their needs for competencies satisfied. Deci and Ryan (2000) point out that individuals are more likely to internalise responsibilities and values when they experience a satisfaction of the need for competence. Note that researchers demonstrate that the construct of competence need differs from the concept of self-efficacy (Hughes, Galbraith & White, 2011; Van den Broeck, Vansteenkiste, De Witte, Soenens &Lens, 2010) which is defined as individuals' knowledge and judgement whether they have the capabilities or competency that are required to conduct a performance or to complete a task (Bandura, 1986; Chen, Gully & Eden, 2001). Van den Broeck et al. (2010) point out that "self-efficacy represents acquired cognitions with respect to one's capacities to successfully accomplish specific future tasks. The need for competence, on the other hand, represents an inborn need. Competence satisfaction refers to a more general, affective experience of effectiveness which results from mastering a task." (p.982). Notably, despite the differences between the ways in which competence need and self-efficacy are conceptualised, these two concepts are often related in empirical studies (Van den Broeck et al., 2010)

4.4.6.3 Need for relatedness.

The need for relatedness indicates that individuals have a propensity to interact, to connect with others, to reach a sense of belongingness (Deci & Vansteenkiste, 2004), and to build meaningful interpersonal relationships with others (Moller, Deci, & Elliot, 2010). It has been

suggested that satisfying individuals' need for relatedness allows them to experience a sense of trust and intimacy (Moller, Deci, & Elliot, 2010). When individuals perceive themselves as a member of a social group and experience meaningful and reciprocal relationships with others in that social group, their need for relatedness is satisfied. In organisational contexts, some researchers apply the concept of relatedness need to understand issues such as social support and loneliness at work (Van den Broeck et al., 2010).

Satisfying individuals' need for autonomy and competence have been suggested as essential facilitators in internalising the external regulations and experiencing more autonomous form of motivation. Satisfying need for relatedness is considered as less essential in enhancing autonomous motivation as some tasks can be completed without social interaction with others (Deci & Ryan, 2000; Haivas, Hofmans & Pepermans, 2012). Conversely, scholars point out that when individuals are conducting interpersonal activities, satisfying need for relatedness becomes essential in enhancing and maintaining intrinsic motivation (Deci & Ryan, 2002). In addition, a recent study demonstrates that experiencing meaningful connections with others and sense of belongingness in an organisation enhances employees' organizational citizenship behaviours (OCB) to help their colleagues and to fulfil the organization requirement (Chiniara & Bentein, 2016). According to Organ (1988), "OCB represents individual behavior that is discretionary, not directly or explicitly recognized by the formal reward system, and in the aggregate promotes the efficient and effective functioning of the organization" (p.4). It may be understood that relatedness need satisfaction has a more significant role in facilitating internalisation and eliciting autonomous motivation than what have been previously suggested in SDT (Deci & Ryan, 2000; Haivas, Hofmans & Pepermans, 2012).

4.4.7 Limitations of SDT.

SDT is a macro theory of human motivation that emphasises the significant influences of environment on individuals' motivations. Scholars suggest that autonomy support provided to individuals in a given environment facilitate them to experience more autonomous forms of motivation (e.g. intrinsic motivation, identified regulation, and integrated regulation). The significance of autonomy support has been demonstrated in different research fields, such as parenting (Joussemet, Landry & Koestner, 2008), teaching (Furtak & Kunter, 2012), and coaching (Conroy & Coatsworth, 2007). Researchers also suggest that the relationships individuals have with significant others may be a key to fulfilling individuals' psychological needs (La Guardia & Patrick, 2008; Ryan & Deci, 2008). Considering the dynamic nature

of the relationship between individuals and their significant others, understanding of how the satisfaction of relatedness need facilitates individuals to experience more autonomous form of motivation may provide valuable insights to promote individuals' behaviour and maintain their motivated performance. However, less attention has been devoted to the influences of relatedness support on individuals' motivation in SDT research.

SDT emphasises the significant role of three basic psychological needs for facilitating individuals to internalise the extrinsic values and regulation and to enhance their intrinsic motivation (Deci & Ryan, 2000) which then leads to their optimal functioning and integrity (Gagné & Deci, 2005), social development and well-being (Gagné & Deci, 2005; Reis, Sheldon, Gable, Roscoe & Ryan, 2000). Gagné and Deci (2005) stress that three basic psychological needs for autonomy, competence, and relatedness are universal necessities for individuals, regardless how they evaluate their basic psychological needs. Sheldon and Niemiec (2006) further suggest that individuals' optimal functioning and integrity are achieved when three basic psychological needs are equally satisfied. However, recent studies argue that individuals may perceive a psychological need more important than others and suggest that there may be individual differences in need strength (Chen et al., 2015; Hofer & Busch, 2011). It seems that there is an ongoing debate regarding whether the satisfaction of psychological needs is to be considered as a universal approach or considering various strengths in individuals' perceptions. On the other hand, scholars point out the negative consequences that individuals may experience when their satisfaction of psychological needs were thwarted. However, little has been known about the consequences that individuals may experience if one or more of their psychological needs were thwarted.

SDT has been criticised for lacking empirical evidence to demonstrate the influences of organisational contexts on autonomous motivation (Ryne et al., 2005). It is worth noting that SDT is frequently applied in exploring individuals' motivation, behaviour and performance in school setting, health behaviour changes, and parenting. With respect to rewards, there is an important difference between these settings and a work setting. The rewards in these settings (school and healthcare setting and parenting) are likely to be intrinsic rewards (e.g. feeling content, achievement or experiencing health benefit) whereas in work setting the monetary compensation (e.g. salary, bonus, or benefit) is expected (Hewett & Conway, 2016). Thus, the applicability of SDT in organisational contexts may be questionable. However, there is a growing body of research examining the relationship between reward and motivation in organisational context (Chiniara & Bentein, 2016; Gerhart & Fang, 2015;

Hewett & Conway, 2016). The findings of these studies demonstrate and support the applicability of SDT in organisational context.

4.4.8 The applicability of SDT in research on care home workers.

To summarise, SDT proposes that individuals have an inherent desire or tendency for activities which leads them to experience growth, competence, self-determination and rewards. SDT also emphasises the influences of social, cultural and environmental attributes on individuals' sense of volition, motivation, well-being, functioning and performance. According to SDT, there is a distinction between intrinsic and extrinsic motivation within human motivations. Being motivated by the interests, enjoyment or values of the activities is described as intrinsic or autonomous motivation and considered as better-quality motivation when compared to motivated by external factors is depicted as extrinsic or controlled motivation. However, the concept of intrinsic and extrinsic motivation is not opposed to one another. In SDT, a self-determination continuum ranking represents different levels of internalisation. A higher level of internalisation leads individuals to have more autonomous motivation, to form an identity, and to enhance and maintain the identity-relevant behaviours. The nutriments provided by the social environment, including the satisfaction of psychological needs for autonomy, competence, and relatedness, are suggested to be essential for individuals' internalisation and are required to experience positive physical and psychological health and intrinsic motivation regardless individuals' SES and cultural background (Gagné et al., 2015; González. et al., 2016; Rouse et al., 2019).

This thesis is to investigate care workers' perceptions, experiences, and motivations of continuing their role as a care worker. Based on the literature review in chapter 2, care work may be considered as a less appealing career choice with limited external incentives. The literature review also suggests that need satisfaction of care workers, social environment of the care homes, and other psychosocial factors may have significant roles in facilitating care workers' job-related performance and encouraging them to continue working as a care worker. It may be understood that these factors imply the significant roles of intrinsic motivation and social environment in care workers' retention intention. However, the relationships between these factors or how these factors influence care workers' motivations of staying employed and their care practice remain unclear. As a career that is dominated by people and interactions with people, care workers are more likely to experience strong interpersonal relationships with residents, residents' families, colleagues, managers and other healthcare professionals. Reviewing SDT makes it clear that it has the potential to

provide a comprehensive understanding of individuals' motivations and the ways in which social and environmental attributes influence individuals' motivations. Applying SDT as the theoretical framework in this thesis may enhance our understanding of the relationships between care workers' need satisfaction, social environment of the care homes, and other psychosocial factors and the extent to which these factors influence care workers' motivation at work.

There may be a critique relating to whether SDT would be an applicable theoretical framework for furthering our understanding of care workers' motivations of staying employed, especially given that care workers are generally considered as individuals with lower SES and limited power at work. It is worth noting that SDT does not conceptualise self-determination as self-governance, empowerment or independence. Instead, SDT uses self-determination to refer to an individual's internal need to experience autonomous motivation where they engage in an activity because it is interesting to them (Deci & Ryan, 1985). Moreover, previous research points out that individuals with lower SES report lower level of satisfaction of their psychological needs and are more likely to experience negative impact on their health status (González. et al., 2016; Rouse et al., 2019). Researchers further suggest that individuals with lower SES are likely to have less support in fulfilling their psychological needs (González. et al., 2016; Rouse et al., 2019). It may be understood that the satisfaction of psychological needs is as important to individuals with higher SES as to those with lower SES. In other words, individuals' SES may not directly influence the level of their satisfaction of psychological needs, but the support for meeting their psychological needs may have a more significant role in promoting positive outcomes. Therefore, applying SDT as a theoretical framework in this thesis may have the potential to advance the understanding of care workers' motivation of continuing their work role and to explore the support care workers have or require for meeting their need satisfaction.

Given that SDT concerns the contribution of motivations, personality, social and cultural attributes on individuals' well-being, sense of volition, functioning and performance, SDT is considered as the adequate and applicable theory to enhance our understanding of care workers' work motivations while reflecting the role of their need satisfaction, relationships with residents, and social environment in the care homes in their job satisfaction and care practice.

4.5 Summary

This chapter first introduces four motivation theories in organisational contexts including behavioural approach, motivation-hygiene theory, expectancy theory, and goal-setting theory and discussed their applicability for research on care home workers' motivation in carrying on their role as a care worker. The limitations of these four motivation theories suggest they are not the most adequate theory for this thesis. This chapter then provides an overview of SDT, a theory that emphasises the contribution of motivations, personality, social environment, and cultural attributes on individuals' well-being, sense of volition, functioning and performance. Despite SDT not being considered a dominant theory in organisational psychology, it emphasises the distinction between the quantity and quality of motivation which is what those four motivation theories are lacking. SDT proposes the significant role of satisfying psychological needs by internalising external regulations, enhancing and maintaining intrinsic motivation. This may help to advance the understanding of care workers' experience and perceptions towards their work and their motivations of carrying on their role as a care home worker. Furthermore, this thesis has the potential to further develop SDT and offer a comprehensive explanation for care workers' motivation, job satisfaction, care practice, and retention based on SDT.

CHAPTER 5
METHODOLOGIES

5.1 Introduction

It has been argued that the methodology applied to conduct research should be in line with the objectives and the research aim (Breakwell, Hammond & Fife-Schaw, 2000). Crotty (1998) argues that four essential elements must be addressed throughout the research process, including epistemology, theoretical perspectives, methodologies, and methods. This view is similar to that of Denzin and Lincoln (1998) who suggest there are four fundamental issues to consider in research design: epistemological assumptions underpinning the research question, the targeting subjects or participants, research strategies, and methods to collect and analyse the data. This thesis aims to investigate care workers' work experiences, perceptions, and motivations that influence their desire to continue their work role. The objectives of this thesis were to further our understanding of care workers' perceptions and experiences at work, to add to the theoretical knowledge on care workers' motivations to continue working as a care worker and to contribute to the limited evidence-based information which could potentially inform future interventions and enhance retention, care practices, and care workers' wellbeing. In order to achieve the aim and objectives of this thesis, mixed methods were applied, including qualitative and quantitative approaches.

Given that the epistemology and associated assumptions underlying qualitative and quantitative approaches are fundamentally different, first the rationale of using mixed methods and the underlying epistemological assumptions will be discussed. Furthermore, the research questions and associated methods used to answer the questions will be presented. Penultimately, ethical issues that arise while conducting research in care home settings are addressed. Finally, the researcher's personal reflexivity is presented.

5.2 Epistemological assumptions underlying the research approaches

Epistemology refers to the theory of knowledge concerning the nature and the extent of the knowledge, such as how knowledge is learned and what knowledge can be learned (Lyons & Coyle, 2016). In the context of social research, Crotty (1998) defines epistemology as "the theory of knowledge embedded in the theoretical perspectives and thereby in the methodology" (p.3). In other words, the epistemological assumptions of research inform the research approaches, methodologies, methodological strategies, and methods (Dallos &

Draper, 2010; Roots, 2007). Moreover, it has been suggested that the epistemological assumptions underlying the research approaches and research methods allow researchers to obtain or discover different kind of knowledge (Lyons & Coyle, 2016; Yilmaz, 2013). It is worth noting that two major research approaches, which are quantitative and qualitative approaches, have contrasting epistemological positions, methodological and theoretical underpinnings, and the embedded concept of paradigm. The following section will discuss the epistemological assumptions of qualitative and quantitative approach and their strengths and restraints in conducting research.

5.2.1 Epistemological assumptions of qualitative approach.

Qualitative approach is informed by a constructivist epistemology which assumes that there is no single or tangible knowledge or reality. Instead, constructivist epistemology assumes that knowledge and reality are multiple holistic and psychologically or socially constructed. Thus, when investigating a social phenomenon, qualitative approach is concerned with the process, context, meanings, interpretations, and understanding of the social phenomenon through inductive reasoning. Moreover, qualitative approach involves using participants' own words to understand and interact with their experiences towards the social phenomenon being studied. The techniques which allow researchers to reach an in-depth description of the social phenomenon from participants' perspectives include interviews, observation, case study, and focus group. Furthermore, a qualitative approach aims to reach a subjective reality or knowledge by understanding individuals' experiences, the context which influences their behaviour, and the meanings which they give to their experiences. This is often achieved by the use of open-ended questions that do not contain pre-set response categories. It is worth noting that in the qualitative paradigm, the researchers' role is viewed as inevitably involved in and connected to the social phenomenon being studied. Therefore, it is suggested that researchers develop an empathic relationship with individuals involved in the social phenomenon being studied (Cohen, Manion & Marrison, 2007; Yilmaz, 2013). Moreover, the quality of qualitative approach is evaluated based on whether a rigorous process is adhered to by researchers and whether the findings have the significance and contribute to our understandings (Golafshani, 2003).

5.2.2 Epistemological assumptions of quantitative approach.

Unlike qualitative approach, a quantitative approach is based on positivist and objectivist epistemology which assumes that there is an objective reality or knowledge within the social and psychological phenomena. In a quantitative paradigm, it is assumed that there is a direct

connection between objective knowledge and individuals' perceptions and understandings. Therefore, explanatory universal laws of social behaviour can be developed through deductive reasoning. One method is to interpret empirical data using statistical analyses to test the developed hypotheses to produce an objective account of the reality or knowledge. Quantitative approach focuses on the explanations of causal relationships between constructs, generalisability, and prediction. Thus, it requires researchers to establish hypotheses prior to data collection, recruit a representative sample and collect data using pre-determined response categories, standardised measurements, or closed-ended questions. The selection of standardised measurement is based on existing theories and whether they reflect participants' different perspectives and experiences of the phenomena being studied. In the quantitative paradigm, researchers are expected to be neutral during the research process and distance themselves from the phenomena being studied. Hence, a standardised procedure and method for collecting data is required.

5.2.3 Limitations and strengths of qualitative and quantitative approach.

Qualitative and quantitative approaches have contrasting epistemological, theoretical and methodological underpinnings. Qualitative approach selects a small number of participants through purposeful sampling procedures to explore the phenomena and produce an in-depth description and subjective understanding of the phenomena. Whereas quantitative approach requires a large sample size to investigate the causal relationships based on prior theories. The former provides insightful understandings of individuals' personal experiences and meanings towards the social phenomenon being studied while the latter often overlooks participants' feelings, views, and personal experiences (Patton, 2002). On the other hand, the purposeful sampling procedure allows qualitative research to focus on the individuals who involved in the phenomenon being studied but limits its possibility to generalise the findings to different situations or settings due to its context sensitive nature (Yilmaz, 2013).

The literature review in chapter 2 revealed that care workers' organisational commitment and job satisfaction have been investigated qualitatively and quantitatively. The literature review suggested that little has been known about care workers' role perceptions, sense-making, and identities which are considered as influential on their expectations towards their work. In-depth descriptions and understandings of care home workers' role perceptions and work experiences in providing care for residents were expected to provide a rich and holistic scope of care workers' retention and motivation. Considering the nature and epistemological assumptions of qualitative approach and its advantage to reach an in-depth description of the

meanings, experiences, and context of the phenomena, qualitative approach is adequate to research on care workers' experience and perceptions of providing care to residents. Nevertheless, qualitative approach has its limitations, including not providing causal relationships between constructs or facilitating prediction or generalising findings to different situations or settings. Thus, the qualitative approach cannot determine definitive causal relationships to identify effective motivators which encourage care workers to carry on their role in the care homes.

Positivist epistemology underpins the research paradigm in organisational studies and psychology. Applying a quantitative approach throughout this thesis could be an option, especially quantitative research assumes findings to be objective. Nevertheless, in some cases the objectivity may be affected by researchers' choice, such as which theoretical framework to base, what constructs to measure, which measures to use, the way to sample the participants, and which statistical analysis to conduct (Craighead, Ketchen, Dunn & Hult, 2011; Podsakoff, MacKenzie, Lee & Podsakoff, 2003). In chapter 2, the literature review revealed some previous issues of research on care workers' retention including the lack of clear definition of the constructs measured and strong theoretical framework (e.g. Karsh, Booske & Sainfort, 2005). These issues may affect the objectivity of quantitative findings in understanding care workers' organisational commitment and job satisfaction. It has been suggested that qualitative research can generate robust theory through rich data from individuals' accounts (Craighead, Ketchen, Dunn & Hult, 2011) which can be used to interpret and offer accounts for the quantitative findings (Willig, 2013). Hence, qualitative research was used in this thesis to provide a rationale and justification for the hypotheses and constructs being tested. In this thesis, qualitative research was conducted to explore care workers' work experience and role perceptions. The findings of care workers' account together with the theoretical framework of self-determination theory was applied to devise a survey study. After examining the relationships between constructs, a qualitative study focusing on the perspectives of care home managers was conducted to learn about care workers' work barriers, motivation and support needs.

5.2.4 Researcher's own epistemological stance.

The researcher believes that individuals have their own views and interpretations towards the reality and knowledge and agrees with the constructivist perspective that the reality or knowledge is socially or psychologically constructed. In order to explore care workers' work experiences and role perceptions, the researcher believes that such understanding should be

socially situated. On the other hand, the researcher also accepts the concept of positivism. In the researcher's opinion, there is an objective reality or knowledge which is shared by individuals and provides a mutual understanding for them to communicate with others. Based on the strengths and limitations of qualitative and quantitative approaches, the researcher considers mixed methods are a favourable approach which allows the researcher to complement the limitations of quantitative and quantitative approaches. The researcher assumes the perspective of pragmatism which concerns the intersubjectivity in the research process, adopts abduction reasoning, and focuses on the transferability of the findings (Morgan, 2007). Intersubjectivity refers to the duality of relationship in the research process where objectivity may co-exist with subjectivity and vice versa. Abduction reasoning refers to the connection between theory and data which involves moving back and forth between induction and deduction reasoning. Transferability concerns the inference of data which involves working between context specific results and the more universal and generalized implication. This requires careful reflection by the researcher concerning the extent that this knowledge may be or may not be applied to different situations or settings.

The use of mixed methods to conduct research is increasing across different research fields, such as organisational studies (Tariq & Woodman, 2013) and health research (Guetterman, Creswell, Deutsch & Gallo, 2016; Reio Jr. & Werner, 2017; Yardley & Bishop, 2015). Some suggest that the use of mixed methods allows researchers to grasp more comprehensive social phenomena and behaviours in social contexts (Leiber & Weisner, 2010; Lyons & Coyle, 2016). This thesis was aimed at investigating how care workers perceive and make sense of their work role, how their meanings and perceptions influence their job satisfaction and organisational commitment, and what facilitates their sense-making and role perceptions.

5.3 Research question

The literature review in chapter 2 examined the chronic issue of high turnover in care homes, its impact on care practices, care quality, and care workers' wellbeing. The review has shown that care workers' job satisfaction and organisational commitment have been strongly linked to their turnover intention. Thus, investigating the antecedences or predictors of care workers' job satisfaction and organisational commitment may help to identify effective motivators that may help with care home workers retention. The literature review suggested that care workers' motivation is associated with their expectations towards their work, need satisfaction, relationships with residents, and social environment in the care homes. Nevertheless, there is limited literature on the understanding of care workers' role, identity

and work values which attribute to their expectations towards their work. Without a comprehensive understanding of care workers' experiences and perceptions towards care work, it can be difficult to further investigate the effective motivators that may help with care home workers retention.

Moreover, many studies have emphasised the role of social interaction in providing quality care for residents. However, only a few studies have addressed how care workers' perceptions of their social interactions with residents, families, colleagues, managers, and other healthcare professionals may impact their work experiences and job satisfaction. The review of SDT in chapter 4 emphasised the significant role of social environment in facilitating individuals to internalise external regulations into the self, enhance more autonomous motivation, and maintain intrinsic motivation. It may be assumed that the interactions care workers may have with others (e.g. residents, residents' families, colleagues, other health professionals, managers) in the care homes would exert influences on their experience and motivation. Moreover, much research focus has been placed on investigating the influences of social environment on residents' social needs and psychological welling. The barriers that care workers experience at work that impede their care practices and the support they require for coping with job demands remain unclear.

Furthermore, the role of care home managers has been suggested as essential in ensuring that residents receive quality care, that training is provided to care workers, and a positive work environment is fostered in the care home. However, little has been known about how each care home manager perceives their staff's support needs and work difficulties or what the managerial role entails in facilitating care workers managing the difficulties at work, meeting staff's support needs, and retaining staff. Thus, it is unclear whether care home managers' roles and perceptions are comparable across the care homes or some have dissimilarities which have positive or negative effects on care workers' motivation, job satisfaction and retention.

The aim of this thesis was to investigate care workers' perceptions, experiences, and motivations of continuing their role as a care worker. More specifically, three research questions of this thesis were:

1. What are the care workers' perceptions and experiences in providing care for residents from the admission to the care home up to the end of life?

a. What are care workers' experiences of providing care to residents up to the end of life?
b. How do care workers perceive their role and conceptualise their work identities as a care worker?
c. What are the barriers or facilitators which impede or enhance care workers' care practices and experiences?
d. What are care workers' coping strategies for the barriers and challenges encountered at work?

2. What are the influences or relationships between care workers' perceptions towards their work roles in care homes, psychosocial attributes, psychological needs, and motivation, and the care workers' organisational commitment and job satisfaction?
3. What are the care home managers' perceptions on the ways in which they facilitate their care workers in the care homes?
    a. What do care home managers perceive as their care workers' support needs and barriers to carry out their role?
    b. How do care home managers facilitate their care workers to cope with the barriers and difficulties at work?
    c. What do care home managers do to facilitate their care workers in developing work identities and organisational commitment

5.4 Research questions and the associated methods and strategies

The first research question concerns the experiences, perceptions, feelings, and views of care workers in relation to their role, care practices, and interaction with significant others, such as residents, residents' families, colleagues, managers and other healthcare professionals. The second research question investigates the influences of care workers' role perceptions, psychosocial attributes, psychological needs, and motivation on their job satisfaction and organisational commitment. The last question deals with the perceptions, views and experiences of care home managers in relation to the ways in which they facilitate care workers to develop work identities and cope with the difficulties and barriers that they may experience at work.

The first research question was aimed to explore the experience of care workers. It is essential to discover care workers' day-to-day interactions with residents and others in the care homes, the ways in which care workers make sense of their experience, and how they

construct meanings out of their role and responsibilities. Thus, a qualitative approach with individual semi-structured face-to-face interviews was conducted. Given that the majority of the social care workforce in England is female (Skills for care, 2018), the participants in this study were all female care workers providing care to residents in care home settings. Homogeneous sampling allowed the researcher to focus in depth on care workers' experience and perceptions at work. In order to enable care workers to describe their work experiences and perceptions of their role, a grand tour question (Leech, 2002) was used to ask care workers to recollect a typical working day with residents. Given that the social interaction has been suggested as a process enabling individuals to learn about the norm and role expectations attached to the position individuals occupied in a given social structure (Stets & Burke, 2000; Stryker & Burke, 2000), the focus of the interview will also include care workers' interaction with others including residents, residents' families, colleagues, managers, and other healthcare professionals. This allowed the researcher to explore how care workers perceive their role in the social environment in the care homes and their feelings about the social interaction in relation to their care practices.

The findings of the first study (presented in chapter 6) highlighted that the barriers care workers experienced at work and the facilitators for carrying on their work role were associated with their perceptions towards their job. It is worth noting that the findings of the first study can only provide transferability, not generalisability, especially as the focus of the first study was on female care workers. The findings also implied the significant role of care workers' work identities in relation to other constructs. It is worth noting that a quantitative approach permits researchers to develop an explanatory universal pattern or law to explain the relationship between constructs (Yilmaz, 2013). Thus, a quantitative approach was chosen for the second study to focus on whether care workers' role perceptions in the care homes, self-concept, psychological needs, and motivation predict or associate with their organisational commitment and job satisfaction. Moreover, the constructs concerned in the second study are not entirely independent from one another. It may be assumed that each construct may have some effects on one another. Thus, a model hypothesising the relationships between each construct based on previous research and self-determination theory was established. Using the pre-existing measures allowed the researcher not only to focus on certain processes of the constructs by limiting participants' options but also to ensure the validity and reliability of the measures. The data were analysed using structural equation modelling (SEM) which is considered as a powerful and flexible statistical method

allowing researchers to reach the unbiased relationships between constructs (Cohen, Cohen, West & Aiken, 2013; Iacobucci, Saldanha & Deng, 2007; Kline, 2015).

The results of the second study (presented in chapter 6) demonstrated suggested a directional linkage from care workers' organisational identification to the satisfaction of psychological needs, to intrinsic motivation and to organisational commitment and job satisfaction. This emphasised the significance of care workers' work identities in experiencing a better job satisfaction and higher organisational commitment. Moreover, the results implied that developing care workers' work identities is a key to positive organisational outcome. Thus, learning about the development of care workers' work identities seemed to be required. Given that chapter 2 and the findings of study 1 and 2 highlighted the significant role care home managers had in training and supporting care workers, understanding their perceptions of care workers' work barriers and support needs and experiences of supporting and facilitating care workers to develop work identities was important. Given that each care home manager may have different experiences, care home culture and values, it was essential to enable them to express their views and experiences. Thus, a qualitative approach exploring the experience and perceptions of care home managers was applied. Care home managers were asked about their expectations towards their care workers, their perceptions regarding care workers' barriers, their management to meet care workers' support needs, and their conception of boundaries for the care workers. Learning about care home managers' experiences and perceptions would enhance the understanding of the issues surrounding care workers' work identities, barriers, motivation, job satisfaction and organisational commitment.

It is worth noting that both the first and third research questions concern participants' perceptions, experiences, views and meanings and require a qualitative approach. The focus of the first qualitative study is on care workers' experiences, understandings, perceptions, in relation to their day-to-day work and care practices, whereas the focus of the third study is on care home managers' accounts and perceptions in relation to care workers' support needs and work barriers. Three different qualitative analyses were considered, including interpretative phenomenological analysis (IPA; Smith & Osborm, 2003), grounded theory (GT; Corbin & Strauss 2008), and thematic analysis (TA; Braun & Clarke, 2006; Clarke & Braun, 2013). IPA assumes a realist perspective to produce knowledge and concerns the ways in which participants perceive, interpret and make sense of the world or reality in detail and allows researchers to explore the meanings participants expressed while acknowledging

researchers' involvement in interpreting participants' sense-making of their own experiences. Thus, IPA is focus on capturing participants' individual and subjective experience of the world instead of the objective perspective of the social world. GT which assumes a positivist perspective to produce knowledge has full and abbreviated versions (Charmaz, 2002). In spite of having different versions of GT, it is used to identify or map social processes between actions and their consequences or the patterns of the social interaction under discussion. According to GT, the theories or patterns are emerged from data and therefore the role of researchers is akin to an observer. However, it has been heavily criticised because GT does not pay sufficient attention to the researchers' perspectives in observations and the research questions asked by researcher that can influence the observation and analysis (Charmaz, 2006).

In contrast, TA is considered compatible with essentialist and constructionist approaches within psychology. Braun and Clarke (2006) state that: "Thematic analysis is a method for identifying, analysing and reporting patterns (themes) within data. It minimally organises and describes your data in (rich) detail. However, frequently it goes further than this and interprets various aspects of the research topic" (p. 79). The advantages of using thematic analysis have been well-documented (Braun & Clarke, 2006; Clarke & Braun, 2013). TA is appropriate for exploring individuals' experience in general or in a specific context. It also has a theoretical flexibility that allows researchers to search and examine the patterns in the data without any theoretical constraint. It can be used in inductive and deductive approach or from the essentialist/realist and constructionist perspective when analysing participants' responses. In order to learn about care workers' and care home manager' experience and perceptions, the thematic analysis (TA; Braun & Clarke, 2006; Clarke & Braun, 2013) was used to analyse both qualitative studies. It is worth noting that the literature reviews in chapter 2 and 3 have emphasised the significance of social environment in individuals' motivation and in care work. The researcher agreed with the perspective of constructionism where human being are social beings and the meanings, experiences, and perceptions are significantly influenced by norm, values, social interaction and social environment. In order to understand care workers and care home managers' experience and perspectives, their accounts should not be assumed as a transparent reflection or articulation. The social-cultural contexts should be considered together with participants' account. Thus, a TA was conducted with the constructionist perspective to analyse both the qualitative studies.

The findings of this thesis have the potential to tackle the issues which may positively or negatively impact on care workers' motivation in carrying on their role, and implications for planning interventions to support care workers and informing the policy change. Thus, in this thesis, both qualitative and quantitative methods were applied to explore the issues and to ensure the validity, reliability, credibility, trustworthiness, transferability, and dependability of the findings.

5.5 Criteria for evaluating research

Given that qualitative and quantitative research have contrasting epistemological positions, methodological, and theoretical underpinning, the criteria for evaluating these two research approaches are different. In this section, the evaluation criteria used in this thesis is described.

5.5.1 Evaluating quantitative research.

In quantitative research, validity and reliability are two important criteria to evaluate the quality of the research. Validity refers to the accuracy of the data collected and whether the measures used reflect the expected constructs. Convergent and discriminant validity are most widely utilised in structural equation modelling (SEM) studies (Campbell & Fiske, 1959; Hair, Black, Babin, Anderson & Tatham, 2006). Convergent validity in SEM refers to the extent to which a measure is adequately measured by its indicators (Alarcón, Sánchez & De Olavide, 2015; Bagozzi & Yi, 1988). Discriminant validity refers to the extent to which a latent construct differentiates from other latent constructs in the measurement model (Farrell & Rudd, 2009; Fornell & Larcker, 1981). In the second study, the multitrait-multimethod (MTMM) approach was used to demonstrate the convergent and discriminant validity in the hypothesised measurement model. Moreover, reliability refers to the extent to which a measure can constantly reflect the construct regardless of the occasion, location, and timing where it was implemented (Cortina, 1993). Cronbach's coefficient alpha (Cronbach, 1951) is the most effective and widely used estimator to evaluate the reliability of a single measure (Cho, 2016; Cortina, 1993; Hogan, Benjamin & Brezinski, 2000). However, it has been argued as inadequate for estimating reliability in a measurement model with multiple latent constructs (Yang & Green, 2011; Zinbarg, Yovel, Revelle & McDonald, 2006). On the other hand, a measure of composite reliability (CR) has been suggested as an effective estimator for reliability in SEM (Bacon, Sauer & Young, 1995; Fornell, & Larcker, 1981), despite it not being an appropriate tool to modify the measurement model. Therefore, in the second study, Cronbach's alpha was used first and then confirmatory factor analysis (CFA) and SEM were conducted, while CR was used to estimate the reliability of the measurement model.

5.5.2 Evaluating qualitative research.

It has been argued that applying the concept of validity and reliability to evaluate the quality of qualitative research is irreverent and misleading (Creswell, 2009; Yilmaz, 2013). On the other hand, given that the focus of qualitative research is on the process, context, meanings, interpretations, and understanding of the social phenomenon, the concept of trustworthiness and authenticity may be vital criteria for the evaluation of qualitative research (Creswell & Miller, 2000). Authenticity involves the concepts of fairness, understanding of others' constructed reality or knowledge, and empowerment. Credibility, transferability, and dependability have been used to depict different aspects of trustworthiness (Graneheim & Lundman, 2004; Yilmaz, 2013). Credibility indicates how well the findings of a qualitative research address the research questions and whether others (e.g. participants, other researchers) consider the findings to be true or credible. Transferability indicates whether the findings of a qualitative research can fit into a different context. This depends on the degree of similarities between two contexts and therefore requires the original researchers to provide in-depth descriptions of the setting, context, and participants being studied. Dependability refers to the consistent process throughout the data collection and across different researchers. Therefore, the explanations for the ways in which research strategies, procedures, and methods are selected, justified, and applied are required in order to achieve dependability. The findings of the two qualitative studies were discussed with both supervisors to ensure the credibility throughout the data analysis and writing up phases. The researcher also provided detailed information regarding participants and care home settings in the findings section of both qualitative studies to ensure transferability. Furthermore, examples of transcripts were provided (Appendix 8 & 23) to demonstrate a consistent process throughout the data collection and to present the ways in which research procedures and methods were applied. This would help to ensure dependability in both qualitative studies.

Moreover, it has been suggested that researchers as having an influential role in qualitative research process because they decide the duration of data collection, select the analytical procedures, interpret the data, and develop the findings and interpretation into a credible narrative (Creswell & Miller, 2000). Therefore, researchers' reflexivity is essential in the evaluation of qualitative research. This requires researchers to disclose their assumptions, personal beliefs, experiences, values, and biases in relation to the phenomenon being studied. The researcher's personal reflexivity in relation to the research on care workers' experience, perceptions and motivation at work will be addressed after the ethical consideration. It is

worth noting that scholars have argued that the quality of both qualitative and quantitative research can be undermined if the ethical issues are not properly addressed (Christensen & Prout, 2002; Drake, 2014; Peled & Leichtentritt, 2002). In the following section, the ethical issues raised in the research process of this thesis will be discussed.

5.6 Ethical consideration

Steffen (2015) points out that ethical issues arise throughout the research process including research planning, data collection, data analysis and findings dissemination. Considering the diversity of ethical issues, the British psychological society (BPS) publishes *Code of Human Research Ethics* (2014) and *Code of Ethics and Conduct* (2018) to address the basic principles of research conduct. In *Code of Human Research Ethics* (BPS, 2014), four principles are discussed: respect for the autonomy, privacy and dignity of individuals and communities, scientific integrity, social responsibility, and maximising benefit and minimising harm (p.7). Steffen (2015) suggests a number of ethical issues in conducting qualitative research including safety, sampling and access to participants, informed consent, confidentiality and anonymity, interviewing and debriefing, online research, and researchers' involvement in research. It is important to consider these issues based on the principles proposed by the BPS. In this section, an overview of these ethical issues and the researcher's decisions in relation to these issues will be provided. The detailed information for the ethical and consent procedures relating to each individual study will be discussed in chapter 5, 6, and 7. Prior to approaching care homes, the ethical approval for each study was granted by the Faculty Research Ethics Committee (FREC) in the Faculty of Art and Social Sciences at Kingston University. This helped to ensure that the researcher addressed the ethical issues and was aware of the ethical duties and obligations in conducting research.

5.6.1 Sampling and access to participants.

A careful consideration was given to the methods used to approach and engage care workers and care home managers which did not lead to any potential harmful effects on their wellbeing or work conditions. In study 1 and 2, care home managers were requested to be the gatekeeper to help recruit participants but also to evaluate whether their care workers' participation in the research is for the best interests of the care workers and the care homes. Thus, care home managers were approached initially by an email enclosing an information sheet to explain the purpose of the research. Obtaining care home managers' support for their care workers' participation in the research prior to approaching care workers was considered as the best engagement because it helped to eliminate any possibilities for triggering care

workers' fear of retribution. After care home managers expressed the support for their care workers' participation in the research, a meeting was arranged with the care home managers. In this meeting, the research aims were presented, and the managers' concerns were addressed. Firstly, a brief introduction of the research aim and research process were presented, as it was important for managers to fully understand the research process. If care home managers had any questions regarding the research, the questions would be answered and clarified. Secondly, researcher's ethical duties and obligations were discussed, including protecting the confidentiality of care workers and care homes, the usage and protection of the data. It was important to articulate that the researcher would not discuss or disclose any information or issues brought up by care workers during the interviews with the care home manager. However, if any care workers indicated a suicidal intention or hurting others, the matters should be reported and discussed with the care home managers. Care home managers helped with the recruitment in the research by disseminating the information sheets and invitation letters to the care workers. This is considered an effective way to express care home managers' support for care workers' participation in the research and to introduce the study and researcher to the care workers which may facilitate forming researcher-participant relationship.

5.6.2 Informed consent and researcher-participant relationship.

It is worth noting that in qualitative paradigm, it is suggested that researchers are inevitably connecting with participants (Cohen, Manion & Marrison, 2007; Yilmaz, 2013) and advised to minimize the differences and distance of the researcher-participant relationship (Karnieli-Miller, Strier & Pessach, 2009). Hence, it appears that developing a trusting relationship with participants is essential. Scholars point out that researcher-participant relationship is rooted in social relations and social and cultural contexts and therefore has a significant influence on the research process and research findings (Christensen & Prout, 2002). The researcher had different social power, life experience, and understanding and expectations of the research from care workers and care home managers. I am also aware of the hierarchical power relations between the care home manager, care workers, and myself, as an external researcher. Care workers may have been perceived as relatively powerless in comparison to the managers in the power hierarch in the care homes. I do not assume that care workers may think their participation in the research is compulsory. Nevertheless, there is a possibility that care workers may think that they are obligated to participate in the research so that they can express their support to the managers or to maintain the relationship with the managers. It is important to emphasise the significance of care workers' self-

determination and informed consent in taking part in this research in the meeting with the care home momagers. In addition, prior to the interview taking place, I took time to explain the research aim to the participants and their right to not participate in the research and to withdraw from the study, as well as the researcher's responsibilities. This explanation provided participants another opportunity to make an informed decision and allowed the researcher to obtain both oral and written consent to ensure the voluntary nature of participation.

Furthermore, the concept of empowerment, which has been suggested in conducting feminist and social research, is perceived as a part of the research-related benefit for the participants. Empowerment is defined as "a process of enabling people, as individuals or as communities, to master their environment and achieve self- determination through the acquisition of skills, knowledge, and emotional as well as material resources, by which meaningful social roles are fulfilled," (Peled & Leichtentritt, 2002, p.149). Scholars argue that participants' adversity should not be treated as merely a research opportunity (Thompson, 1992) but as an opportunity for empowering the participants throughout the research process. To reflect this view in this research with care workers and care home managers, it is essential to ensure their views and voices being heard (Butler, 2000; Peled & Leichtentritt). Thus, I familiarised myself with the interview guide so that I could pay attention to the participants throughout the interviews. This is also considered as a means to express my respect towards the participants. I also conducted a thematic analysis in a deliberate and rigorous manner to ensure the findings reflect participants' views and voices. On the other hand, despite care home managers not always being considered as vulnerable or powerless as care workers, I believed that paying respect and attention to the care home managers, ensuring their voiced being heard, and rigorous data analysis process were important and a part of the researcher's obligation in conducting research.

5.6.3 Confidentiality and anonymity.

According to the guide to the General Data Protection Regulation (ICO, 2018), the integrity and confidentiality are a key principle in terms of the personal data protection and process. The issues of anonymity and confidentiality were important consideration when conducting the research. For the data analysis purposes, and with the participants' permission, all the interviews were audio-recorded and transcribed verbatim. Whereas the responses in the questionnaires were entered to a password-protected computer file. In order to ensure the confidentiality of care workers and care homes, participants' names were replaced with their

assigned identification number (e.g. R01), whereas the name of the care home was removed and simply referred to as “this care home” or “the care home”. Other individuals who were mentioned in the interviews also had their names removed and referred to as “the resident”, “families”, “the manager”, and “the colleague”. Any information which may be used to identify care workers or care homes was removed. Furthermore, the audio-recorded data and the interview transcriptions were stored safely in a password protected file and only accessible by the researcher and her supervisors.

Confidence around confidentiality was particularly important for those participants who chose self-administered questionnaire (in study 2) because care home mangers were the one to collect the completed questionnaires. Confidentiality was brought up in the meeting with care home managers to emphasise the significance of ensuring care workers’ anonymity and confidentiality prior to the data collection. However, a discussion with care home managers may not reassure care workers that their data would be protected properly. Thus, a document pack enclosing an envelope, information sheet, consent form, and questionnaire was provided to each participant. With this envelope, participants were able to seal the questionnaire in the envelope before returning it to the managers. For those participants who preferred to complete the questionnaire electronically, a link to an online survey (https://kingstonpcs.eu.qualtrics.com/jfe/form/SV_d5O1sSjv0InESCV), which content was set up as identical to the hardcopy document packs, was sent to the care home managers so that they could forward the link to their care workers.

5.6.4 Researcher’s responsibilities while conducting research in care homes

There have been negative media coverage and reports of poor care practices in care homes. In conducting research in care homes to explore care workers’ perceptions and experiences at work, the researcher was aware that the aim of the interviews was not to evaluate care workers’ care practices or the quality of care in the care homes. It was important to explain to participants that an interview was not an assessment and that their accounts were not subject to evaluation in terms of quality of care practices. As discussed above, it was the researcher’s responsibility to protect participants’ data and ensure their confidentiality and anonymity. The researcher was also aware of her responsibility to report to the care home managers if any participants expressed their intent to hurt themselves or others, or any incidents of abuse or poor care were mentioned. It is suggested that it is a researcher’s responsibility to report and intervene when witnessing or learning about an incident of poor care during research in care homes (Krause, Palmer, Bowers & Buckwalter, 2011). However,

a question has been raised with respect to what extent the care provision should be conceptualised as poor or abusive. According to Shanahan (2019), poor care is suggested as "an umbrella term covering the unsatisfactory standard of the (care) delivery and or receipt of clinical and interpersonal attention." (p. 121). Therefore, poor care may include care recipients being neglected (Mandelstam, 2014), the activities or care being experienced by care recipients as unsatisfactory, and care without respect or sensitivity (Shanahan, 2019). When witnessing poor care, scholars acknowledge the struggle researchers may experience while trying to balance their own interests in completing the research in care homes with their commitment to fulfil their ethical responsibilities as researchers (Kayser-Jones, Beard & Sharpp, 2009; Krause, Palmer, Bowers & Buckwalter, 2011; Mayo & Wallhagen, 2009). Krause, Palmer, Bowers and Buckwalter (2011) suggest researchers could extend the observation time, collect more information about the incident, speak with the resident and the member of staff involved, inform management, and file a report with the local council or ombudsman.

The researcher did not witness or learn of any poor care while conducting research in care homes. As a result of the researcher's efforts to eliminate the possible influences on care workers' workload, the researcher had limited opportunity to see the interactions between care workers and residents. The interviews with care workers and care home managers were arranged during less busy time in the care homes and scheduled no more than two interviews in one care home on the same day. The interviews in the care homes were done in waiting rooms and a quite reception area. The research was not conducted as an observation study and contact in the premises of the care home was limited to the interview and waiting times. However, the researcher was aware of her ethical responsibility of being a researcher and her ethical responsibility of conducting research in care homes. If any incident of poor care had been witnessed, heard or learned, the researcher would have informed the care home manager and discussed these observations with her supervisors.

Some participants recollected the incidents where they witnessed unsatisfactory care provided by their fellow care workers. This was not a question in the interview guides, however participants spontaneously provided detailed accounts of such instances. Participants often recalled the instances relating to care facilities they previously worked in and also actions taken. In no instance, did the research need to report back to managers or her supervisors about instance of abuse or safeguarding issues. For example, one of the participants discussed an incident few years ago that a care worker physically abused a

resident. The participant stated that once she learned the incident from other care workers, she immediately reported the incident to the authority, ensured the resident's safety, and dismissed the care worker involved. As the participants had followed protocols, the researcher did not require to report this incident.

5.7 Personal reflexivity

Despite the researchers' role being viewed as independent from the quantitative research process, it has been suggested that qualitative researchers should be aware of their inevitable relationship with the participants and involvement in research process. Moreover, it has been suggested that researchers' background knowledge, theoretical concerns, and biographic experiences have an influential role on their choice of theoretical framework, data analysis and sense-making (Lyons & Coyle, 2016). Thus, it is important for researchers to reflect on their previous experience and knowledge of the subject matter which may be significant in the research process.

5.7.1 Research interests in end-of-life care.

I had experienced two close relatives' end-of-life care. I still remember the struggles, tension and the induced emotions at the final stage of their lives in Taiwan. One was my mother who passed away due to the complications of kidney failure and the other was my grandfather. Live-in care worker looked after my mother and grandfather. I remember that she understood my grandfather's unclear talk and his care needs. The fact that my grandfather was at the end of his life induced the conflict, struggle, and negative emotions in our family and the care worker was involuntarily involved in our family conflicts and having to dealing with the negative emotions. In spite of my grandmother's negative emotions and misunderstanding toward the care worker, I was surprised that she just carried on her work supporting my grandfather. To some degree, I might be able to empathise with my grandmother's feelings because I too felt a sense of guilt about not knowing my grandfather' needs which then made me feel like I had neglected my familial obligation. Nevertheless, it was difficult to reassure my grandmother that the care worker was only doing her job in caring for my grandfather. Witnessing what happened in my family at my grandfather's end of life makes me wonder how care workers carry on working under such conflict, emotions, and tension and how they cope with those situations. These questions ultimately led to this thesis.

When I was doing the MSc in Health Psychology at the University of Surrey, I become interested in end-of-life in care home settings. I explored the conflicts care workers

experienced in providing end-of-life care for my MSc dissertation. What I have learned was that while care workers experience difficulties physically and psychologically, they endure the difficulties, and some enjoy what they have achieved. The population is ageing globally, and the care demand is increasing. Care home settings have become an important site for older people to receive end-of-life care. I am interested in care workers' perception of their role and the support they need to assume their care role.

5.7.2 Being aware of my own expectation in the research.

Despite the negative media coverage concerning abusive care workers in care home settings, I had the positive personal experience with care workers and their care for my relatives. Yet, the positive experiences may foster my expectations towards the care workers that they were dedicated to care work. I came to realise this issue when I went to interview some care workers in a care home where I experienced strong sense of discomfort despite the fact that the care home managers and workers were supportive of my study. Reflecting on the discomfort I experienced in that care home, I realised that I personally had very strong expectations about care homes and care work, even though I have never personally worked as a care worker before. In order to avoid my expectations affecting my research, I had been advised by my supervisors to keep a record about my feelings during the data collection and data analysis which could help to remind me of my stance as a researcher in conducting research in care homes.

5.7.3 Being aware of different social power and position.

I was aware that I had different social power, understanding of care work, and expectations of the research from care workers and care home managers. As a foreign PhD researcher, my understanding of care work was mainly obtained from literature and my expectation of the research was to learn from care workers' experiences. Care workers, on the other hand, had their understanding of care work through training and experience. Despite care workers and I having different education background and social power, I believe they are the experts of their own experiences and in their care work. Thus, learning from participants' care work experiences without judgment or pre-set expectations was crucial. I would ask participants to provide an example of what they had just mentioned or to further illustrate their response. However, I felt that I had to choose wording carefully because I wished to avoid being perceived as questioning their decisions or judging them. it was important that my questioning style made care workers feel their contributions towards my research were valued.

Moreover, I felt that many care workers expected the research to make their voice, opinion, and story heard, whereas some care workers expected the research to reveal their struggle at work and bring changes to their work environment. There were a few care workers who did not seem to have any specific expectations towards the research. Many care workers who would like to have their voice heard were keen to share their stories and offer clear messages in the interviews. Some care workers discussed the difficulties they experienced when providing care to residents or working with care home managers. Although no participants vocalised a feeling that I should show support to them or pick sides, I often found some interview scenarios difficult to respond in a non-judgemental or neutral manner. For instance, a participant described an incidence where a resident threw a cup of juice at her. I asked about her feelings and management towards the incident. However, I wondered if I responded to participant's story in a positive and empowering manner. These difficulties were sometimes repeated in interviews with care home managers. For instance, one participant made a comment about care workers' personal attitude and their job satisfaction which in my personal opinion was generalised and inaccurate. At that moment, I felt emotionally provoked by the comment and I expressed that I was uncertain about her comment. The participant further illustrated her comment. I came to realise that the participant's comment was the result of a struggle experienced in management. Being aware of my position in conducting interviews and analysing data allowed me to examine my involvement in the research process and evaluate the quality of research.

5.8 Conclusion

This chapter provided an overview of epistemological assumptions underlying the research approaches, criteria for evaluating research, ethical consideration and personal reflectivity relevant to this thesis. Considering the epistemological assumptions underlying the research approaches and their strengths and limitations, the researcher assumed the perspective of pragmatism and considered mixed methods a favourable approach to investigate care workers' perceptions, experiences, and motivations of carrying on their role as a care worker. Thus, a mixed method approach was applied in this thesis.

CHAPTER 6
CARE HOME WORKERS' EXPERIENCES OF CARE PROVISION FROM RESIDENTS' ADMISSION TO THE END OF LIFE: A QUALITATIVE STUDY

6.1 Introduction

The Chapter 2 literature review highlights that good care practice in care home settings requires care workers' involvement and participation and stable staffing. Care home workers have an important role in meeting residents' care needs (Bone et al., 2018; Brady, 2016; Kadri et al., 2018), offering social and emotional support for residents and their family (Brazil et al., 2004; Chan & Kayser-Jones, 2005; Gallagher & Krawczyk, 2013), and promoting residents' autonomy and well-being (Bishop et al., 2008; Edvardsson et al., 2010; Hockley & Clark, 2002). However, care home workers often experience demanding work schedules, heavy workloads (Caruso, 2014), job stress (Pitfield et al., 2011), burnout (Chamberlain et al., 2017; van de Ven et al., 2012), negative media representation and care work related stigma (Jervis, 2002; Pfefferle & Weinberg, 2008). Persistent high care home worker turnover undermines care quality and has negative impacts on the wellbeing of residents and care workers, and care home management.

A number of studies investigating care home worker turnover and retention have been previously conducted (Karsh, Booske & Sainfort, 2005; Mittal, Rosen & Leana, 2009; Pillemer et al., 2008; Pitfield, Shahriyarmolki, & Livingston, 2011). The findings suggest a number of constructs influencing care home worker retention, including extrinsic incentives and reward (Wiener, Squillace, Anderson & Khatutsky, 2009), psychosocial factors, such as care workers' sense of being valued and respected (Bishop et al., 2009; Coogle, Head & Parham, 2006; Mittal, Rosen & Leana, 2009), care workers' self-esteem (Coogle, Parham & Young, 2007), and job satisfaction (Decker, Harris-Kojetin & Bercovitz, 2009; Hasson & Arnetz, 2008; Karsh, Booske & Sainfort, 2005; Pitfield, Shahriyarmolki, & Livingston, 2011), and organisational factors, such as management and training (Coogle, Head & Parham, 2006; Menne, Ejaz, Noelker & Jones, 2007), organisational support (McGilton, Hall, Wodchis & Petroz, 2007), and effective working relationship (Decker, Harris-Kojetin & Bercovitz, 2009). The literature review in chapter 2 suggests that care home workers' psychological needs at work, expectations of care work, social interaction, and other psychosocial factors may have significant roles in facilitating their work performance and encouraging them carrying on their work role.

It is worth noting that care workers' expectation towards the job may involve their personal beliefs, values, and perceived meaning of the care work. Given that care home workers' perceptions of their work role, meaning-making, identity, and personhood are often overlooked and under-researched (Kadri et al., 2018; Pfefferle & Weinberg, 2008), how their perceptions and expectations influence their motivations of staying in their current position remains unclear. In addition, the social interaction and relationship between care workers and residents have been emphasised as important for delivering person-centred care (Edvardsson, Fetherstonhaugh & Nay, 2010; McGilton & Boscart, 2007). This also suggests the significance of social context in care home settings in facilitating care workers to provide person-centred care. The term of social context and social environment has been suggested as interchangeable and defined by Casper (2001) "Human social environments encompass the immediate physical surroundings, social relationships, and cultural milieus within which defined groups of people function and interact." (p.465). However, little is known about the extent to which the social interaction between care workers and residents and the social context in care homes influenced care workers' experience and perceptions in providing care to residents. This points to a need to explore care workers' experience in care work and perceptions towards their role and what motivates, encourages or facilitates them to carry out their role as a care worker.

6.1.1 Aim of the study.

The aim of this study was to explore care workers' perceptions and experiences in providing care for residents from the admission to the care home up to the end of life. Specifically:

a. What are care workers' experiences of providing care to residents up to the end of life?
b. How do care workers perceive their role and conceptualise their work identities as a care worker?
c. What are the barriers or facilitators that impede or enhance care workers' care practices and experiences?
d. What are the care workers' coping strategies for the barriers and challenges encountered at work?

6.2 Methods

6.2.1 Research design.

In order to learn about care worker experiences and perceptions towards their role and what motivates, encourages or facilitates them to carry out their role, a qualitative study using a semi-structured interview guide containing open-ended questions was conducted to explore care workers' experiences, perceptions, feelings, and views in relation to their role, care practices, and interaction with others.

6.2.1.1 Inclusion criteria for care home settings.

This study focused on care home settings in residential care homes and nursing homes where residents receive 24 hours care from care workers. The inclusion criteria for care home settings were a) care homes providing care for older people aged 65 years old and over, b) care homes not providing care for individuals with learning disability or other mental illness, and c) located in South West England and Greater London area.

6.2.1.2 Inclusion criteria for care workers.

Eligible criteria for care workers were: a) working in the care homes which met the aforementioned inclusion criteria; b) providing care for residents aged 65 and over; c) having experiences of providing care for residents from the entry to the care home up to the end of life; d) able to converse in English; and e) willing to share their experiences regarding their care practices.

6.2.2 Participants.

Twenty-two participants from two residential care homes and two nursing homes located in South West England and Greater London area took part in this study and were interviewed individually. Given that the majority of the social care workforce in England is female (Skills for care, 2018), the participants in this study were all female care workers providing care to residents in care home settings. Participants' age ranged from 26 to 70 years old. Less than half of participants were white (45.45%) and slightly above half of participants were British (54.5%) which was significantly lower ratio in comparison to the social care workforce in England (Skills for care, 2018). Participants' years of working as a care worker in the UK ranged from 10 months to 31 years. Three participants (13.6%) who had less than 3 years' care work experience. This suggested that the care homes participated in the current study had more experienced care workers and relatively stable staffing in comparison to the average social care sectors in England (Skills for care, 2018). Three quarters of the

participants worked full time (77.27%). The working hours per week of full-time care workers ranged from 32.5 to 45.5 hours whereas part-time care workers worked between 10 and 36.5 hours per week. The detailed participants' demographic information is presented in table 6.1.

Table 6. 1 Participants' demographic characteristics

Participant	N=22	
Gender	Female	N=22
Age (years)	M=47.32, SD=11.29	Range [26-70]
Ethnicity	White	N= 10 (45.5%)
	Mixed/multiple	N= 3 (13.6%)
	Black	N= 2 (9.1%)
	Asian	N=7 (31.8%)
Nationality	British	N=12 (54.5%)
	Non-British	N=10 (45.5%)
Years' work experience	M=11.9 (years), SD=8.35	Range [10months – 31years]
	Less than 2 years	N= 3 (13.6%)
	2-10 years	N= 10 (45.5%)
	More than 10 years	N= 9 (40.9%)
Contract type	Full-time	N=17 (77.27%)
	Part-time	N=5 (22.73%)
Working hours	Full-time	M=38.75 hours, Range [32.5-45.5 hours]
	Part-time	M=23.9 hours, Range [10-36.5 hours]
Training	NVQ1	N= 3 (13.63%)
	NVQ2	N= 8 (36.36%)
	NVQ3	N= 8 (36.36%)
	NVQ4	N= 3 (13.63%)

6.2.3 Semi-structural interview guide.

In order to provide structure to the interview and encourage participants to freely discuss their care work experience in the care homes, open-ended questions were used in the interview guide. The interview guide was developed based on the literature review in chapter 2 and modified through the discussion with the researcher's supervisors. In order to explore care workers' work experience and perceptions of their work, the interview guide focused on four different aspects: care workers' general work experience, their experiences of working with new residents, their experiences of providing end-of-life care, and their social interaction with residents' families and other health professionals in the care homes. There were six broad questions in the interview guides and each question had prompts (listing below) which were used to encourage participants to illustrate or discuss their work experience in detail. The interview guide was first used in a pilot interview to ensure the

questions were comprehensive and clear before implemented in care homes. The full interview guide is presented in appendix 7.

To learn about care workers' general work experience, a grand tour question (Leech, 2002) was asked at the beginning of the interview guide: "Please can you tell me about a typical day for you working as a carer?". This question acted not only as an icebreaker but also allowed the researcher to learn about participants' work experience, their work routine, views of their job, and their perceptions of their role as a care home worker. Participants were encouraged to narrate their experience and interaction with residents in the context of providing care and casual interaction. Any noteworthy scenarios or events of interactions with residents or care practices were further explored in terms of their view, perceptions and explanations about their reactions, decision, approaches, or strategies.

To understand participants' experiences of working with new residents, two questions were asked: "Please can you tell me about how residents feel when they first move to a care home?" and "Please can you tell me how you help residents when they move to a care home?". The former allowed the researcher to explore ways in which participants made sense of new residents' subjective experiences of moving into the care home, whereas the latter helped the researcher explore participants' care practices and their interaction with new residents. In the former question, if there was any mention of a new residents' reactions towards admission, the participant was probed further to learn about their approaches, thoughts, and views in relation to provide care to new residents. In the latter question, the focus was on the approaches that participants used to get to know new residents and learn about the care needs, preference, and personal characteristics. The interview also covered whether there were any differences in participants' perceptions, care practices, and interaction when residents first moved into the car home and after residents have been living in the care home for a period of time: "How much time do you spend with resident?" or "As time goes by, do you find you spend more time or less time talking to them?".

During the interview, if participants mentioned any events or scenarios in relation to residents' deteriorating health conditions or end-of-life care, the event or scenario was followed up. Alternatively, participants were asked about their experience of providing end-of-life care for residents: "I'd like to ask you about your experience of providing end-of-life care for residents. Can you please tell me what end-of-life care means to you?". To further explore participants' end-of-life care practices and experiences of providing end-of-life care to residents, some prompts were used: "How do you care for a person at the end of life?"

and “what do you think is good end-of-life care?”. In this thesis, end-of-life care is conceptualised as the care residents received from their entry to a care home up to the end of life. Thus, participants were asked to recollect the discussion they may have with residents and residents’ families about planning end-of-life care: “Can you please tell me your experience about discussing end of life with residents or their families?” or “What do you think is important to talk about planning for end of life?”. This helped to learn about participants’ views of end-of-life care, role and involvement in residents’ end-of-life care.

The literature review in chapter 2 suggested that the social interaction within the care home had a significant role in facilitating a care worker’s care practice and encouraged them to continue their work role. Thus, exploring the participants’ social interaction with others in the care homes is important. The interaction between participants and residents was explored by encouraging participants to narrate their experience and interaction with residents in the context of providing care and casual interaction. The literature review in chapter 2 suggested that socially and emotionally supporting residents’ families and informing health professionals about residents’ changing health conditions were an important part of care workers’ role. This pointed to a need to explore the social interaction participants had with residents’ families, colleagues, and other health professionals: “Can you please tell me how you work with residents’ families or friends?” and “Can you please tell me how do you work with other professionals in a care home?”. Again, participants were encouraged to describe the scenarios or events where they interacted with residents’ families and other health professionals. Participants’ approaches and views of the interactions with residents’ families and other health professionals were then further elaborated. At the end of interview, participants were asked if there was anything that they would like to share with the researcher. This last question gave participants an opportunity to express their views, perceptions, and experiences at work that were not covered by the interview guide.

6.2.4 Ethical considerations.

The detailed ethical consideration in relation to the research process, including research planning, data collection, data analysis and findings dissemination, has been presented in chapter 5 (section 5.6). Considering the possible disadvantage or risk of participating in the current study, the researcher was aware that inviting care workers to discuss situations of providing care for residents from the entry up to the end of life might lead care workers to recall unpleasant or distressing memories. Thus, prior to the interview, it was explained to each participant that if they felt upset or distressed, the interview would be stopped. If they

did not wish to continue the interview, they could withdraw immediately from the study. If participants felt distress after the interview, they would be encouraged to discuss their feelings with their GP. Moreover, for the safety consideration, the researcher would conduct interviews with participants in the care home, at Kingston University, or neutral places such as café or library. In current study, all interviews were conducted in the care homes where participants were working as a care worker. In order to ease the participants and ensure the privacy, a quiet private room or space in the care home was arranged for conducting interviews. Given that listening to participants' potentially distressing work experiences might cause the researcher to feel sad or uncomfortable, the researcher was encouraged to discuss her feelings with her supervisors. Ethical Approval for this study was received from the Faculty Research Ethics Committee (FREC) in the Faculty of Art and Social Sciences at Kingston University (Appendix 1).

6.2.5 Procedure.

An invitation letter (Appendix 2) and information sheet (Appendix 4) were sent to the manager of each identified care home to explain the purpose of this study. When the managers expressed an interest in taking part, the researcher arranged a visit to discuss the project further. After the managers gave approval for the care home to be involved, the managers helped to disseminate the invitation letter (Appendix 3) with an information sheet attached to invite care workers to take part in an interview. Care workers who were willing to take part in this study would be asked to participate in an interview. Before the interview started, the purpose of this study was explained, their rights as participants were comprehensively covered and they were informed that their responses would remain anonymous and confidential. After the participants fully understood what the study involves and have agreed to take part, they signed a consent form (Appendix 5) prior to the start of the interview. With the participant's permission, their responses were audio-recorded.

Participants completed a demographic questionnaire before the interview commenced (see appendix 6). At the end of the interview, participants were thanked for agreeing to be involved in the study. In addition, participants were informed that they were welcome to contact the researcher if they have any further questions about the study. In order to avoid participants being recognised or identified by their personal information or their responses, each participant was given an identification number to ensure the data remained anonymous. To preserve confidentiality, names of residents, care workers, managers and care homes mentioned in the interviews were removed or replaced with an alias. All interviews were

recorded and were carried out by the same investigator to ensure consistency in data collection. Interviews lasted between 30 to 90 minutes.

6.2.6 Data analysis.

In order to explore care workers' perceptions and experiences in providing care for residents from the admission to the care home up to the end of life, three qualitative analyses were considered: interpretative phenomenological analysis (IPA; Smith & Osborm, 2003), grounded theory (GT; Corbin & Strauss 2008), and thematic analysis (TA; Braun & Clarke, 2006; Clarke & Braun, 2013).

IPA allows researchers to explore individuals' subjective experiences of the world. The phenomenological lens of IPA helps researchers to understand an individual's personal perception or account of the social world instead of producing an objective perspective of the social world. IPA also involves a double hermeneutic where researchers explore the ways in which a participant makes sense of the world and attempts to make sense of how this participant tries to make sense of the world. Furthermore, IPA assumes an idiographic approach and focuses on producing a specific statement about a participant who has shared his/her story. Therefore, using IPA in data analysis often involves treating participants as a group of individuals and then analyse participants' accounts on a case by case basis. IPA can be used to learn about some generic or shared themes from the data. However, the emphasis of using IPA in data analysis is to understand the way in which each participant perceives an event or the world as well as the participant's subjective interpretation of the world. In other words, the objective perspective of the social world is not the main focus of IPA. Considering the aim of this study, the patterns from participants' accounts were considered adequate for furthering our understanding about care workers' experiences and perceptions of being a care worker and providing care for residents. Thus, IPA was not considered most adequate analysis in this study.

Grounded theory (GT; Corbin & Strauss 2008) assumes an inductive approach where the theory is elicited or derived from the data and it is an adequate method for the exploratory and explanatory studies. GT is often used to generate a theory to explain a specific psychological construct and applies theoretical sampling in data collection. Theoretical sampling refers to an on-going data collection process and this process is determined by the previous data analysis. Thus, the model previously generated from the data would be used to guide the subsequent data collection. GT is used to identify or map social processes

between actions and their consequences or the patterns of the social interaction under discussion. GT requires researchers to analysing the data through developing the initial categories from the data, saturating categories, defining categories, theoretical sampling, developing and testing the relationships between categories, grounding the theory and filling in the gaps by further data collection. Considering the research design, the difficulties of collecting data in care home, and the aim of this study, GT was not considered most appropriate analysis in this study.

Thematic analysis (TA; Braun & Clarke, 2006; Clarke & Braun, 2013) is "a method for identifying, analysing and reporting patterns (themes) within data. It minimally organises and describes your data in (rich) detail. However, frequently it goes further than this and interprets various aspects of the research topic" (Braun & Clarke, 2006, p. 79). TA is suitable for exploring individuals' experience in general or in a specific context. It also has a theoretical flexibility that allows researchers to search and examine the patterns in the data without any theoretical constraint. It can be used in inductive and deductive approaches or from the essentialist/realist and constructionist perspective when analysing participants' responses. There were few reasons for choosing TA for analysing the qualitative data in this study. First, the aim of this study was to explore care workers' experiences and perceptions in care homes. This included the understanding of what barriers and facilitators impede or enhance care workers' care practices and work experiences and what care workers' coping strategies for the barriers and challenges in their care practice. As TA allows the researcher to identify the patterns within the data to learn about participants' subjective and shared experiences in care homes, TA fulfils the needs of this study. Second, this study has specific research questions which focus on care workers' experiences in a specific context – care home settings. Given that TA allows the researcher to search the patterns within the data to answer the research questions and highlight participants' experiences in care home context, it is considered as a suitable analysis in this study. Based on the strengths and suitability of TA, it has been selected to analyse the qualitative data in this study.

TA involves 6 phases: 1) repeatedly reading through the transcriptions in order to familiarise the content, 2) generating initial line by line codes, 3) searching the codes for themes, 4) reviewing themes, 5) defining and naming themes, 6) writing up the findings (Braun & Clarke, 2006; Clarke & Braun, 2013). The emerged themes provide important descriptions of the phenomena (Daly, Kellehear, & Gliksman, 1997) related to the aims of the study. In order to learn about the care workers' experiences and perceptions in doing care work,

participants' responses were transcribed verbatim and analysed using thematic analysis (TA; Braun & Clarke, 2006; Clarke & Braun, 2013).

Participants were from residential care homes and nursing homes. According to the contextual background information of care home settings in the UK discussed in chapter 2 section 2.2, participants worked in residential care homes or nursing homes might have different responsibilities, work experience, and perceptions towards their job. Thus, the transcriptions of participants working in residential care homes were first analysed separately from those working in nursing homes.

All the transcriptions were analysed following the 6 phases suggested in TA. To become familiar with the participants' responses, the twenty-two transcriptions were repeatedly read before commencing the initial coding. Most of the initial codes were short phrases indicating the basic elements or meanings within the data in relation to what participant did for residents, how they provided care for or interacted with residents, their perceptions of the role and care work, and what helped them and what impeded them to care for residents at work. The initial coding process was done using the qualitative research software, NVivo 10. Once the initial code was completed, the patterns were identified within the clustered codes based on whether the clustered codes represented the meanings from the data relating to the research questions of the current study.

After examining the relationship between the patterned codes, candidate themes and subthemes, the researcher started adding the extracted coded data to examine whether the candidate themes and subthemes were supported by the data. If it was evident that any candidate themes or subthemes were not adequately reflecting the meaning of the data, they would be refined or removed. It is worth noting that the patterned codes, candidate themes and subthemes from the residential care home dataset largely similar, but not identical, to the nursing home dataset. Therefore, the researcher combined the analyses of two datasets and further reviewed the patterned codes, candidate themes and subthemes based on all 22 transcriptions.

Each theme was defined and named based on the 'essence of what each theme is about.' (Braun & Clarke, 2006, p.92). Moreover, the identified themes and subthemes were considered whether they reflected the meanings of the data to ensure their validity. After the refinement, the candidate themes and subthemes were defined and then discussed with the

researcher's supervisors in order to ensure that the themes, subthemes, and extracted data were organised in a coherent and consistent manner and fitted into the narrative of the whole dataset. Four master themes with their subthemes that emerged from the data regarding the participants' perceptions of their work identities and their influences will be presented in the findings and discussion section. Each master theme and subtheme will be reported with the direct quotes form participants with the interpretations of the researcher.

6.3 Findings and discussion

This study focused on care workers' perceptions and experiences in providing care for residents from the admission to the care home up to the end of life. Findings from participants' account reflect their perceptions of role expectations, work identities, sense-making towards the barriers, support needs, and the facilitators for their care practices. Four master themes were identified from the transcripts relating to care workers' perceptions of the role, work identities and the influences of work identities on their care practices. An overview of four master themes and their subthemes is presented in table 5.2. The findings are presented with illustrative quotes from the interviews. The first master theme illustrates participants' perceptions of their care worker role in providing care to residents and the meanings of being a care worker. The second master theme concerns the processes and approaches that enabled participants to learn about the expectations and values of the role that helped them to acquire the meanings of being a care worker in the care home. The third master theme discusses the barriers and challenges that participants encounter while providing adequate care to residents or maintaining their work identities. The last master theme presents the facilitators or motivators participants experienced at work that encouraged their care practices and commitment to their care worker role.

Please note that some participants used the term 'carer' or 'carers' to refer to care workers. In order to maintain the integrity of the direct quotes from participants and the consistency in the use of language referring to participants, '(care worker)' or '(care workers)' will be added to the participants' quotes where 'carer' or 'carers' were used.

6.3.1 Perception of their care worker role

Participants discussed their work experiences and care practices in the care homes. Their accounts reflected the meanings of being a care worker, the role expectations they perceived from the care home, their views about maintaining residents' best interests, and the ways in which they met the role expectations at work. Participants' descriptions of their care

practices reflected their perceptions and understanding of what their role entailed in the care homes. Participants suggested that enabling residents' independence and meeting residents' social and emotional needs were integral to their role. They felt that caring for residents in an adequate manner required the collaboration with residents' families and their colleagues.

Table 6. 2 An overview of themes and subthemes

Master theme	Subthemes
Perception of their care worker role	Supporting residents' adjustment to the care home
	Maintaining residents' independence and meeting their changing care needs
	Meeting residents' social and emotional needs
	Liaising with residents' families
	Working with colleagues as a team
Work socialisation within the care home	Care work training
	Peer support
	Continuous learning through interaction and experiences
Barriers in assuming care worker role	Struggling with meeting role expectations
	Attachment versus maintaining boundaries
	Maintaining work-life balance
Facilitators of commitment to care worker role	Satisfaction of autonomous needs and being independent at work
	Sense of belongingness to the care home
	Self-efficacy and sense of competence
	Being valued
	Sense of pride in their work

6.3.1.1 Supporting residents' adjustment to the care home.

Many participants felt that the complex care needs and dependency of new residents were often the reasons for their admission to a care home. Participants perceived that supporting residents' adjustment to the care home was important part of their role and responsibilities. Most participants felt that a new resident's admission to a care home was a major event for residents, their families, and care workers. They pointed out that a new resident's adjustment involved learning about the care home, social environment, and the support they would receive from the care workers. Many participants also stressed that it was crucial for them to learn about the resident' preferences and care needs. It seemed that information sharing was an important element of residents' adjustment to a care home. Many participants felt that it was a crucial aspect of their role to facilitate the process of information sharing between new residents and care workers.

> *"In the first few weeks, you will, you will, we (care workers) need to adjust, we will find what you (new residents) want, we will find what you (new resident) don't like it, you (new resident) will find what is me (care worker). That's why we adjust things together, me and [colleagues] will adjusting to her (new resident), and the [resident] will adjusting the home* (P08, Residential care home, 10 years' care work experience)

Many participants frequently mentioned new residents' negative emotional responses when they recollected their experience of a new resident entering a care home. Some care workers felt that new residents seemed to feel more frightened by new experiences and perceive loss of independence when entering the care home.

> *"They always like scared, the first week, they're nervous, they don't… you see them, they are not settle, it's frighten, it's frightening after you've been in an environment that you know everyone, and then come to a care home where you don't know anyone, ..., you can see them crying, they start crying 'oh, I have to sell my home to be able to come here' You know, so it's like they realise that's it, they have to let go everything that they have, they used to do, it was different life for them."* (P06, Residential care home, 1 year's care work experience)

Many participants stated that they understood new residents' difficulties in adjusting to a different environment and empathised with residents' complex emotional responses. One participant felt that it was important to reassure new residents and to comfort them by expressing that care workers would care for them and provide for both their emotional and physical needs. It seemed that care workers may view reassuring new residents and offering emotional support as a crucial element to facilitate new residents' adjustment. On the other hand, some participants accept that these complex emotional reactions from new residents were a process of adjustment.

> *"There is a disparity and you (residents) do lose a lot of sense of self and identity when you come in to an institution like this, it is an institutionalised care, as much as you try to give that person you know, basic comfort, basic love and they will lose a lot of who they were, and that's the reality of life"* (P21, Nursing home, 5 years' care work experience)

In addition, some other participants pointed out that in some cases, care workers experienced difficulties while supporting a resident's adjustment to the care home, especially when the resident was living with dementia, cognitive decline or memory loss.

> *"If you imagine how they (residents with dementia) feel, it's unsettled, obviously it's bit frightening for them, you know, they don't know what to expect, where they are, a lot of strangers to meet, strange people they have never met."* (P03, Residential care home, 26 years' care work experience)

Participants seemed to feel that residents with dementia or memory loss would be less likely to process new information or make sense of their relocation, thus, experience greater difficulties in adjusting to the care home. One participant addressed her method of

facilitating residents with dementia after their entry to the care home as being mainly focused on comforting them rather than helping them to learn about the environment in the care home.

> *"People with dementia basically, they cannot understand, …, they believe they are going home, basically they want to go home. For me it's not really a point and a reason to tell them 'Oh you are not going home, you stay in here now' …, So I just support her in that idea 'Yeah, you're going home'. And until tomorrow, she will forget what she asked you the day before. She is happy because I said, 'Yeah you're going home tomorrow, you stay only for stay for one night, your family book it in here for you for one night.'."* (P09, Residential care home, 11 years' care work experience)

It seemed that a care worker's understanding of the impact of dementia on residents facilitated their ability to modify their approaches to comfort new residents with dementia. Therefore, it was important that care workers remained adaptive and flexible in utilising different approaches to facilitate the adjustment of new residents with dementia or without dementia.

Furthermore, many participants felt that it was important to actively approach new residents and offer support during their adjustment into a care home. However, some care workers were uncomfortable with actively approaching new residents. Some participants mentioned that some of their colleagues had less active engagement with new residents because they found it difficult to start conversations with new residents or worried about upsetting new residents. Some participants expressed that being reluctant to actively interact with new residents was considered equivalent to neglecting new residents and was a failure in fulfilling their roles and responsibilities. One participant stated that approaching or interacting with new residents was vital because it helped care workers to learn about new residents and to start building the relationships with new residents.

> *"If you are in the new environment, you will be happy if someone come in to talk to you, …, if we (care workers) won't welcome them, we won't talk to them, how they will feel? For example, you are new here, if I don't talk to you, 'She is new, I don't know what to say'. No, you have to approach, you have to get to know how is he, how is she, and from there, you build up your relationship, you just, try to get to know each other, …, day by day, you will get to know, your resident".* (P11, Nursing home, 11 years' care work experience)

Care workers actively interacting with new residents might be viewed as a way to learn about residents' preferences and interests and this might subsequently help care workers to develop relationships with new residents and lead to positive impacts on residents' quality of life and quality of care (Bradshaw, Playford & Riazi, 2012; Cooney, Murphy & O'Shea, 2009). Thus, care workers may perceive that approaching new residents not only allows them to reassure new residents but also enables them to provide person-centred care to the residents and

enhance their sense of quality of life. It is worth noting that one participant expressed that a care worker's excessive enthusiasm in continuing conversation with new residents might have an adverse effect on reassuring new residents. This participant felt that some new residents required a period of time to process their relocation and they might have different pace or needs in adjusting to the care home. Therefore, instead of being keen to interact with new residents or to involve them in social activities, care workers may need to have more flexibility in helping residents adjust and to modify their approaches to interact with new residents while fulfilling their perceived role expectations.

> *"When they just come, we don't want to do… to start chatting to them and give them earache, no, we have to be careful, don't we? (laugh) going blah blah blah blah blah. No. When they first come in, we can't do that [laugh] and then we will get so mad, you know, [laugh] They (new residents) won't like it. 'What's wrong with her, she is talking to me'. They will get really upset, they, some carers (care workers), they just talk and talk. That irritated them (new residents). Yeah".* (P04, Residential care home, 10 years' care work experience)

Previous research frequently points out difficulties new residents experience while adjusting to a new environment (Lee, Woo & Mackenzie, 2002) and suggests that care workers' support during this adjustment period was important. Yet, less focus has been placed on the way in which care workers adjust to new residents and how new residents may have an impact a care worker's care practices and/or their perceptions of their role. Moreover, many participants expressed their views about the care home being resident's own home and perceived that their role was to support new residents to get to know the care home, to settle, and to be content while living in the environment. Thus, care workers who avoid actively interacting with new residents may be perceived as unprofessional or lacking an awareness of their role expectation. Notably, being flexible and modifying the approaches to interact with new residents based on their responses seems to be a significant aspect of care workers' role. Furthermore, the findings may also imply that care workers facilitating a new resident's adjustment to the care home is not only about introducing them to the physical and social environment but also reassuring them and helping them to alleviate the negative feelings induced by the relocation.

6.3.1.2 Maintaining residents' independence and meeting their changing care needs.

Many participants emphasised the importance of incorporating residents' care needs, choices, and preferences into their care practices and viewed care plans as an important information source enabling them to understand residents' care needs. Furthermore, participants expressed that care workers should not merely perform the care tasks listed in the care plans

or take no notice of residents' changing condition. Most participants expressed that, being the primary person responsible for the resident and therefore they were required to pay close attention to the resident's changing condition or care needs (Dobbs et al, 2014; Holloway & McConigley, 2009) and to report any changes so that the adequate care can be arranged.

> *"We report back anything we found, if we see any skin tear, or any pressure areas, or we think that person is coughing, whether in their supper or drink, we would report that back to the nurses, and the nurses will speak to the doctor, call the doctor"* (P15, Nursing home, 8 years' care work experience)

It seemed that care workers' everyday interaction with residents allowed them to notice small changes which may not be easily detected by other members of the multi-disciplinary team. Many participants stressed the importance of detecting the sign of residents' physical discomfort and changing health condition (Bradshaw et al., 2012). In some cases, care workers might notice the sign of residents' discomfort or additional care needs before residents verbally expressed any physical discomfort. Many participants expressed that they often compared what they observed from residents, such as residents' emotional and physical changes, to their knowledge about residents' routine, health condition, and behaviour pattern. The result of such comparison seemed to serve as an early indicator to care workers that residents might require additional support and care.

> *"Sometimes they are very happy, and everything is okay, then they might change, their mood changes, and you just wonder sometimes something wrong, but you don't ask them if something wrong, you just try to find out, check the sign like blood pressure, heart beat, oxygen, and all that, and this is not physical something begin like infection, they may be different"* (P16, Nursing home, 19 years' care work experience)

It seemed that detecting residents' discomfort and changing care needs relied heavily on care workers' understanding about residents' personal characteristics, behaviour patterns, and routine. Thus, having insufficient understanding of residents may lead care workers to miss subtle signs of a resident's physical discomfort or changing care needs. One participant depicted her recent experience of recognising the signs of a resident's physical discomfort.

> *"Like last week, a gentleman upstairs, he was upset, and I said 'come on, Mr X, let's have your supper' and he got hot temper and shout at me, you know, he was aggressive. I don't get upset or I don't take it personally, I can tell you this because something wrong with him, that's why he was like this, there's a reason behind it, you see."* (P04, Residential care home, 22 years' care work experience)

This participant did not seem to act to the resident's challenging behaviours but interpreted it as a sign of the resident's physical discomfort. She felt that it was more important to focus on finding the possible causes of residents' sudden behaviour change and to arrange the

necessary intervention to meet residents' needs. This might also imply the importance of care workers being confident of their care practices and understanding of residents so that they could take notice of residents' unusual expression or behaviour from their changing care needs.

Furthermore, many participants stressed that maintaining residents' level of independence and mobility was an important aspect of their job role. Some participants felt that encouraging residents to complete tasks of which they were capable helped them maintain a level of independence and experience a sense of competence.

> *"I don't want to take that away from them, I let them do it as much as they can for themselves, we just, yeah, but some of them cannot bend, you see, then you do the leg or something like that. That will make them still feel like they are worthwhile, they are not worthless, they are worthwhile, they still can, they are still okay, they still can do things, it's no matter where they are, they can still do whatever they do back home"* (P19, Nursing home, 13 years' care work experience)

It seemed that care workers were aware of their ability to be an enabler while providing care to residents. Being an enabler while caring might be perceived as overprotective, patronising, and not serving residents' best interests and could have adverse effects on residents' level of independence and mobility. For example, encouraging residents to conduct some activities of daily living on their own might be perceived as less efficient in completing care tasks or time-consuming. In some cases, this might create additional workload or care tasks to care workers. However, many participants felt that it was their responsibility to provide appropriate care to the level that residents required and to encourage or help residents to maintain resident's level of independence and mobility.

> *"It's independence, ..., as soon as you stop, they can lose it, like a lot of people when they came, they can eat themselves, that will be slow, but they will do it, I have seen a staff feed 'Here is your lunch' and of course they can start eating it, now they lose the ability to do it. If I'm there, the person can do it themselves, I will leave them, if they get dirty, and the napkin gets dirty, put a new napkin, if their top is dirty, offer them to change it, no problem, if you do that for them, they will lose their ability.'* (P14, Nursing home, 22 years' care work experience)

Many participants frequently emphasised the importance of residents' choice, consent, decision, and preferences in their care practices. It seemed that many participants did not conceptualise their role as to merely complete the care tasks, but to also cater to residents' care needs. This might also imply that care workers advocate the promotion of the residents' sense of autonomy, empowerment, and being in control in relation to their own care needs (Murphy et al., 2014; Rodgers et al., 2012;). Many participants depicted the ways in which

they interacted with residents prior to conducting the care tasks as learning about residents' consent or choices to the care tasks. This implies that care workers value residents' autonomy and perceive respecting residents' autonomy as an important part of their work role (Brownie & Nancarrow, 2013).

> *"We ask them if they want to get up, when they get up, we help to give them a wash, and I'll ask them what they want to wear, or they want the hair, or makeup, if they wear makeup, erm, just everything they need"* (P05, Residential care home, 23 years' care work experience)

When participants addressed their experiences of residents' refusal to receive personal care tasks or to take medication, some felt that residents should not be coerced to have their personal care or medication. Nevertheless, many also felt that it would be equivalent to neglecting residents if care workers did not try to encourage residents to have personal care or take medication or find novel ways to assist residents.

> *"I always say it's like acting, coz you're working with people that got dementia, um you will put on an act with that particular person I can say to her that she is my best friend, that we get along really really well, we like a little cuddle, and we will go and have a little laugh and make a cup of tea and a piece of cake, and then she feels a lot more comfortable, and then I would say to her 'should I do your hair to make you look more beautiful' and she will be happy with that, and predominantly she will come in to have a shower. ..., it doesn't always work, a lot of time it does, but she seems to be more comfortable with certain people as well, I think it's about three of us can manage to do it."* (P15, Nursing home, 8 years' care work experience)

Furthermore, many participants expressed that it was not their role to help residents recover or restore their health when residents approached the final stage of their life. Nevertheless, they felt that it was their role to provide the required personal care to the residents' discomfort.

> *"You cannot do anything to make that person like be well or you know what I mean like to recovery like one hundred percent, so all you can do it to provide you know the best quality of care that she need, coz it depends on the individual's need as well, so just make sure that you provide that care that she really needs or he really needs"* (P12, Nursing home, 5 years' care work experience)

Some participants stated that many residents at the end of life tended to have much smaller appetite and less water intake, and sometimes they responded less well to personal care. In such a scenario, participants tended not to encourage residents to consume food or drink water or to participate in social event or activities. Many felt that their responsibility at this stage was to pay close attention to the signs of a resident's increasing need for pain management, to communicate with the care home mangers or nurses about a resident's increasing care needs, to accompany, comfort, and fulfil the resident's emotional needs.

> *"Like cancer patients who are terminally ill, all the time they are not as mobile, ..., you sitting there with them holding their (residents) hands. ..., when they (residents) get to that stage, the whole aspect of care becomes just a bit more just on making sure, you know, if they are thirty, they are dehydrated, they are comfortable, you fresh their face their lips, um in that stage, you don't have shower or bath in that stage, it's too much, it's too much moving and handling, if they are in pain."* (P21, Nursing home, 5 years' care work experience)

When a resident approached their end-of-life, it seems that a care worker's priority shifts from encouraging residents to receive personal care to offering comfort and companionship. It is worth noting that maintaining residents' independence may be considered as a means of promoting residents' autonomy (Heggestad, Høy et al., 2015; Knight et al., 2010; Sims-Gould et al., 2014). Shifting from encouraging residents receiving personal care to focusing on offering comfort to residents implied that care workers understood residents' changing care needs and were aware of the multidimensional and situational nature of respect and implementing respect into their care practices in accordance with the circumstance. This implied that participants experienced ethical issues or challenges in their care practices. It might be understood that participants modified their care practices in accordance with what they considered as serving the residents' best interests and avoiding harm to the residents. Participants might assume that it was an important part of their role to implement the value concepts into their care practices. Thus, it might be understood that the value concepts constructed and influenced care workers' perceptions and understanding of their work role.

6.3.1.3 Meeting residents' social and emotional needs.

Many participants emphasised the importance of continuous communication with residents in their care practices. Participants pointed out that their role entailed ensuring their residents feel more reassured instead of feeling being treated as if they were invisible. Participants were aware of residents' needs for meaningful connections with others.

> *"All the time you're communicating while you're washing and dressing, erm, coz you, you had staff which haven't kept obviously, we had staff coming give the care to a lady, which is very sadden, very lonely for that lady, ..., you cannot have two girls talking to one another, coz it's not fair to the lady, because the lady again, it's just sitting there alone."* (P05, Residential care home, 23 years' care work experience)

Some participants pointed out that they were the ones who had frequent contact with residents, thus, they felt that it was part of their responsibility to offer social and emotional support to residents. Encouraging residents' involvement and engagement in interactive activities was viewed as a way to increase the degree of a resident's social connection with others. Some participants expressed that they often took notice of a resident's emotional

support needs and developed a trust relationship with residents in order to encourage the resident to express their worries and concern. It seemed that it was important to respond to residents' negative feelings. Some participants felt they needed to distract residents with outings, activities, and amusement, while some other participants offered company to reassure residents.

> *"I mean usually they say 'oh, I want to die today'… 'Oh, you cannot be doing that, come on, let's go out,' we'll do something else we haven't got time for that today', you know, and then you change the subject, 'Oh, don't talk like that', and we change… we make them happy, we change the subject. Because they do have very down day some days."* (P05, Residential care home, 23 years' care work experience)

> *"Sometimes they will tell you that they are not happy and tell you their problems, um …, like resident's husband is ill, she will say he is not well, he has got dementia, and she is worried about him, so I sat down with her, and she will talk to me about it, um and then I would make a cup of tea, so we can have a cup of tea together.* (P16, Nursing home, 19 years' care work experience)

It is worth noting that some participants emphasised the importance of presenting a positive mood and attitude while interacting with residents.

> *"Something like sitting down and talking to them (residents), and make them (residents) feel good, …, see we are talking with friendly, that's important, we smile and… you know, we (care workers) don't want to look like angry, bored, fed up, grumpy face, miserable, yeah, that can put them (residents) off, isn't it? (laugh)"* (P04, Residential care home, 10 years' care work experience)

> *"I think it's when you walk into this house, you are here for them, anything there is aside, …, when I'm working, smiling, laughing, and chatting with them (residents). …, I come here and make them happy, coz that' why I'm here for"* (P05, Residential care home, 23 years' care work experience)

It seemed that care workers conceptualised their role as not merely completing care tasks, but also taking residents' emotional and social need into account in their care practices. This might imply that care workers identify themselves as working with residents while maintaining their personhood rather than merely completing care tasks. Kitwood (1997) defines "Personhood is a standing or status that is bestowed on one human being, by others, in the context of relationship and social being. It implies recognition, respect and trust" (p. 8). Thus, care workers offering emotional and social support might be seen as their ways of maintaining residents' personhood in their care practices.

Furthermore, many participants experienced situations where some residents behaved aggressively towards them. Many felt that, as a care worker, they were expected to maintain a natural expression and attitude rather than countering with residents' inappropriate

behaviour. It seemed that care workers felt a counterattack would not help them to provide care to residents and it might result in worsening the care relationship, provoking residents' negative emotions, and possibly triggering a resident's refusal to personal care. Thus, many participants emphasised that they had to present a neutral emotional expression and to focus on their care practices despite uncomfortable feelings around the residents' unkind attitudes or behaviours. It seems that care workers presenting a neutral emotional expression when managing the incidents was a means of maintaining a boundary and self-respect at work.

> *"Because every… most of the time every day, they will swear at you and… just that's everyday life, that just calls to your ears, mainly insult you (laugh), …, we just don't take it personal, that's the thing about this job."* (P07, Residential care home, 10 months' care work experience)

> *"A man, he is quite a big man, you have to get him up from the hoist to a chair, and he always just get everything ready, he put his hand beyond my back, and punch me straight on the back, and I just said to him 'we can do two things, I said you can now apologise or we have to walk out the room', 'sorry' he said to me 'I'm sorry', and we continued, and we got him dressed, washed, and in the wheelchair, and he came out the room"* (P17, Nursing home, 17 years' care work experience)

Many participants expressed that showing emotional responses to residents, families, and colleagues might have a negative impact on others in the care home. Showing negative emotional expression might be perceived as weak, unhelpful, and unprofessional. Even in the event of residents' passing, some participants stated that it was their priority to provide care after death to residents and support the resident's family by presenting themselves in an emotionally balanced manner.

> *"I have never never cried, I'm very strong, in front of the family, I never never cry, I just hide it, to make it, it looks like 'oh, my god' like this, you know"* (P08, Residential care home, 10 years' care work experience)

Emotional regulation seemed to be perceived by participants as an expected manner of conducting their care practices and demonstrating their training, skills, and respectability in care work.

6.3.1.4 Liaising with residents' families.

The majority of participants emphasised that it was essential to involve residents' families in care provision. In many cases, a resident's family provided valuable information about their loved one's life history, preference, and hobbies that aided care workers' care practices. Many felt the input of a resident's family was particularly helpful especially when a resident was living with dementia or having difficulties in communication. Some participants felt that insufficient understand of the behaviour pattern of a resident with dementia could

impede their ability to offer adequate care or emotional support. One participant discussed her experience of working with a resident with dementia. She felt that care workers could observe and learn about a resident's behaviour pattern, but to fully grasp the meanings of their behaviour often required their family's knowledge about the resident. It seemed that the input of a resident's family facilitated care workers to better interact with the resident without inducing that resident's confusion or negative emotions.

> *"You may notice the pattern of the behaviour and you may have family members come up, you made a point and go and talking to them (family) and say you have noticed that and they may actually be able to tell you 'That's what they've done when they were younger'. So you get to understand what the pattern of behaviour are all about. We have a gentleman at the moment and he constantly packs his bag and he's gone, he is leaving, you know, if you saw that as an incident, your response will be trying to stop him from going, ..., And what he actually does is he packs his bag and he would come and say goodbye to everybody, he is going to work, ..., and we just act a little bit at the moment, you know, you cannot turn to somebody and say 'look, you know, you don't go to work no more, that was long time ago'."* (P18, Nursing home, 10 years' care work experience)

This may suggest that the information a resident's family has about a resident can help care workers provide person-centred care and enhance their care practices and approaches to interact with the resident. On the other hand, many participants expressed that some of the residents' families were less experienced in interacting with residents with dementia and more likely to approach their loved ones in a way that did not take into account the resident's current condition or emotion. It seemed that many families of residents with dementia did not have sufficient understanding about the influence of dementia on their loved ones. Some participants witnessed situations where residents' families experienced negative emotions when interacting with their loved ones with dementia.

> *"When they (residents) have dementia, they (residents) just cannot help it, they (residents) have bad day, they (residents) can be aggressive, depends of how their family approach them, so I have seen the families cried or something, but it's hard."* (P06, Residential care home, 1 year's care work experience)

Some participants felt that their care home should provide information to residents' families regarding the symptoms and the influence of dementia on residents and the better approach to interact with residents with dementia. Other participants felt that it was part of their role to work with residents' families, to offer them educational information about dementia, and to reassure them emotionally. This might suggest that care workers feel that it is their extended care worker responsibility to support residents' families emotionally and socially (Bradshaw, Playford & Riazi, 2012; Gallagher & Krawczyk, 2013)

> *"Due to the dementia or whatever, so it's very difficult, and we work alongside with the families, you know, because we have a lady and her daughter struggle badly when her mom came in, and she is like every time she came to visit, just doesn't seem to go too well, and I spoke to her 'come and find me, you know when you visit your mom come and find me, and we had a cup of tea and we talk, I asked her you know, what's the general just the visit, and it's a bit of things about talking and not being to remember things and everything being reparative, and you know and I said that's how we work, ..., and it's a bit of explaining what we do, and I said you know, if you can learn, observe and try to put some of that in to your visit, your visit will be more enjoyable, and then that's exactly what she does, and they have lovely visit when they come up"* (P18, Nursing home, 10 years' care work experience)

This may be understood as care workers acknowledging the important role residents' families have in care provision.

'*Working alongside with families*' seemed to emphasise that care workers did not merely view families as informant, but a partner in meeting residents' care needs. Many participants perceived that the many residents valued the support of their families. Although some participants felt that care workers should be able to look after and reassure residents, many others expressed that the role of a resident's family in offering emotional support was irreplaceable.

> *"Some of them (residents) really shout or really cry, you have to reassure them, or if you can phone the family, maybe they (residents) can talk to their children, you know, ..., you can phone them (family), and then talk to them(family), or ask them (family) to have time to come for visit."* (P11, Nursing home, 11 years' care work experience)

Furthermore, many participants expressed that some families found it difficult to accept their relative's condition and therefore felt worried or uncertain when considering their loved ones' end-of-life decision. It seemed that care workers viewed planning end-of-life care in advance was in a resident's best interest as well as preparing and reassuring the family. Many participants felt that it was important to facilitate a resident's family in making end-of-life care decisions and managing the difficulties a family might encounter in relation to a resident's care. It is worth noting that discussing sensitive issues with a family, such as the end of life decisions, might induce distressed feelings or conflicts in that family. Some participants felt that a well-developed trust and relationship with families helped them to discuss end-of-life decisions, reduce possible conflicts, and comfort and reassure families.

6.3.1.5 Working with colleagues as a team.

The majority of participants emphasised that care work is about cooperation and teamwork and expressed that teamwork and cooperation with their colleagues enabled them to prioritise and meet residents' complex care needs. It seemed that care workers perceived a collective responsibility embedded in their work responsibilities. Working with colleagues as a team seemed to be perceived as a means of fulfil their care worker role. Meeting a resident's care needs before their own needs suggests an ethos of the care work. Some participants expressed that care workers failing to cooperate with other colleagues in their care practices or not prioritising residents' care needs were viewed as irresponsible in regard to their role, unfitted for the care work and difficult to work with. One participant described her frustration of having to work with a colleague who did not prioritise residents' care needs.

> *"I'm patient, I'm patient, I cannot be upset so easy, yeah, but I… at that time, I feel like angriness inside me, …, um this is care job about to put um… another person on the first place, not to think about myself 'oh, I need a cigarette now, so I don't care if she's got blood sugar too low, I'm going to have a cigarette'. …, I said to her 'it wasn't right what she has done', I can see this is not right person for caring environment, because she put herself first in front of somebody who need her basically."* (P09, Residential care home, 11 years' care work experience)

It seemed that care workers with a careless attitude were ill-suited to the role and would have a negative impact on the work ambience in the care home. Many participants addressed that it was essential for care workers to fulfil their role and responsibilities and working with other colleagues as a team was equally important. One participant discussed an incident where she and her colleagues did not work together in offering assistance to a resident. She expressed her frustration about the incident and felt that the lack of effective teamwork could undermine the quality of care.

> *"I found one of the residents when I was giving the medication, she (resident- Mrs.X) was on the floor, …, we (care workers) just get her (Mrs.X) out and my trousers is full of poo, the first thing I will do, I need to clean myself first, …, because at that time, you (care workers) need to get up the residents and give them breakfast everything, but you know the priority. …, I said to a carer (care workers) 'Can you get this (resident Mrs.X)?' 'Yeah, after this resident.' (replied the other care worker) …, and then I left the resident (Mrs.X) and I reported it to the manager 'Mrs X, she had a fall, she is on the floor at the moment, she (Mrs.X)) said 'give me five minutes, and then I will get up'. …, Some of the carers (care workers) there, no one touch resident (Mrs.X), …, when I came back, um, she (resident- Mrs.X) is still in the floor."* (P08, Residential care home, 10 years' care work experience)

Researchers use the term *effective interdependence* to depict care workers' abilities to adjust their care practices to the situation and other's work in order to enhance group effectiveness (Toles & Anderson, 2011; Wageman, 1995). When care workers only focus on completing

their own care tasks without paying attention to their colleagues' work, this may lead to ineffective teamwork and negatively impact the quality of care residents receive.

The findings of this master theme outline the participants' work experience, perceived role expectations, and views regarding their care worker role and care practices. The findings highlight care workers' views and understandings of what their work role entail and the ways in which they were expected to conduct their care practices. Participants perceived their care worker role entailing the provision of care to residents in accordance with residents' care needs and best interests, maintaining residents' independency and autonomy, meeting residents' emotional and social support needs, and fostering a trust and close relationship with the residents. To be able to fulfil care worker role, participants felt it is essential to liaise with residents' families and work cooperatively with colleagues. The participants accounts reflect not only what their role entailed, but also their meanings of being a care worker. It is worth noting that Burke (2003) states that "identities are the meanings that individuals hold for themselves, what it means to be who they are. These identities have bases in being members of groups (social identity), having certain roles (role identities) or being the unique biological entities that they are (personal identities)." (p.196). Thus, the findings of this master theme contribute towards the understanding of the care worker's perceptions of their role expectations and their work identities.

6.3.2 Work socialisation within the care home.

In this theme, participants described the ways in which they learned about their care practices, values, and meanings in relation to the care worker role. They felt that they learned through their training, the support of their colleagues, and their own experiences of interacting with others in the care home. It may be understood that care workers acquire skills, knowledge, values, and norm of care work and the meanings of being a care worker through explicit training and implicit learning on the job. The findings may contribute towards understanding what inform care workers of their role and the meanings of care work which subsequently and foster the development of their work identities.

6.3.2.1 Care work training.

The majority of participants stated that they had no training or care work experiences in caring for older people when they first started working as a care worker. Some participants described experiencing stressful and anxious feelings when they first started working with residents. Participants also expressed feelings of doubting their competence in providing

appropriate care to residents and uncertainty about what they might encounter in a care home environment. *"When I first came here, I was bit scared, I didn't know anything, because this is first time for me"* (P07, Residential care home, 10 months' care work experience). Some participants felt reassured after receiving care work training, especially if they had an understanding about what their role entailed, what they had to do, and how to conduct their care practices. Moreover, some participants expressed their feelings about being competent in providing care after they have received the training. This might imply that receiving care work training reassured care workers by preparing them to manage the care work and to make sense of their work experience. *"It's (care work) not difficult, because we're trained to do this job, so it's not difficult."* (P04, Residential care home, 22 years' care work experience). Notably, participants working in a specialist dementia unit said that they could feel mentally and emotionally exhausted at work and emphasised the significance of receiving training for dementia care.

Many participants looking after residents with dementia often stressed the importance of care workers remaining emotionally balanced when providing care for residents with dementia. It seemed that residents with dementia would be more susceptible to care workers' emotional responses. One participant expressed that the training she received prepared her to work with residents with dementia.

> *"Um I think in the [training]..., it makes you more um aware of dementia, and you are able to work in that environment so much easier."* (P15, Nursing home, 8 years' care work experience)

Therefore, care work training may not only deliver care workers with the care knowledge, but it also strengthens care workers' confidence and feeling of competence in providing care for residents.

Many participants felt that the introductory training enabled them to provide care without causing any harm. It seemed that receiving continuous training was perceived as a means of improving the care practices and advancing their career development. Some participants, even those with years of experience working in the care industry, felt that continuous training offered them stimulation to rethink how their role can meet residents' care needs.

> *"Previous home I worked, everything was routine, you know, structured, that's institutionalised filed, and it's so easy to go along with that, but when you do this caring work and work in this module and you reflect when you see things like that clips, that actual makes you stop and think about that person that you are caring for."* (P18, Nursing home, 10 years' care work experience)

Care workers in the current study discussed their feelings about the continuous and advanced training courses and felt they facilitated better job satisfaction and left them feeling more confident at managing difficulties, as noted in other studies (Han et al., 2014; Maas et al., 2008).

6.3.2.2 Peer support.

Participants suggested that one of aspect of care provision less likely to be taught in care work training was the ways in which care workers could establish a trust and close relationship with residents. The majority of participants emphasised that the interpersonal relationship with residents and a sufficient understanding about residents were key elements in providing good care to residents. However, a few participants who just joined the care industry recollected the difficulties they experienced. It seemed that new care workers might struggle with adjusting to their role and adapting to the social environment at the same time.

> *"When I first come here, I was bit scared, I didn't know anything, because this is first time for me, and after like a month, I get used to everything, and you start to know each one of them (residents), their habit, their attitude, and you get to know them"* (P07, Residential care home, 10 months' care work experience)

Participants felt that they were expected to provide person-centre care to residents and thereby had to effectively learn about residents' needs and preferences. Many participants suggested that learning from their colleagues' experiences was an effective way for new care workers to provide person-centre care to residents and to adjust to the social environment within the care home.

> *"There are other senior staff that the things you pick up, you learn from them also, what the interests of this person, and what their like and dislike, and that's a big learning curve, that's biggest way to learn about residents is from other carers (care workers) who have been working with that person."* (P21, Nursing home, 5 years' care work experience)

It seemed that learning from colleagues' experience and their understanding of residents prepared new care workers for the care practices and helped them to avoid upsetting residents. Many participants expressed that new care workers often experienced difficulties in finding an appropriate way to approach a resident and managing the negative impact of working in the care industry. Some participants stated that sharing their experience and understanding about residents' personal characteristic, preferred approach, and behaviour pattern with new care workers were helpful strategies. They felt that it was important for new care workers to be aware of the potential safety issues when providing care to residents, especially when some residents had aggressive behaviour or inappropriate verbal expression

toward other care workers. Thus, learning from experienced colleagues might be understood as a form of protection which helps new care workers to prepare themselves to deal with the possible.

> *"We will try to tell them everything we know, um ..., we will introduce them to certain people, certain residents, and just make sure she goes to certain people, if they do fight, we got one just fight you, 'just be aware of his arm, because he can shout', that sort of things we said, we just tell the new carer (care workers) which person is aggressive, and just be careful, put your gloves on or use whatever you need to use, just basically talk to her what we do, how we do it, usual teach her as we go along."* (P17, Nursing home, 17 years' care work experience)

On the other hand, many participants pointed out that some residents who had negative views about ethnic minorities often treated migrant care workers harshly. British-born senior care workers felt that it was important to express their support and concerns to migrant care workers when residents treated them harshly and to be protective towards the new migrant care workers. Some British-born participants expressed that they would offer to swap residents with migrant care workers so that they could help to prevent migrant care workers from experiencing the possible conflict or discrimination and to alleviate their distress at work.

> *"Some (residents) are racists, ... when you are new here, you're not used to it, ..., you are like, a bit shock to begin with, but I think, as gradual, when you get to know that resident, then you'll realise, it's nothing you can do about it, erm, say personally is not that person (migrant care worker), it's about the colour, isn't it? ..., We say to that person (migrant care worker) 'you do that lady, I'll do that resident (who had issues with migrant care worker), so that person (migrant care worker) doesn't get stress out."* (P05, Residential care home, 23 years' care work experience)

Moreover, some participants recollected distress and negative feelings when they first started working as a care worker. It seemed that new care workers often experienced difficulties in managing their stress. One participant mentioned that at the beginning of her career, she had nightmares about care work and felt she was hallucinating the beeping of residents' buzzers indicating their support needs even after she was off duty. This participant felt reassured and less anxious after she discussed her concerns with her colleagues, especially when she found out that she had the same experience as her colleagues when they first started working as a care worker. New care workers learning from their colleagues' experience of managing distress or anxiety is an effective way to reassure new care workers and alleviate their distress and negative feelings at work.

> *"I would tell my colleague about it (the nightmare about caring work), they told me they had it… they had it as well when they first started, but after a while, two months*

or more, you, just go away, just normal." (P07, Residential care home, 10 months' care work experience)

It is worth noting that peer support was highly valued by participants who were working in specialist dementia units. They expressed that it was important to remain emotionally balanced when working with residents with dementia, but it could be difficult to manage the emotional issues without any support.

> *"Not physically, but mentally you can be quite exhausted, especially when you have somebody that, tend to repeat things a lot, or it's consistently on your shoulder asking you the same question over and over again, and you have that for 7 hours, ..., it's really hard but you do learn to get by with that, coz you can always get another member of staff to take over so you can clear your head for a minutes, and go to do something healthy, I think coz we all work as a team, it's quite, it works"* (P15, Nursing home, 8 years' care work experience)

Furthermore, some participants indicated that new care workers without care work experiences could feel helpless, anxious, and other negative emotions while experiencing end-of-life care. One participant recalled her feelings when she first experienced a resident's passing. She felt that she was psychologically underprepared, and this then led her experiencing negative emotions about providing care after a resident's death.

> *"I just got a nightmare you know you… it's like in a movie, you see something like a dead person, you always think about something horrible, and you are scared, ..., a resident passed away, I didn't want to go there by myself, so I had to wait for my colleague to go with me, so, it was really scary."* (P07, Residential care home, 10 months' care work experience)

Additionally, some participants noted more positive experiences about providing care to residents after their death. They pointed out that they were supported and instructed by the experienced colleagues while providing care after death and therefore felt more prepared and reassured.

> *"I have never dealt with somebody passing, erm, and I did the first one with [a colleague's name] that was here, ..., I have a very good teacher, ..., it was first time, although it really quietened me, make me go quiet, whereas now, it's sad, but you know what you got to do, so that was learning, I suppose."* (P05, Residential care home, 23 years' care work experience)

A few participants shared their experiences where some new care workers who had previous care work experience showed a reluctance to learn about the new residents and care home culture from their colleagues. Such reluctant attitude seemed to be perceived as unfit for being a care worker and some participants expressed their unsatisfactory feelings when they had to work with the care workers with these reluctant attitudes.

> *"Even you are a good carer (care workers), whatever you come in the first place, this is a new place, you're back to zero, because you don't know what is the place, you don't know what's the routine in this place, you don't know the people in here, as a good carer (care workers), you need to ask everything."* (P08, Residential care home, 10 years' care work experience)

It is important to note that the perceived role expectations and the meanings of care work which care workers acquired and were used to establish the work identities seemed to contain slightly different meanings from care home to care home. Thus, if care workers moved from one care home to another, they will be expected to adopt the new care homes' social environment, values and ways of providing care to residents. Stryker and Burke (2000) indicate that individuals learn about their role in an interactive social structure. Individuals develop their role through identification, which provides meanings for individuals including expectations and the appropriate ways of behaviour in the social structure. Given that the majority of care workers learned about care work in a care home, their care practices is anticipated to be heavily influenced by the care home routine and values (André, Sjøvold, Rannestad & Ringdal, 2014).

Many participants emphasised the importance of peer learning in care work and they felt that it was important to all care workers regardless how much experience one had in care industry. One participant stated: *"We need to learn, learn, and talk to the other, other colleagues and we have to ask for their experience."* (P01, Residential care home, 7 years' care work experience). Furthermore, some participants expressed that sharing experiences between new and experienced care workers should be reciprocal. They felt that new care workers transferred from other care homes might have different approaches or views in providing care to residents which might help to improve their own care practices.

> *"Well it's nice sometimes if somebody is new, because you think, I mean I have been here working for long, I'm experienced, but somebody new can be also be experienced so they can give you a few of their ways of doing and you can always try to put your way and my way together, and yeah, so I always, I always seem to work nicely with them, coz we can share ideas."* (P19, Nursing home, 13 years' care work experience)

It seemed that exchanging care work experiences between care workers might stimulate their creativity or reflections on their care practices. This might be considered as an opportunity to polish or improve care workers' care practices.

6.3.2.3 Continuous learning through interaction and experiences.

In the first two subthemes, much emphasis was placed on the ways in which care workers acquired the skills and knowledge of care work and how they grasped the meanings of care

work in the care homes. It is worth noting that many participants seemed to conceptualise their learning of care work as ongoing and continuing. Many participants pointed out that taking residents' feelings into consideration helped them modify their care practices, meet residents' care needs and form a closer caring relationship with residents. Thus, they paid additional attention to ensure that their approach or interaction with residents in their care practices was appropriate.

> *"Carers (care workers) we have to care them, yeah? and we have to understand their feelings that is so only we can deal them properly, means we can… we can take care them properly, …, if I started to chatting with them, if they ignore, yeah? if they ignore, if they will not listen properly, I can easily understanding or their mood is not good"* (P10, Residential care home, 1 year's care work experience)

Many participants felt that the positive feedback from residents helped them know whether they fulfilled their care worker role adequately and affirmed that what they learned was adequate for residents. It seems that residents' feedback might also be perceived as a standard for evaluating care workers' work outcome. This might also imply that many care workers perceive the importance of promoting residents' involvement in their own care and recognise its influence on modifying their care practices.

> *"Good carer (care workers), the way you approach, that the way you deal the residents, any feedback, you have to talk to them, you have to get feedback from them, you have to make sure that… you know, they are comfortable, you need to go and talk to them, ask them what do they need"* (P11, Nursing home, 11 years' care work experience)

> *"The feedback from, because it's important like how would you know that you are good, even if you know for yourself 'oh, I'm good, blah blah blah'. But the end of the day is the resident feel the same way, so it should be like a two-way process as well, yeah"* (P12, Nursing home, 5 years' care work experience)

Participants modified their care practices and approaches based on the feedback they received from residents. Many participants recollected their work experience and stated that it could be difficult or awkward for residents to receive personal care provided by care workers who were essentially strangers to residents. Thus, many participants emphasised the importance of easing residents' awkward or uncomfortable feelings while providing personal care for them.

> *"Nothing more personal than wash someone, you know, if I had to start to wash you, expose you and wash you, you know, how will you feel about that? how uncomfortable, I'm a completely stranger, you know, so you have to try to find a way, and it's about building up that trust, you know about someone genuinely interested in you or whether just going through the motions, you know, you sense that."* (P18, Nursing home, 10 years' care work experience)

It seemed that participants' care work experiences exerted influences on re-shaping their care practices and polishing their meanings of being a care worker. Participants felt that being patient and expressing their caring attitude to residents were an appropriate and effective approach to encourage residents' participation in personal care tasks. Notably, participants frequently used certain words, such as "patient", "loving", "polite", "compassion", "caring", "not to panic", "no rough", and "responsible" to describe what they have conceptualised as an ideal or good care practice.

> *"To deal with they (residents) we (care workers) have to be patient, patient, and talk with them, polite, kind, kindly, be polite, because the main thing is kind, not rough."* (P02, Residential care home, 17 years' care work experience)

> *"I have patience, and in this job you have to have patience, lots of patience, you know, I think I have it"* (P19, Nursing home, 13 years' care work experience)

Mackintosh (2006) suggests that the process of work socialisation is complex and interactive where employees learned about the role, internalised the values, attitudes, and goals of the work, and reached a sense of assuming the special characteristics of members of the groups. In care home contexts, participants seemed to perceive those characteristics were essential and particular to be a care worker through examining and modifying what they have learned and experienced at work. Demonstrating certain characteristics in care practices may signify that care workers have learned the significance of these characteristics in care work and internalised these characteristics into their meanings of being a care worker.

The findings of this subtheme suggested that care workers' meaningful interaction with residents in the care home and their own work experiences modified their care practices and approaches and their view and meanings of care work. This can be understood as the process of care workers' work socialisation being constant and continuous. Weidman, Twale and Stein (2001) defines socialisation as "the process by which persons acquire the knowledge, skills, and disposition that makes them more or less effective members of society" (p.4). Moreover, in SDT, socialisation is conceptualised as the process of fostering internalisation where individuals "take in values, attitudes, or regulatory structures, such that the external regulation of a behavior is transformed into an internal regulation and thus no longer requires the presence of an external contingency" (Gagné & Deci, 2005, p.334). SDT indicates the relationship between socialisation and internalisation and suggests the facilitators, which are the nutriment provided within the social environment, help and enhance the process of internalisation (Deci & Ryan, 2000). It may be assumed that the peer support and interaction with residents provide care workers with the nutriment that fulfils care workers'

psychological needs and facilitates them to internalise the regulations learned from their care work training.

In the current study, participants' accounts reflect that examining and modifying what they have learn from care work training and support from experienced colleagues, through their interaction with residents and their own work experience, helped them to polish their meanings of being a care worker and to improve the efficacy of their care practices. Moreover, Stryker (2008) states that individual experiences are influenced by their interaction with others in the social structure and the social structure symbolically influences individuals' experience and modifies their cognitive schema. Care workers develop their cognitive schema of being a care worker through their interaction with residents, residents' families, peers, managers, and other health professionals. The interaction helps care workers to establish their work identities via providing them with information and modifying their experience in the care home. Burke and Stets (2009) argue that individuals experience identity verification where they compare their self-meanings with others feedback in a given social structure. Individuals are likely to experience negative emotions when they realised the incongruence between their self-meanings and others' feedback. The negative emotions would then lead individuals to modify their role behaviour or situation to enhance the compatibility between self-meanings and feedback. The findings of the current study suggest that care workers learn about their role expectations through the work socialisation in the care homes and construct what they should or should not do as a care worker. Therefore, the care workers' work identities might be influenced by their colleagues, the training care home provided, and care home culture. Although the role of care home managers was infrequently mentioned in participants' accounts, the findings of this theme imply the significant role managers have in providing continuous training which subsequently shaping care workers' work identities.

6.3.3 Barriers in assuming care worker role.

In this theme, participants reported difficulties they experienced when providing care to residents at work and outside work. Many felt that these difficulties and barriers impeded them from providing adequate care and promoting residents' sense of autonomy and independency. Participants expressed that they endeavoured to fulfil their role expectations and responsibilities. However, they felt that it could sometimes be difficult due to a resident's condition or some contradicting expectations of a resident's families. Many participants stressed that they developed a close relationship with residents and sometimes experienced negative emotions due to the emotional attachment they formed with residents. Some

participants stated that they sometimes found it difficult to maintain the balance between life and care work.

6.3.3.1 Struggling with meeting role expectations.

Many participants expressed that it was difficult to provide care to residents with dementia while promoting the residents' sense of autonomy and being in control of their own care. When residents with dementia had insufficient capacity to recognise their own care needs, some participants felt that it was their responsibility to meet residents' unrecognised care needs. Many participants described scenarios where residents with dementia were unable to communicate their needs for personal care. Some participants stressed that when considering a resident's best interests, they tended to provide care to residents with dementia, such as offering drinks and food, or helping them dress, without being able to ask for their consent.

> *"Some of them, they will tell you what they need. Some of them (residents with dementia) you have to like tell them 'here is your drink, you drink that', otherwise, they won't drink anything. ..., Because some of them, they don't think they need to drink, they don't think they need to eat, you need to tell them, because they are blank, you just tell them 'this is your tea, have your tea, or this is your supper, have your supper'."* (P07, Residential care home, 10 months' care work experience)

These participants seemed to actively make decisions for meeting residents' unexpressed care needs based on their observation, care work experience and act on behalf of the residents' best interests. In these cases, many participants expressed that they were unable to simultaneously fulfil the responsibilities of promoting residents' autonomy and considering residents' best interests and decided to prioritise residents' best interests. Many participants also expressed their uncomfortable feelings of leaving residents unattended, especially when a resident's decision might not be in their best interests or be harmful. The uncomfortable feelings might result from the dilemma participants encountered in that given situation. Some participants stressed that they tended to take the consequences of fulfilling a resident's wishes into consideration and act to the less adverse one.

> *"She [resident with dementia] is sitting in chair in the evening time and if you will ask her 'Would you like to go to bed?' and she will tell us 'No, no, no'. and we will accept which is fine, but she will stay all night in the chair because she cannot make a decision about herself, ..., so it's really difficult to find balance um, to accept their [residents with dementia]wishes and um, what's the best for them, sometimes we really have to make a decision what is the best for them [residents with dementia], otherwise she will be sleeping in the chair in lounge all night, ..., if she refused to be checked, she will be like neglected, to be honest, yeah?* (P09, Residential care home, 11 years' care work experience)

It seemed that the participants' perception of their roles, experiences and understandings of residents' condition influenced their decision about care practices when experiencing the dilemma at work. On the other hand, some other participants expressed that it was crucial for care workers to facilitate residents with dementia to make their own decision even though they might not always be aware of their own needs. In order to involve residents in their own care, some participants offered a few options following their decision of providing care to residents. The approach care workers applied to promote a resident's involvement might be seen as efforts to avoid compromising a resident's autonomy while ensuring the resident's best interests.

> *" They (residents with dementia) are answering but they don't really know what they are saying, ..., so you are choosing for them, because maybe that time they cannot choose themselves, but you are choosing for the weather, ..., I'm giving two choices, you cannot give them too many choices, she loves blue, it's all about blue, so in her top choices, I will hold a blue top, and I will hold another different colour, and I will say to her 'what colour of top would you like to wear it today?' blue? So I put the top up to here so she can visualise the top, and then I put the trousers here, and when she is looking down, she sees the top and trousers."* (P14, Nursing home, 22 years' care work experience)

Some participants felt that some residents' families expected care workers to assist residents in an orderly routine or they might see it as care workers neglecting residents. Despite some residents making their own decision not to follow the routine, some participants felt that they had to assist or provide care to residents in an orderly manner in order to demonstrate that they did not neglect residents to their families. Some participants perceived that some expectations from a resident's family or the care home management were contradicting their care responsibilities to residents and often felt they had to comply with expectations that might involve compromising residents' sense of autonomy.

> *"In some homes it can be bit more regimented, and they want the residents up because sometimes family expect their relatives up, if they come and see their relatives still in bed, they sometimes not look at the bigger picture and think maybe it's residents' choice, they may think you neglecting, I have seen where they think we are um in another home, if that resident is not up or showered or certain things at the certain time, when the family comes they get really upset, and they may think we are not doing our job as carers (care workers), ..., some residents are depressed, sad, they just want lying in bed, you let them, I personally have, ..., you probably, you want him out of bed at least your task is done, you think you have done the job. To me, the expectation of the company will 'have you actually given to the residents the choice they want'."* (P21, Nursing home, 5 years' care work experience)

Some participants discussed the dilemma of meeting the expectations of residents' families had left the care homes where they encountered the dilemma. This may imply that experiencing significant differences between a care worker's personal values and care home

values may lead them to consider whether the care home was a right organisation to work for. On the other hand, some participants expressed that they had to take the role of protecting the residents' best interests even when it contradicted the families' expectations. Some participants experienced debates where a resident's families felt their loved ones needed additional medical care even though it was not the best option for a resident. Therefore, when a resident's family insisted on having additional medical support in place for their loved ones, many participants tended to involve other health professionals in the discussion with the resident's family member. One participant, whose role was equivalent to a care team leader in a residential care home, recollected her experiences of managing the situation where she explained her role and responsibilities to the families and reassured them that the resident was well looked after.

> *"She (family) wants to do syringe driver', she wants to put syringe in her mom, but we know that her mom is comfortable not in pain, I said… I said 'you need to talk to the doctor, not to talk to me, because that part is gonna be deal form the district nurses and the doctor, not to me, I just follow what doctor said, I just prepare what your mom's need, I change the bed to hospital bed, I change everything, I make your mom comfortable, I offer everything what she wants, and what she needs, but in the medical term, you need to talk to the doctor or district nurses, because we are not dealing about it, sometimes family is quite difficult. 'I had the power of attorney' (said the family), I know you have the power of attorney."* (P08, Residential care home, 10 years' care work experience)

It is worth noting that providing additional medical support to residents is not the care worker's role or responsibility. It seemed that some residents' families were not clear about what a care worker's role and responsibility entailed. The misunderstanding potentially causes conflicts between care workers and residents' families and may lead both sides to experience distress and frustration. It is worth noting that participants had different reactions when they encountered situations where the expectations of a resident's family were contradicting with resident's best interests. These differences among participants may imply the influences of the hierarchical power structure and the culture in the care home on care workers' care practices.

As mentioned above, many participants felt that monitoring a resident's changing care needs was a key aspect of their responsibility. However, when residents were approaching the final stage of their life, some participants felt that it was difficult for them to tell whether a resident's care needs were met.

> *"They ask me if I think she is in pain, which I cannot answer it, because I… the way she is screaming out, I cannot say yes, and I cannot say… because she is not just*

doing that when you touch, she is just lying there and screaming out, so I cannot say yes or no" (P05, Residential care home, 23 years' care work experience)

"I was asked to stay with the resident, and it was really quite hard, coz he was in pain, he might not be in pain, I'm not sure, but he was very heavily breathing, ..., we have something to make him comfortable, change clothes, and give him some drinks" (P16, Nursing home, 19 years' care work experience)

Many care workers stated that they understood that a resident's passing at an older age is inevitable and what they could do was to try to comfort residents at the end of life. Yet, it seems that experiencing a resident approaching the final stage of their life could lead care workers to experience negative emotions and a sense of helplessness. Some participants discussed the bereavement after a resident's passing and felt that it was much harder to process a resident's passing when they were not mentally prepared for it.

"If you have time to realise 'okay, they stop eating, and then you realise 'okay, that's dementia, then they are falling down, you know, like stop, you see, um then you have time to prepare yourself, but sometimes they just, it's very odd and sudden and then you start like: oh, when did that happen?" (P06, Residential care home, 1 year's care work experience)

It seems that care workers recognising a resident's deteriorating health or being informed about end-of-life care enables care workers to psychologically prepare themselves for a resident's death. In addition, it seemed that being unable to fulfil the duty of care as a care worker might escalate their distress. It is worth noting that the support from care home managers is infrequently mentioned in coping with the difficulties impeding care workers to fulfil their role expectations. This may require further research concerning care home managers' perceptions about care workers' support needs.

6.3.3.2 Attachment versus maintaining boundaries.

Many participants expressed that their relationships with residents were often developed through their interaction, care practices and emotional support. Some participants stated that they appreciated the relationship they had developed with residents while some participants described as akin to familial relationship.

"We (care workers) are the second family, when they (residents) reach that stage, we are their second family, yes, they have their family, but not 24/7, we are 24/7, they(residents) see us more than their family, they recognise us, sometimes family come in really upset, family come in, of jealousy, because the relationship we have with them (residents), and if the family come in, they (residents) push the family away, because they (residents) don't know them (family), they (residents) lose the memory of them. (family), ..., They (family) come in and they (residents) will push them (family) away." (P22, Nursing home, 4 years' care work experience)

However, a very close relationship between care workers and residents did raise concerns regarding attachment issues and boundaries. One participant mentioned that she had a very close relationship with one resident and that resident was wanting to make her the beneficiary in the will. The participant expressed that it was unacceptable to accept monetary presents from residents.

> *"I had a resident, ..., she wrote the letter to the lawyer, she said 'I want to change my will. I will give this one'. She mentioned my name, and my colleague's name, and I said 'don't do that'. She sent it to the lawyer, I said 'no, no, no, no, no, no'. Because they said 'you look after me, but that two boys, they just asking for my money', I said 'no, no, no, no, no, no, no'."* (P08, Residential care home, 10 years' care work experience)

A close relationship developed between residents and care workers might encourage care workers to assume a familiar role in their care practice. Nevertheless, establishing a close relationship with residents, assuming a familial role to residents, or accepting monetary gifts from residents may lead to blurring boundaries or care workers stepping the boundaries. This might require care workers to maintain a self-awareness of whether their interaction with residents was appropriate and whether they were emotionally involved or attached with residents.

Many participants felt that care workers should maintain an adequate working relationship with residents in order to prevent the negative influence of emotional dependency between residents and care workers. It seemed that the emotional dependency could lead care workers or residents to experience the negative emotions, such as anxiety, worries, jealousy, depression, and distress.

> *"This is job, it's fine, when they build relationship, but the relationship on respect, on basis of respect ..., but there should be just little bit like distance, I mean they shouldn't be like, too much involved, because it's not good for the [residents], and it's not good for the carers (care workers) as well, if there is really very strong relationship, the resident is probably dependent certain carer (care workers, and carer (care workers will go on holiday for one month for example, so that residents can be really really devastated, it's not really point, so it's always to just, little bit to find that normal barrier to keep that relationship is normal."* (P09, Residential care home, 11 years' care work experience)

> *"He (a resident) treated me as maybe his family, he became so close to me that, because he hasn't has any kids, so I think he must think I'm one of his kids, his daughter, that every time when I talk to somebody else, he would get offended of it, yeah, he would get really offended."* (P19, Nursing home, 13 years' care work experience)

Many participants expressed that they sometimes felt more connected with certain residents than others and the stronger connection they felt the more they would emotionally engage with the residents. They emphasised that they would endeavour to provide care to all the residents with the same amount of dedication regardless of their relationship with the residents. Some participants expressed that witnessing residents' deteriorating and passing was difficult, particularly the residents with whom they had developed a close relationship.

> *"You are not supposed to, but everybody does, their favourite, and… you give the same care to every resident, but there will always be one (resident) that you'll (care workers) be more emotional, …, so it's probably a little bit more feeling, so that one (favourite resident) passed away, you'll be like 'oh…' (with facial expression of frown)"* (P05, Residential care home, 23 years' care work experience)

This might result from the nature of the care work and the role expectations participants perceived, they seemed to feel it was difficult to stay distant, especially for the residents they were close to. One participant felt that it could be difficult to keep boundaries after they have been working closely with residents and often found herself in mourning for her residents.

> *"When he (resident) passed away, it was really hard, I didn't even go to the funeral, I just, I just couldn't do it, it's just too much, yeah, it's hard every time, and the day when he died, I was wanting to visit him in the hospital, but then I had to exchange my shift and then suddenly he passed away, so it's hard in that stage, and I admit that I get really close to people, I treat them all like mum and dad whatever, we become too close which is hard at the end of the day"* (P19, Nursing home, 13 years' care work experience)

In addition, many participants expressed that physical touch or contact between care workers and residents was a means of reassurance for residents that facilitates an alleviation of distress and anxiety. They felt the physical touch or contact was an effective means of nonverbally expressing their care and affection to the residents and used physical touch or contact as part of their care practices.

> *"The most important thing for them is we care for them, that we look after for them, and we meet their needs, um and we can talk to them, not just you know, we can sit down have a saviours conversation or we can have cuddle and you know, a kiss, just holding somebody's hand, um I think just knowing we are there for them"* (P15, Nursing home, 8 years' care work experience)

Nevertheless, some participants mentioned in some care homes care workers were forbidden to have the physical touch or contact with residents or had to minimise the physical contact with residents.

> *"Love is when you hug them, and you kiss them, when you stroke them you just feel, you are giving what you can give to them, make them feel happy, …, you stroke the hair, the forehead, you know, you just be gentle, you just be gentle, that's it, gentle,*

> *caring, …, I was coming from a home (care home) where you couldn't kiss the residents, you couldn't kiss the residents on their cheek"* (P22, Nursing home, 4 years' care work experience)

This suggests different views or standards regarding the appropriate care practice, interaction with residents, and boundaries across care homes. In some cases, care workers may have their own personal values which are incompatible with the ways in which boundaries are conceptualised in the care homes. Care workers may feel obliged to modify their practice whereas some care workers may move to work in a care home with the values more compatible with their values.

The nature of care work might lead care workers forming close relationships with residents, assuming a familial role, and experiencing sadness, grief, and bereavement after a resident's death. This points to care workers' support needs in managing the negative emotions induced by the attachment with residents at work.

6.3.3.3 Maintaining work-life balance.

Participants mentioned that working shifts and long hours impacted their social or family lives. It seemed that care workers were more likely to prioritise work time over home or recreational time.

> *"I don't get much time of the weekend to go places I want. One weekend I work, one weekend I will be off, so when I was working back home, I used to be off every weekend, so I'm working weekend shift, I need to get used to it, that's the thing."* (P07, Residential care home, 10 months' care work experience)

> *"My husband takes them (the kids) to school, I got help with the kids. I always try like my days doing as much as I can, yeah, but they (the kids) have to understand mummy has to have a job, otherwise no food is on the table, (laugh)"* (P19, Nursing home,13 years' care work experience)

Moreover, the majority of participants mentioned that they could feel physically and emotionally drained after their shift. Some participants expressed that they would endeavour to switch off from work and avoid bringing work issues home. It seems that some participants conceptualised work and their personal life as two different dimensions and felt that care workers should maintain a clear separation between care work and their personal life.

> *"It's (care work) tiring physically and mentally sometimes, yeah, it's sort of you know the optical you know how to get over mentally, and then you got round and you sort of close the door and you know, you get on with your own life outside,…, that's the way I switch off personally, yeah, I mean I sign out the book there, I get my bus cross*

> *the road, and that's my work finished, I don't take it on with me, or I tried to not take it on with me, you got strategies to deal with it over the years."* (P20, Nursing home, 31 years' care work experience)

However, some participants expressed that they experienced difficulties to eliminating the impacts made by the care work on their personal life. One participant mentioned that she worried about residents even when not at work and would contact her colleagues to enquire about residents' health and wellbeing.

> *I'm here for the residents, I'm here for them not for anybody else, that's how I do, and I like this, this is like my home, you find sometimes when I'm at home, and I'm off that day, and I heard so and so ill that day, I will be worried, I'm thinking about how so and so is, or sometimes I can speak another workmate and I know they are, I will send a text 'how is so and so today?* (P19, Nursing home,13 years' care work experience)

It seemed that care workers are required to develop their own strategies to manage the negative influences of emotionally dwelling on work on their personal life, even for care workers with years of experience. The findings of the current study reveal the barriers care workers may experience when they devote to fulfilling their role expectations, deal with attachment issues while maintaining boundaries, and work-life balance. The barriers care workers encountered may be understood as stressors induced by the incompatibility between care workers' self-meaning and the feedback obtained though social interaction.

6.3.4 Facilitators of commitment to care worker role.

In this master theme, participants discuss the motivation and facilitators they experienced at work that encouraged them to continue working as a care worker. Their accounts reflect the significance of these facilitators in enhancing their commitment towards the care work. The facilitators included experiencing autonomous need satisfaction, meaningful connection and relationship with others in the care homes, enhanced self-efficacy, being valued, and sense of pride.

6.3.4.1 Satisfaction of autonomous need.

Despite the negative public views regarding care work and care workers' care practices in general, many participants acknowledged the importance of supporting residents. Many participants expressed a belief that they have made a rational and conscious decision to work as care workers due to their own personal characteristics.

> *"I was just doing on the computer, I wouldn't want to do that again, no. Now I like to talk, you can see how I talk, (laugh). ..., I want to share, I mean, to add smile on people's face and care for them (residents), do whatever you can do for them, help*

them, yeah, be there for them, be their friends for them, that's me" (P19, Nursing home, 13 years' care work experience)

It seemed that some care workers were satisfaction with the nature of the care work and the achievement they could reach. Moreover, the participants who made an autonomous decision to be a care worker felt that the experience of positive interaction with residents reinforced their motivation to stay at their current position. It seemed that the participants who autonomously chose the care profession would be more likely to experience satisfaction at work.

"I actually am proud be a care assistant, I love my job. My first job was in London, I actually worked in a day centre for people with dementia, …, and I never look back since, I like working with people with dementia, because they're most fascinating people you can ever meet, the stories are absolutely amazing, the experience is brilliant." (P13, Nursing home, 10 years' care work experience)

In contrast, the participants who felt that they became a care worker as a career of last resort discussed their intention to leave their job.

"Because that's the only job I got when I came here, but I'm not gonna be here forever, I started looking for other jobs, I'm planning to do courses and get few qualifications" (P07, Residential care home, 10 months' care work experience)

Care workers who felt forced into the care work by circumstances may feel their autonomous needs were thwarted or frustrated. In the case above, the participant (P07) seemed to plan for changes which aimed as satisfying autonomous needs. In addition. many participants' accounts reflected the positive and significant influences of working in an autonomy-supportive environment in their care practices and in interaction with residents. Where participants had the flexibility in adjusting their care practices and making their own decision about planning care work and prioritising the interaction with residents, some participants working in specialist dementia units praised the flexibility. Care home management that allows care workers to provide care to residents in a relatively unconstrained schedule may permit more flexibility in care workers' practice and remove possible pressure from the expectations of residents' families on assisting residents in an orderly routine.

"They don't want to sit down and eat their meal, um it might be a case of they don't like that meal, or they don't want to have that meal at 5.30 pm, so we wouldn't force somebody to sit down and have their meal at that particular time, if they want to walk around the unit, which I would say it's fine, just let them carry on their walk, and then they may come back later and have something to eat." (P15, Nursing home, 8 years' care work experience)

"We call person centred care, so we don't care if the bath is dirty, we don't care if there is washing up in the sink, that tasks can be done when you are free, and our main purpose is residents, everything can wait, yeah, like… if I'm leaving today to go

> *home and I haven't finished my tasks, I will say to my colleagues, sorry, didn't get time to do that, and they will take it over, and I spent my day out in the garden to look after somebody."* (P14, Nursing home, 22 years' care work experience)

It seemed that the care workers who were supported and encouraged to adjust their care practices might perceive stronger autonomy and better participation in planning the processes. This might imply that the organisational culture in care homes could influence care workers' care practices for residents and their perception of care worker role.

6.3.4.2 Sense of belongingness to the care home.

Many participants expressed their satisfaction of being able to care for residents and establishing meaningful connection and relationships with residents. One participant stressed that she appreciate that she was being able to form a bond with residents, to meet residents' care needs, and to be relied on.

> *"I was always a such a loving person, this is my dream job, because I haven't got the children to care for, of course I got nieces and nephews, but they are not mine, so that's why I love my job, I love caring people and I love dementia"* (P14,Nursing home, 22 years' care work experience)

It might imply that care workers derive a sense of meaning from their work or have a need which can be fulfilled by offering support to the residents who are in need. Moreover, some participants suggested that they felt privileged to be recruited by a care home with good external reputation. Moreover, some participants who participate in the development of a new care home unit expressed their proud feeling to achieve this goal with their colleagues and manager. They expressed that they were not merely hired by the care home, they were also a part of the care home. This might imply that encouraging care workers' involvement in the care home leads care workers reaching a sense of belongingness.

> *"Because before we moved here, …, we made this (the unit), all the staff up here and the manager, we made it (the unit) happened, and I just think we have worked so so hard to make it what it is now, it was just empty shelf when we came in here, we have done all the decoration, um you know, we've done, you know, we have built up this this unit and I just feel really proud"* (P15, Nursing home, 8 years' care work experience)

A number of the participants mentioned previous work experiences in other care homes and revealed the impact of care home management and culture on their care practice. One participant expressed that she had very different views regarding care practices from those of her manager and felt she did not belong or want to continue working in that care home. She declined the offer for further career advancement and moved to work for the current care home, where she shared the similar values.

> *"The manager (of the previous care home) wants to hold me there, ..., what I want I wasn't getting it, it's to reach out the residents, that's all, you know, ..., he said 'I want to send you to a college to do massage', I said 'you lie.' he said 'What you mean?' I said 'you lie, because you cannot hold me here, even if I go and do that course, you are not going to let me work with this resident how I want to work with'."* (P22, Nursing home, 4 years' care work experience)

It seemed that care workers prefer to work in care homes where they share the same values in relation to care provision. This might imply that experiencing a higher level of compatibility between the care home and care workers' values leads to care workers feeling a sense of belongingness. Some participants implied their reason for leaving previous care homes was that the care homes' values were incompatible with their personal values (Edwards & Cable, 2009; Verquer, Beehr, & Wagner, 2003). Stryker and Burke (2000) suggest that individuals' identity is formed through negotiation and adjustment of an individuals' personal knowledge and understanding of the social environment.

6.3.4.3 Self-efficacy and sense of competence.

Many participants perceived that care work can be physically and emotionally demanding, especially when they provide care to residents with dementia. However, some participants expressed their feelings of being contented, confident, and empowered when they were able to provide care to residents with dementia and to comfort residents emotionally and psychologically.

> *"We have got somebody like that in our unit that doesn't like to have a shower, ..., coz you're working with people that got dementia, um you will put on an act with that particular person. I can say to her (resident) that she is my best friend, that we get along really really well, we like a little cuddle, and we will go and have a little laugh and make a cup of tea and a piece of cake, and then she feels a lot more comfortable, and then I would say to her 'should I do your hair to make you look more beautiful' and she will be happy with that, and predominantly she will come in to have a shower, ..., it doesn't always work. A lot of time it does, I think it's about three of us can manage to do it."* (P15, Nursing home, 8 years' care work experience)

> *"A resident [with dementia] always take off her skirt in front of the residents, I said 'what we are gonna do, this one you love it, I will find one for me that is same like this, and we will wear it together'. And she (resident) says 'yes'. 'Can you wear it now and I will find one for me' [P08 said], and she says 'Yeah'. We have a study with dementia last year, they (researchers) said P08, 'how can you be so good at this?'"* (P08, Residential care home, 10 years' care work experience)

Moreover, participants working in a residential care home seemed to have more contact with other health professionals. Interestingly, some participants expressed that it was their responsibility to contact district nurses or GP if any residents in the care home had nursing needs or needs for medical attention. In a residential care home, medical support from other

health professionals are essential in looking after residents. Health professionals who are properly medically trained and qualified might be recognised as external support with greater power and influence on the care provision. Contacting or interacting with other health professionals seems to be perceived as the job only for those at a higher level within a hierarchy in the care homes. Thus, being able to contact or interact with other health professionals seems to provide care workers with a sense of improvement regarding their position within the care home and their career progression. Such progression seems to aid the care workers' confidence of providing care for the residents as well as their sense of competence at work.

> *"Residential home, we are the carers (care workers), see, we all have to handle, so when somebody going ill, not eating, different mood and depression, …, and so we have to judge and call the doctor. That's the different. Here is professional we are, residential home is more experience, we are doing. …, I'm really happy here, because more knowledge, more writing, more English, you know I was climbing, not down, down, coming up up up, when I was in nursing home, just the skill job I was doing, just wash and dress, and now, I'm like a nurse, like higher, going up, and more knowledge coming is good."* (P02, Residential care home, 17 years' care work experience)

Positive experiences of interacting with other health professionals might lead care workers to experience the sense of partnership with the health professional. It might be understood that the relationship between the care workers and health professionals eliminate the sense of being powerless and offer a sense of moving upwards within the hierarchy in a care home.

It is worth noting that care workers who experience being empowered by the managers tend to take on more responsibilities and report a higher self-efficacy, confidence, and job satisfaction, as noted in other studies (Barry, Brannon & Mor, 2005; Colón-Emeric et al., 2006; Corazzini et al., 2014). Some study participants who worked in residential care homes where there are no nurses expressed a greater sense of achievement at work due to the increased responsibilities. It seems that being entrusted with the responsibilities of contacting and interacting with other health professionals is perceived as a form of career advancement and a means of enhancing care workers' self-efficacy and self-esteem in the care home. This may imply an association between care workers' organisational identification, self-efficacy and self-esteem, where care workers' self-esteem and self-efficacy are enhanced by the internalisation of care homes' values. The enhancement of care workers' self-esteem and self-efficacy then leads them to experience better job satisfaction and a stronger organisational commitment (Podsakoff, MacKenzie, Paine & Bachrach, 2000; Van Knippenberg & Sleebos, 2006).

6.3.4.4 Being valued.

It is worth mentioning that care workers seem to consider the opinions from residents, their family members, and care home management as more significant than any self-evaluation when considering their work performance. Many participants stated that they received residents' feedback through residents' verbal presentation and attitude while interacting with residents. It seemed that care workers perceived residents' affirmative attitude and friendly responses as a means of approval for their care practice. Some participants expressed that they would take such positive responses as a form of appreciation from residents and a positive reinforcement for their work outcome.

> *"I don't know about others, but for my care, yeah, they are satisfied with me, because when I enter the room, I can see their faces smiling and greeting 'good morning', like that, yeah? it means they are happy, that's why their faces is smiling, otherwise no, they won't."* (P10, Residential care home, 1 year's care work experience)

> *"If you treat them with respect and you help them and they are very thankful, 'oh, thank you for doing that', something so simple like maybe dong the hair, doing the nails, simple little things, and they are so thankful and then brace, 'thank you for that, that's wonderful, you have no idea what you just have done for me', they don't cost nothing, you know, that don't cast nothing, that's something comes from with and you together to somebody else"* (P18, Nursing home, 10 years' care work experience)

Many participants pointed out that residents with dementia or approaching their end of life often had difficulties articulating their care needs. It seemed that care workers with sufficient understanding about residents would be able to provide personalised care to residents up to the end of life. Some participants expressed their feelings of being valued when they experienced residents' positive response or verbal expression. It seemed that care workers felt encouraged or motivated when they realised that their efforts in the care provision were recognised by residents.

> *"Because they go to hospital, they don't get the same end of life care, because they don't know their personal needs like we do, erm, I think they get to know our voices, even if they cannot see or anything, they get to know your voices, they know when you come to the room, you see the smile on the face."* (P05, Residential care home, 23 years' care work experience)

> *"I gave him a cuddle, and he likes a hand massage, I was giving him a hand massage, and it was wonderful, wonderfully said 'you have no idea what you have done for me', and I said to him 'you have no idea what you have done for me' you know, you get as much from them, you truly do, if you, if you put that much into it, you will get that much back from them"* (P18, Nursing home, 10 years' care work experience)

Many participants expressed that encountering a resident's death was difficult for them to process and manage emotionally. On the other hand, some participants mentioned that some residents' families expressed their satisfaction and appreciation for the care their loved one

received at the end of life. It seemed that care workers perceived such satisfaction and appreciation as a form of recognition of their work effort in providing end-of-life care.

> *"When the last moment stage, the resident, then we are doing their caring, …, they think she die soon, no, not in six months, she is dead, so how we (care workers) do the caring good, how feeding and look after, so they (resident's family) know how we (care workers) look after, and they (resident's family) are happy."* (P02, Residential care home, 17 years' care work experience)

This might also imply that a resident's family has an important role in the care home. As noted in previous research, residents' families are more likely to take the role of inspectors to evaluate the quality of care after older people's admission to a care home (Knight & Emanuel, 2007). Thus, when care workers' work effort was recognised and appreciated, it would have a significant positive impact on care workers' work identities.

6.3.4.5 Sense of pride in their work.

Many participants recollected experiences where they have seen some care workers having negative views about care work and providing care to residents in a careless manner.
They expressed that care workers should have a diligent and positive attitude to provide care to residents.

> *"Being a carer (care worker), used to be sort of not very important, you know, and, and everybody would come, but really to be… you know, you got to be patient, you got to be a lot um caring as well, …, if you are not enjoy your work or what you are doing, it's not going to be a good carer (care worker), if you doing say for example, just you need the money, and you will work as a carer (care worker) just to get some money, well, it's not good, it's not good."* (P16, Nursing home, 19 years' care work experience)

> *"Some carers (care workers) they don't have pride in their work, …, I have seen few carers (care workers) come and go, not here, but in previous (care home)… and they just have no pride in their work whatsoever, when they finished assisting someone with the meal, they just leave them aside, walk away do something else, …, you do get people that just haven't got caring in them and have no pride in their work"* (P13, Nursing home, 10 years' care work experience)

It seemed that care workers felt that a reckless attitude was equivalent to self-disrespect and that a lack of understanding of the value of the care work often led to unsatisfactory care practices. This might imply that care workers internalise the meanings attached to their role and perceive their work identities as part of their self. Some participants discussed the changes in residents' responses towards life in the care home when they recollected their experience of facilitating residents' adjustment to the care home. It seemed that a resident who becomes well-adjusted to the care home implicitly provides care workers with a sense

of achievement. The participants felt that it was their goal to reassure residents, provide emotional and social support. When care workers observed residents feeling content with their life in the care home, it seemed to be reasonable to believe that care workers achieve their goal.

> *"We have one of the lady, when she transferred to the home, she wasn't happy crying, crying at night, she was even grumpy, she was upset with the staff, ..., But we are surprised that lady now, it's like her own house, you see her very cheerful, always smiley, even the family comes, you know, 'no problem, no problem', because the way that we staff look after her, she's always pleases, yeah."* (P11, Nursing home, 11 years' care work experience)

Moreover, some care workers expressed positive emotions when talking about how their care helped a resident recover from an illness or residents showed a stable positive mood. It seemed that participants conceptualised looking after residents as their most important priority in the care home. Thus, when care workers associated a resident's recovery and positive emotions with their care practice, they would feel contented and satisfied. This suggests that residents' improving health condition might strengthen a care worker's confidence at work and enable them to reach the sense of achievement.

> *"It's quite rewarding when they are doing well and they are healthy, ..., or they are ill and they have been so ill, and they recovered, you know, and you see them, they are being very well, and that's very rewarding to see in this job, ..., when they are well, they are happy. that's what we aim, this is our job, this is what we, you know, we want them to achieve, their health, their good heart, their well-being."* (P04, Residential care home, 10 years' care work experience)

> *"I think it's really rewarding, very rewarding, coz you are helping people, you know, you making people laugh and chatting with them, um coz they don't live with us, they don't know people to look after them, you know, so it's very rewarding"* (P17, Nursing home, 17 years' care work experience)

One participant expressed her pride that a resident in their care improved after being in critical condition. It seems that care workers perceive their provision of optimal care as facilitating the resident's recovery. Being able to look after residents and experience their health improving seemed to provide care workers with a great sense of achievement. Notably, residents' improved health might imply care workers' competence in providing care for residents and subsequently lead them to have a positive evaluation of their work.

> *"Someone going very ill, she is going to… we thought really dying, she, so we think she finish end of life, finish, I challenge with her, give her food and one week, now, she is walking, yeah, I challenge, a few times I challenge like this, yeah, look after very well, so I look after her and now she is walking. Everyone thought she would go, doctor thought she would go."* (P02, Residential care home, 17 years' care work experience)

Furthermore, some care workers working in a specialist dementia unit addressed the support from care home management in encouraging their involvement in developing that unit and creating a friendly and family-like environment for residents.

> *I think the whole unit up here are very family orientated, …, before we moved here, we didn't have dementia unit, we mad this, all the staff up here and the manager, we made the unit happened, and I just think we have worked so so hard to make it what it is now, …, we have built up this this unit and I just feel really proud of it."* (P15, Nursing home, 8 years' care work experience).

It seems that care workers' increased involvement provides them with a strong sense of belongingness in the care home (Edwards & Cable, 2009; Verquer, Beehr, & Wagner, 2003) and a strong sense of pride in their affiliation with the care home (Bartel, Dutton, Hogg & Terry, 2001). Participants who were proud of their care home's culture and values seemed to implement care home values in their care practice. This supports the premise that care workers compare care homes' organisational values with their personal values and tend to work for care homes that hold values that agree with theirs' (Ibarra, 1999; Pratt, 1998; Slay & Smith, 2011). Subsequently, they are more willing to devote their efforts in support of the care home. Therefore, value congruency in some scenarios may be viewed as the antecedent of their organisational identification.

In addition, some participants expressed feeling privileged and honoured to look after residents approaching the final stage of their life. It seemed that some participants viewed doing care work as a calling and felt a sense of pleasure and satisfaction when they completed their caring role to a resident.

> *"My experience is that somebody is passing need to be loved as much as… or even more I think, when they leaving this world as to when they're up here, you know, they are leaving the world, and I want to leave my mark on that person, so that they can pass peacefully and I think it has been a real honour to have looked after that person, so they should leave, you know, with me respect."* (P18, Nursing home, 10 years' care work experience)

One participant perceived her role as making sure residents were treated properly after their death until they left the care home. She stated that it was her way of giving residents a proper send-off.

> *"When the undertaker's come, I'd like to be there, just to make sure it's done nicely, …, if they cannot do it their own, I will say 'Do you need a hand?' It doesn't bother me, …, after that [the undertaker collected the body], I will follow the coffin to the lift, hands in my back, and just see them out their final journey, I run down the stairs, when they come out of the lift, I then follow them out the door, then I will go outside and I will wave to the person to the ambulance and when they go off, then I*

will come in, so if they die, I will follow them completely to the end, …, I think it's nice." (P14, Nursing home, 22 years' care work experience)

This participant's giving residents a proper send-off might be explained as a form of closure of her caring responsibilities to the residents. It seemed that by doing so she would be able to focus on other residents' care needs.

It may be understood that care workers' perceptions of the values of care work, their sense of achievement at work, and the compatibility between their personal values and the nature of the care work lead them to experience a sense of pride in doing care work. This sense of pride seems to be valuable, meaningful, and important to care workers and encourages them to continue their work role.

6.4 Summary of the findings and general discussion

The aim of the current study was to explore care workers' perceptions and experiences in providing care for residents from the care home admission up to the end of life. The findings of the current study revealed that participants perceived their care worker role as providing care to residents in accordance with residents' care needs and best interests, maintaining residents' independency and autonomy, meeting residents' emotional and social support needs, and fostering a trust and close relationship with residents. Fulfilling care workers' role required care workers to liaise with residents' families and work with their colleagues as a team. The role expectations that care workers learn from the training, other colleagues' shared work experiences, and interaction with residents informed them of the meanings of being a care worker and establishing their work identities. Internalising care home values and regulations may also refer to establish care workers' organisational identification where they adopt and integrate the organisational attributes, beliefs, values with their personal ones (Ashforth, Harrison & Corley, 2008; Ibarra, 1999; Pratt, Rockmann & Kaufmann, 2006; Slay & Smith, 2011). Participants expressed the significance of their work experience and interaction with others in the care home where they examined, modified, and verified the values and meanings of care work they had learned. Care workers often experienced difficulties and barriers which impeded them from meeting their role. The barriers involved care workers' struggles with meeting multiple role expectations, issues of emotional attachment, and difficulties in balancing life and work. It is worth noting that participants' perceived role expectations and responsibilities seemed to establish their work identities and implicitly inform the boundaries in the care home. It seemed that participants did not have a definite guideline for indicating clear boundaries at work. This may imply that care workers

would have to go through a process to negotiate, examine and construct their own boundaries based on their social interaction with others and the care home culture.

The findings reveal that care workers emotionally engage with residents and may become emotionally attached to the residents. Emotional attachment between care workers and residents may be considered as stepping or pushing the boundaries and may have adverse effects on residents, care workers and care quality. Participants seemed to struggle with meeting organisational role expectations, especially when they experience residents' inappropriate behaviour or residents' imminent death. This might imply that care workers' struggle with navigating between offering emotional support and the norm of emotional self-regulation (Funk, Peters & Roger, 2017) at work. Self-emotional regulation is noted in previous research as emotional labour, which refers to individuals' emotion management (Sorensen & Iedema, 2009; Ryan & Seymour, 2013) and is related to higher levels of burnout and deteriorating health conditions (Hochschild, Irwin & Ptashne,1983; Mikolajczak, Menil & Luminet, 2007). Individuals whose role involves emotional labour express or regulate their emotions in accordance with organisational expectation when providing service to the customers (Ashforth & Humphrey, 1993; Hochschild, Irwin & Ptashne, 1983; Sorensen & Iedema, 2009; Ryan & Seymour, 2013). Although a positive association between emotional labour and task effectiveness has been proposed (Ashforth & Humphrey, 1993), individuals often experience emotional dissonance while complying with the organisational emotional display rules (Mikolajczak, Menil & Luminet, 2007). Emotional dissonance refers to the conflict that individuals experience when the expressed motions contradict their own emotions (Abraham, 1999). Burke and Stets (2009) argue that individuals experiencing incongruence between meanings they internalised and feedback for their internalised meanings in a social structure are likely to experience distress, pressure, and negative emotions. When care workers perceive that emotional self-regulation is expected and experience difficulties in meeting those expectations, they might experience distress, pressure, and negative emotions. This might point to a need to arrange appropriate support from colleagues and/or their care homes to facilitate care workers in managing their struggle and negative emotions.

The participants in the current study frequently mentioned support they received from colleagues and infrequently mentioned the direct support of care home managers. However, participants' accounts reflected the significant influences of the care home culture on the development and maintenance of their work identities. Given that a care home manager's

role has been suggested as influential in forming and maintaining care home culture, these accounts imply the significant role managers may have in establishing care workers' work identities. It may require further research to explore how care home managers can effectively facilitate care workers to develop their work identities and encourage care workers' assuming their roles. In addition, the findings reveal that a care home's value and culture may heavily influence the care workers' perceptions of their role expectations and identities. When care home values and culture empower care workers and encourage them to take on more shared responsibilities, care workers can experience an enhanced self-efficacy and sense of belongingness which may help them to form a stronger organisational identification, to experience a better job satisfaction and, therefore, a higher commitment to the care work in that care home. The compatibility between a care worker's personal values and a care home's values may be seen as an antecedent of a care worker's organisational identification. Furthermore, the findings of the current study reveal the motivation and facilitators participants experience at work which encourages them to continue working as a care worker and enhance their commitment towards the care work. The facilitators include experiencing autonomous need satisfaction, meaningful connection and relationship with others in the care homes, enhanced self-efficacy, being valued, and sense of pride. The findings of current study revealed that care workers' sense of being valued, meaningful connection and relationship with residents and colleagues, satisfaction of autonomous needs, and enhanced self-efficacy seemed to encourage them to continue working as a care worker and lead to better job satisfaction and commitment to their work. Moreover, it seems that through positive interactions with residents, care workers are likely to experience a meaningful connection which might foster a trusting care relationship. Building up a close relationship with residents seems to be an important aspect of care workers' care practice. Moreover, care workers with a good relationship with residents seem to perceive such relationships as a means of being accepted by residents. This might imply care workers' need of relatedness (Deci & Ryan, 2000; Deci & Vansteenkiste, 2004; Ryan & Deci, 2000). The findings are consistent with previous research on care workers' psychosocial factors of motivation (Bishop et al., 2009; Bowers, Esmond & Jacobson, 2003; Coogle, Head & Parham, 2006; Mittal, Rosen & Leana, 2009; Sikorska-Simmons, 2005).

Moreover, the findings of the current study suggest that the application of the SDT approach (Gagné & Deci, 2005; Ryan &Deci, 2003) offers a comprehensive account explaining the relationship between work socialisation in care home context and care workers' motivations of continuing their roles. For instance, from the perspective of SDT (Gagné & Deci, 2005;

Reis, Sheldon, Gable, Roscoe & Ryan, 2000), obtaining consistent nutriments in a social environment would facilitate care workers to internalise the extrinsic values and regulation, enhance intrinsic motivation, and feel a sense of enhanced well-being. Thus, a care worker's satisfaction of autonomous, competent, and relatedness needs would lead them to experience a sense of achievement, satisfaction at work, and enhanced wellbeing. Future studies may quantitatively investigate the relationship between care workers' work identities in the care homes, psychological needs, motivation, self-esteem and self-efficacy in relation to their job satisfaction and organisational commitment.

6.5 Limitations of the current study

This study conducted a qualitative research to explore care workers' experience in providing care for residents from entry up to end of life and the ways in which they perceived their care home roles. The participants in the current study were recruited from the care homes where the care home manager gave their consent for their care workers taking part in this study. It is possible that care workers might wish to present themselves positively or tend to be protective towards their care home, residents, and colleagues. This could constrain the findings of the study which relied on participants' accounts to understand care workers' experiences and the meanings of being a care worker. The recruiting procedure also limited the access to the care workers who were working in the less research-supportive care homes or to those care workers who had left the social care sector. Thus, the extent to which the findings on the barriers in assuming care workers' role influenced care workers' decisions to leave the social care workforce remains unclear. A future study may investigate ex-care workers' experiences, perceptions and decisions for career change and leaving the social care workforce. Moreover, this study focusses on care workers' accounts for their experiences and perceptions regarding their role expectations and identities. Previous research addresses the different perceptions between care workers and the care home managers (Forbes-Thompson, Gajewski, Scott-Cawiezell & Dunton, 2006; Scott-Cawiezell et al., 2006). Therefore, the current study may be limited by the care workers' accounts in understanding care workers' role expectations and work identities. Future studies may investigate care workers' work identities, role expectations from the perspectives of care home managers, residents, or residents' families.

6.6 Conclusion

The current qualitative study has provided a rich evidence-based understanding of care workers' experience, perceptions, and meanings of being a care worker. This study may

contribute towards understanding what informs care workers of their role and the meanings of care work which subsequently fosters the development of their work identities. The findings reveal that the role care workers perceive and the meanings of being a care worker they establish through training, peer learning, and social interaction with residents may have a significant role in facilitating them to manage the barriers in providing care to residents and encouraging them to assume their role and continue working as a care worker. The findings imply the significant role of care workers' work identities. It may be assumed that by facilitating and supporting the development and maintenance of care workers' work identities, care home management and policy makers could foster and maintain a stable and dedicated care workforce in care home settings.

CHAPTER 7
INVESTIGATING THE PREDICTORS OF CARE WORKERS' JOB SATISFACTION AND ORGANISATIONAL COMMITMENT: A SURVEY STUDY

7.1 Introduction

Chapter 5 presented qualitative findings which showed that care workers working in both nursing homes and residential care homes shared high degree of similarities in their working experience, such as the role expectations they perceived and the difficulties and challenges they encountered in care practice. The findings of study 1 (see chapter 5) suggested that care workers acquired the meanings and values of care work and formed their work identities through the processes of learning care home expectations and interacting with others in the care homes. The findings also suggested that care workers' work identities exerted influences on the ways in which they perceived the barriers at work and the facilitators for continuing their role as a care worker. Polit and Beck (2010) suggest that insightful, in-depth, and detailed qualitative research findings are adequate for extrapolation, whereas Willig (2013) argues that the generalisation of qualitative findings may only be validated to the research participants. Thus, there is possibility that participants' perceptions of their work identities are unique and may not represent other care workers in care home settings. Subsequently, the difficulties, challenges, and motivation care workers addressed in the first study findings, which impeded or facilitated them to carry out their care worker role, become blurred and unclear. Given that participants in the first qualitative study were all female and close to two third of them were migrants, the extent to which the first study findings apply to male care workers and native care workers is important to explore.

The rationale of the current study was to build on the findings of study 1 and to investigate whether care workers' perceptions towards their roles in the care homes, psychosocial attributes, psychological needs, and motivations influence the extent to which they are more likely to stay in their job. Organisational studies conclude that organisational commitment and job satisfaction are significant predictors of turnover intent (Gaertner, 1999; Lambert & Hogan, 2009; Kim et al., 1996; Mor Barak, Nissly & Levin, 2001) and linked to better job-related performance (Podsakoff et al., 2000; Van Knippenberg & Sleebos, 2006) and care workers' wellbeing (van de Ven et al., 2012; Zhang et al.,, 2016). Thus, care workers' organisational commitment and job satisfaction may be applied to understand the extent to which care workers are more likely to continue their role.

In addition, care workers' perceptions of their roles presented the meanings attached to the position of care workers. Burke (2003) states that "identities are the meanings that individuals hold for themselves, what it means to be who they are." (p.196). Thus, care workers' work identities can be understood as the meanings of being a care worker which incorporate the values and meanings of the care work and their care practice. The findings of study 1 suggested that care workers' motivation and coping strategies used to deal with work barriers were associated with their meanings of being a care worker. In order to investigate the influences and significance of these meanings in relation to care workers' care practices and retention intention, the construct of identification is applied in the current study. Identification is viewed as an explicit orientation to present individuals' identity (Ashforth, Harrison, & Corley, 2008; Jones & Volpe, 2011) and indicates the extent to which individuals feel belonging in their position in the social structure (Alvesson, Ashcraft & Thomas, 2008; Ashforth, Harrison, & Corley, 2008; Miscenko & Day, 2016).

Furthermore, the findings of study 1 emphasised the significance of care workers' work identities on their care practices and suggested the ways in which care workers acquired their work identities. The literature review in chapter 2 indicated that individuals' different identities relating to organisational settings, including work and organisational identities, may overlap and nest within each other (Ashforth & Johnson, 2001). Ashforth, Rogers and Corley (2011) further suggest that nested identities are somehow linked to each other, especially in an organisation where individuals' work and organisational identities are "relatively isomorphic" because achieving organisational goals "require some internal coherence" (p.1). Given that the intention of the current study was to investigate the influences of care workers' perceptions towards their roles in the care homes on the extent to which they are more likely to stay in their position, organisational identification, which comprises work identities (Ashforth &Johnson, 2001), is used in this study to show the extent to which care workers defined themselves in terms of the care homes where they are working. It is suggested that individuals identifying with the organisation are prone to integrate more organisational values and attributes into their self-concept (Sluss & Ashforth, 2008; Stinglhamber et al., 2015; Van Knippenberg & Sleebos, 2006)

In addition, the literature review in chapter 2 addressed the theories and models that were developed by scholars to understand the predictors and antecedences of turnover intent (Karsh, Booske & Sainfort, 2005; Kim, Price, Mueller & Watson, 1996; Lambert, Cluse-Tolar, Pasupuleti, Prior & Allen, 2012; Price & Mueller, 1981). The models built to predict

care workers' commitment and/or job satisfaction often focus on demographic characteristics, such as age, gender, marital status, and education; extrinsic incentive (Bishop et al., 2008; Decker, Harris-Kojetin & Bercovitz, 2009; Karsh, Booske & Sainfort, 2005); organisational factors, such as workload, staff-resident ratio, supervision, leadership (Bishop, et al., 2009); and psychosocial factors, such as interpersonal relationship, and self-esteem (Coogle, Parham & Young, 2007). Nevertheless, care workers' identities have rarely been investigated in relation to job satisfaction and organisational commitment. Thus, a new model concerning care workers' identities, psychosocial attributes, job satisfaction and organisational commitment may be required.

7.1.1 Aim of the study.

The aim of the current study was to investigate how care workers' perceptions towards their work roles in the care homes, psychosocial attributes, psychological needs, and motivations influence their organisational commitment and job satisfaction.

7.1.2 Hypothesis development.

A structural regression model is proposed based on Self-Determination theory (SDT, Deci & Ryan, 2000; Gagné & Deci, 2005; Gagné & Koestner, 2002), the literature review in chapter 2, and the findings of study 1 in chapter 5. Mowday, Steers and Porter (1979) define organisational commitment through three aspects: ones' belief and acceptance regarding the organisational values and interests, ones' willingness of striving for supporting the organisation, and whether ones are keen to affirm the membership of the organisation. Research on organisational commitment and job satisfaction suggests a number of influential attributes, such as organisational identification (Riketta, 2005; Smith, Amiot, Callan, Terry & Smith, 2012; Van Dick et al., 2004), self-esteem (Johnson, Morgeson, Ilgen, Meyer & Lloyd, 2006; Pratt, 1998; Van Knippenberg & Van Schie, 2000), self-efficacy (Vignoles, Regalia, Manzi, Golledge & Scabini, 2006), the satisfaction of psychological needs and intrinsic motivation (Gagné & Deci, 2005; Gray & Wilson, 2008). The paths denoted in the hypotheses refer to figure 6.1.

Hypothesis 1a: Organisational identification (path d), self-esteem (path p), self-efficacy (path l), the satisfaction of psychological needs (path h) and intrinsic motivation (path n) have positive direct effects on organisational commitment.

Hypothesis 1b: Organisational identification (path b), self-esteem (path o), self-efficacy (path k), the satisfaction of psychological needs (path f) and intrinsic motivation (path m) are have positive direct effects on job satisfaction.

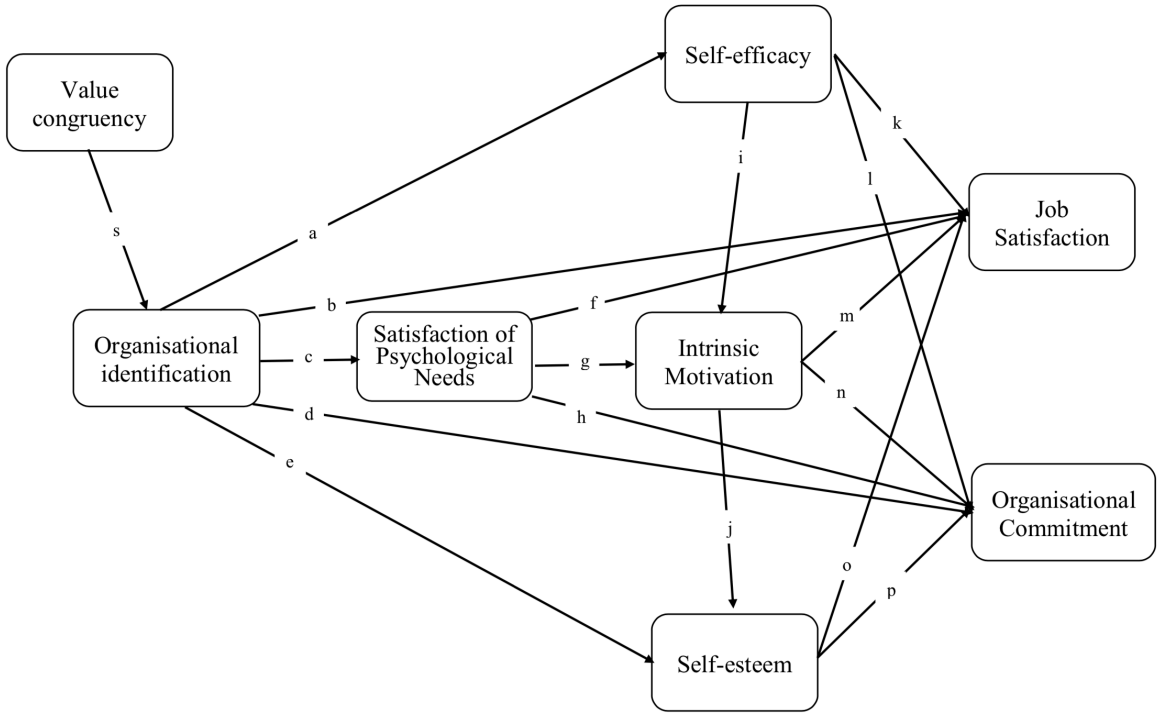

Figure 7. 1 A hypothesised structural regression model of the hypothesised relationships.

Notably, both organisational identification and organisational commitment are used to reflect a psychological relationship between employees and organisations. Some suggest that the concept of organisational identification is equivalent to affective commitment (Karsh, Booske and Sainfort, 2005). However, many others argue that organisational identification and organisational commitment are two different but related concepts (Stinglhamber et al., 2015; Van Knippenberg & Sleebos, 2006). Organisational identification, which is defined as "the perception of oneness with or belongingness to an organisation, where the individual defines him or herself in terms of the organisation(s) in which he or she is a member" (Mael & Ashforth, 1992, p. 104), reflects employees' 'self-definitional' perspective of their relationship with the organisation (Van Knippenberg & Sleebos, 2006). Thus, when individuals identify with the organisation, they are more likely to integrate more organisational values, attributes, and interests into their self-concept (Sluss & Ashforth, 2008; Stinglhamber et al., 2015; Van Knippenberg & Sleebos, 2006). In addition, the findings of study 1 suggested that care workers with compatible values with the care homes tended to express their positive feelings in working in that care homes. This suggested that value congruency may be perceived as the antecedent of their organisational identification.

Hypothesis 3a: Value congruency has a positive effect on organisational identification (path s).

Scholars point out that internalising organisational attributes and values provides meanings to employees and in some cases enhance their self-esteem (Ashforth & Mael, 1989; Smidts, Pruyn & Van Riel, 2001) and self-efficacy (Vignoles, Regalia, Manzi, Golledge & Scabini, 2006). Moreover, researchers suggest that employees' self-esteem can be influenced by their organisational identification and the prestige of the organisation which then results in the extent to which they are likely to commit to their role in the organisation (Carmeli, Gilat & Weisberg, 2006; Fuller et al., 2006; Riketta, 2005; Smidts, Pruyn & Van Riel, 2001).

Hypothesis 3a: Organisational identification has positive direct effects on Self-esteem (path e) and self-efficacy (path a).

Hypothesis 3b: Self-esteem and self-efficacy mediate the relationships between organisational identification, organisational commitment and job satisfaction.

Self-efficacy refers to ones' knowledge about their own capability or competency in completing a task (Chen, Gully & Eden, 2001). Scholars suggest that self-efficacy is a strong predictor of intrinsic motivation which has an essential role in enhancing self-regulated behaviour and achievement (Pajares, 2003; Schunk, 1995; Zimmerman, 2000).

Hypothesis 4: Self-efficacy has a positive direct effect on intrinsic motivation (path i).

Self-esteem refers to the knowledge of individuals' emotional judgement or attitude toward their own worth (Rosenberg, 1965). Previous research states that individuals, who are intrinsically or autonomously motivated, experience more interests, more confidences, higher self-esteem, and greater general well-being (Deci & Ryan, 2000; Hodgins et al., 2007).

Hypothesis 5: Intrinsic motivation has a positive direct effect on self-esteem (path j).

Organisational identification as discussed above is suggested as one of the attributes of organisational commitment. Van Knippenberg (2000) argued that assuming the membership of an organisation does not guarantee that individuals would constantly behave in accordance with the organisational expectations. Researchers suggest that other attributes play a more important role in facilitating individuals to act as expected, such as identity salience (Burke & Stets, 2009; Stryker & Burke, 2000) and motivation (Dutton, Dukerich & Harquail, 1994; Van Knippenberg, 2000). Developed organisational identification provides employees a sense of belongingness in the organisation (Dutton, Dukerich & Harquail, 1994), which facilitates them to "take the group's perspective and to experience the group's goals and interests as their own." (Van Knippenberg, 2000, p.360), and a higher level of autonomous motivation (Deci & Ryan, 2002; Gagné & Koestner, 2002). Thus, developed organisational identification may be seen as an indicator of the satisfaction of relatedness and autonomy needs. Moreover, SDT suggests that the satisfaction of psychological needs

has an important role in facilitating individuals' internalisation and experiencing automatous motivation (Deci & Ryan, 2000; Ryan & Deci, 2000).

Hypothesis 6a: Organisational identification has a positive direct effect on the satisfaction of psychological needs (path c).

Hypothesis 6b: The satisfaction of psychological needs mediates the relationships between organisational identification, organisational commitment and job satisfaction.

Hypothesis 6c: The satisfaction of psychological needs has a positive direct effect on intrinsic motivation (path g).

Hypothesis 6d: The combined path of satisfaction of psychological needs and intrinsic motivation mediates the relationships between organisational identification, job satisfaction, and organisational commitment.

7.2 Methods

7.2.1 Research design.

A cross-sectional, questionnaire study was conducted to test the hypothesised model based on the findings of study 1 (chapter 5) and self-determination theory (Deci and Ryan, 2000). The detailed rationale for the research design of this study was presented in chapter 4.

7.2.1.1 inclusion criteria for care homes.

The inclusion criteria for care home settings were a) providing care for older people aged 65 years old and over, b) not providing care for individuals with learning disability or other mental illness, and c) located in England.

7.2.1.2 Inclusion criteria for care workers.

Eligibility for participation were a) working in a care home which meets the aforementioned inclusion criteria, b) fully conversant in English, and c) willingness to participate.

7.2.2 Participants.

7.2.2.1 Response rate.

Two hundred and seventy-one care homes located in Southern England, including 153 nursing homes and 118 residential care homes, were invited to take part in the study. Fourteen nursing homes and 5 residential care home managers expressed their interests in taking part in the study. The response rate of the nursing home was 9.15% and the response rate of residential care home was 4.24%. Two nursing homes and one residential care home withdrew from the study. Twelve nursing homes and 4 residential care homes participated in

the current study. Among these 16 care homes, two were voluntary / not for profit, eight were privately owned by the providers only operated one home, and four were privately owned by the providers operating multiple homes.

According to the market study conducted by Competition and Markets Authority (2017), around 95% of beds in care home settings were provided by the independent sector or private providers, including for-profit and charitable providers. Three hundred and eighty-five copies of the questionnaire were given to the care homes where the participants chose self-administrated questionnaires. One hundred and fifty-six completed questionnaires returned, and the return rate was 40.5%. The other 48 completed questionnaires from three nursing homes were researcher administrated questionnaires. Eight participants used the online survey. Yet, only 3 of them were completed and the complete rate was 37.5%. A flow chart containing the detailed information of recruitment, questionnaire distribution and data collection is presented in the figure 7.2.

7.2.2.2 Demographic information.

The detailed participants' demographic information for different care home settings is presented in table 7.2. There were 207 participants who took part in the current study. Similar to the social care workforce in England (Skills for care, 2018), the sample was 80.7% female. Participants aged from 18 to 77 years old (*Mean* = 39.57, *SD*= 14.04). Thirty-six participants were working in residential care homes, 171 participants were working in nursing homes. The ethnicity of the participants included white (*n*=123, 59.4%), multiple ethnic group (*n*=2, 1%), Black (*n*=19, 9.2%), Asian (*n*=53, 25.6%), other (*n*=2, 1%) and prefer not to respond (*n*=8, 3.9%). There was a diversity of the workforce in care home settings and in the sample of the study. Slightly above half of participants (50.7%) had English as their first language. Considering the possible differences between native and non-native English-speaking care workers in understanding the survey, measurement invariance tests were conducted to examine whether the measures used in the current study had equivalent psychometric properties. The average years of work experience in a care home were 8.93 years (*n*=197, *SD*= 8.35). Twenty-six participants (13.2%) had less than 1 year of work experience in a care home and 44.7% of participants had work experience between 1 to 5 years. The second largest proportion of participants (21.3%) had been working in care homes for between 6 to 10 years. The average participants' hourly pay rate was £8.43 (n=179, SD=1.08, range =£7.1 to £12, median =£8.05) which was slightly higher than the care workers' hourly pay rate in the independent sector in England (£7.89).

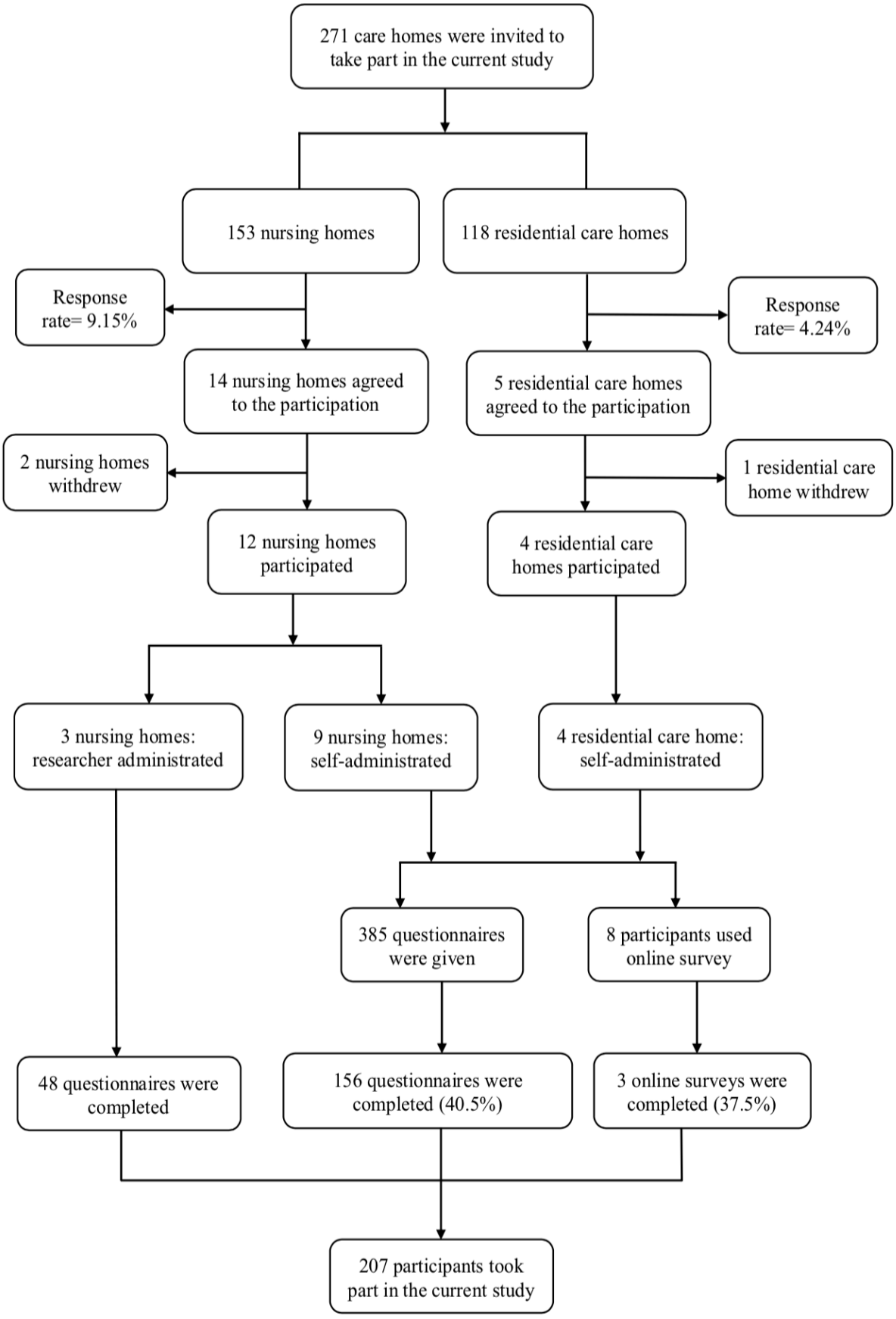

Figure 7.2 The flow chart of recruitment, questionnaire distribution and data collection

Table 7. 1 Participants demographic information

		Care home settings N (%)				Total	
		Nursing		Residential			
		171	82.6%	36	17.4%	207	100%
Gender	Male	36	21.1%	4	11.1%	40	19.3%
	Female	135	78.9%	32	88.9%	167	80.7%
Ethnicity							
White		95	55.6%	27	75%	123	59.4%
Mixed/ Multiple ethnic group		2	1.2%	0	0%	2	1%
Black/African/Caribbean/Black British		15	8.8%	4	11.1%	19	9.2%
Asian or Asian British		49	28.7%	5	13.9%	53	25.6%
Other		2	1.2%	0	0%	2	1%
Prefer not to response		8	4.7%	0	0%	8	3.9%
First language							
English		83	48.5%	22	61.1%	105	50.7%
Other		88	51.1%	14	38.9%	102	49.3%
Education background							
No qualification		14	8.2%	3	8.3%	17	8.2%
GCSE or earlier		39	22.8%	7	19.4%	46	22%
Secondary school/A-levels		50	29.2%	10	27.8%	60	29%
Undergraduate degree		40	23.4%	4	11.1%	44	21.3%
Postgraduate degree		13	7.6%	4	11.1%	17	8.2%
Doctorate degree		1	0.6%	0	0 %	1	0.5%
Others		2	1.2%	3	8.3%	5	2.4%
Prefer not to response		12	7%	5	13.9%	17	8.2%
Qualification							
NVQ1		7	4.1%	0	0%	7	3.4%
NVQ2		41	24%	3	8.3%	44	21.3%
NVQ3		46	26.9%	18	50%	64	30.9%
Others		27	15.8%	6	17.7%	33	15.9%
None		35	20.5%	2	5.6%	37	17.9%
Prefer not to response		15	8.8%	7	19.4%	22	10.6%
Employment status							
Full-time		150	87.7%	29	80.6%	179	86.5%
Part-time		19	11.1%	6	16.7%	25	12.1%
Prefer not to response		2	1.2%	1	2.8%	3	1.4%
Years of work experience		N=197, Mean=8.93, SD=8.35, Range: 0.25-35 (year)					
Hourly pay rate		N=179, Mean=8.43, SD=1.08, Median: 8.05 (£)					

7.2.3 Measurement of latent variables measures.

7.2.3.1 Demographic information.

Participants were instructed to complete a demographic questionnaire. The questions included care workers' age, gender, nationality, first language, religion, ethnic background, education background, and qualifications. The information about employment status was collected, such as hours of work per week, years of care work experience, and the hourly pay rate. Additionally, four questions regarding care workers' perception of their salary in

relation to their everyday needs and their quality of life were included. Participants rated each question on a 5-point Likert scale from 1 (not at all sufficient/ very poor/ very negative influences) to 5 (completely sufficient/ very good/ very positive influences).

7.2.3.2 Organisational identification.

Care workers' organisational identification was measured using organisation identification scale containing 6 items (Mael, & Ashforth, 1992) (Cronbach's α = .79). The scale was originally developed in educational organisations. Thus, the term "this school" used in the items was modified for use in care home settings. The scale included questions such as "When I talk about this care home, I usually say 'we' rather than 'they'", "This care home's successes are my successes", and "When someone praises their care home, it feels like a personal compliment". Participants rated each item on a 5-point Likert scale from 1 (strongly disagree) to 5 (strongly agree). Participants with a higher score suggested that they had a stronger perception of belongingness to the care home and were more likely to identify themselves with the care home.

7.2.3.3 Self-efficacy.

Self-efficacy is defined as ones' knowledge regarding their capability in completing tasks (Chen, Gully & Eden, 2001) and was measured with the new general self-efficacy scale (NGSE; Chen, Gully & Eden, 2001) with 8 items (Cronbach's α = .85). Items included statements such as: "When facing different tasks, I am certain that I will accomplish them", "I will be able to successfully overcome many challenges", and "I am confident that I can perform effectively on my different tasks. Participants rated the items on a 5-point Likert scale from 1 (strongly disagree) to 5 (strongly agree) based on the extent to which they think the description of the item applied to them. Participants with a higher score suggested that they had higher assurance in their abilities in relation to their care practice.

7.2.3.4 Self-esteem.

Self-esteem refers to the knowledge of individuals' emotional judgement or attitude toward their own worth (Rosenberg, 1965) and was measured using the Rosenberg self-esteem scale (Rosenberg, 1965) with 10 items (Cronbach's α = .90). Five of the 10 items were reverse scored and required recoding prior to the data analysis. An example reverse scored item was "I feel I do not have much to be proud of". Here are two example non-reverse items: "I feel that I have a number if good qualities" and "I take a positive attitude toward myself". Participants were asked to rate the items on a 5-point Likert scale from 1 (strongly disagree)

to 5 (strongly agree). A higher score denoted that participants had a higher level of self-esteem.

7.2.3.5 Value congruency.

The compatibility between organisational and personal values was measured using two scales with an identical list of values. The list of values was mostly adopted from the value survey (Liedtka, 1989) together with other values addressed by the care workers in Chapter 5 findings. The example items of the value survey were “Honesty”, “Employee welfare”, “Organisational growth”, and “Achievement”. The items added from the findings of the chapter 5 include “The reputation of the care home” and “Independence”. Participants were asked to rate the importance of each value they perceived within the organisation on a 7-point Likert scale from 1 (of lesser importance) to 7 (of greater importance). In order to find out the compatibility between organisational and personal values for each participant, value congruence was calculated using the difference between organisational values and personal values of the same item. The smaller average score indicated a better compatibility between the organisational values participants experienced and their own personal values.

7.2.3.6 Satisfaction of basic psychological needs.

The extent to which participants’ basic psychological needs were satisfied in workplace was measured with basic needs satisfaction at work scale (Baard, Deci & Ryan, 2004). Twenty items in the scale were used to measure three dimensions of the satisfaction of psychological needs: autonomy, competence and relatedness needs at work. An example item from each subscale of the satisfaction of autonomy, competence and relatedness needs was “I feel like I can make a lot of inputs to deciding how my job gets done”, “I have been able to learn interesting new skills on my job”, and “I really like the people I work with” respectively. Participants were asked to rate how true each item is based on their feelings about the job during the last year on a 7-point Likert scale from 1 (Almost never true) to 7 (Almost always true) (Cronbach’s $\alpha = .81$). Those participants who have not been working as a care worker for a year were instructed to consider their feelings since they first started working in care homes. Participants who obtained a higher score on this scale suggested that they experienced a higher level of satisfaction of psychological needs.

7.2.3.7 Intrinsic motivation.

Participants’ perception of intrinsic motivations at work were measured using task evaluation scale from Intrinsic Motivation Inventory (IMI; McAuley, Duncan & Tammen,

1989) with 22 items (Cronbach's α = .81). There are four subscales within the task evaluation scale: interests and enjoyment, perceived competence, perceived choice and pressure/tension at work. Notably, the pressure/ tension subscale is conceptualised as a negative predictor of intrinsic motivation (McAuley, Duncan & Tammen, 1989). Thus, the scores for the items within pressure/ tension subscale would be the reverse of participants' responses. The scale was originally developed to measure individuals' levels of intrinsic motivation to the task. In order to avoid the ambiguous interpretation of the phase "the task", it was replaced with "care work" in the questionnaire. A sample item from the subscale of interests and enjoyment, perceived competence, perceived choice and pressure/tension at work was "I enjoy doing care work very much", "I think I am pretty good at care work", "I feel that it was my choice to do care work", and "I feel tense while doing care work" respectively. The total scores of the intrinsic motivation scale denoted the extent to which participants internalised the external regulations and felt more autonomous motivation. Hence, a higher score in this scale suggested that participants were more autonomously motivated at work.

7.2.3.8 Organisational commitment

Participants' organisational commitment was measured with the organisational commitment questionnaire (OCQ; Mowday, Porter & Steers, 1982) containing 15 items. There were 6 reverse scored items which were recoded prior to the data analysis. An example reverse scored item was "I would just as well be working for a different company as long as the type of work was similar". An example of non-reverse items was: "This care home really inspires the very best in me in the way of job performance". A higher score suggested that the participants had a higher level of acceptance of the care home's values, were more willing to contribute to the care home, and more likely to maintain their current position in the care home. The participants rated each item on a 7-point Likert scale from 1 (always never true) to 7 (Almost always true). Participants were asked to rate on a 7-point Likert scale from 1 (Almost never true) to 7 (Almost always true) (Cronbach's α = .9).

7.2.3.9 Job satisfaction

Care workers' levels of job satisfaction were measured using the nursing home nurse aide job satisfaction questionnaire (NHNA-JSQ; Castle, 2007) with 21 items (Cronbach's α =.74). The NHNA-JSQ was developed based on 5 domains including co-workers, work demands, work content, workload, and work skills. Here are three example items: "How much you enjoy working with residents", "The people you work with", and "The amount of time you have to do your job". Participants were asked to rate each item based on their working

experience in the care home on a 10-point Likert scale from 1 (very poor) to 10 (excellent). A higher score in NHNA-JSQ denoted a higher level of job satisfaction.

7.2.4 Procedure

An invitation letter (Appendix 10) and an information (Appendix 12) sheet were sent by the researcher (ILY) and two research assistants (KH & BP) to the manager of each identified residential care home and nursing home to explain the purpose of the current study. If the manager expressed an interest in taking part, the researcher arranged a visit to discuss the project further. After the managers gave approval for the care home to be involved, the managers help to disseminate the invitation letter (Appendix 11) with an information sheet attached to invite care workers to take part in a survey study. Care workers who were willing to take part were asked to answer a questionnaire that contained 9 scales (Appendix 14). The participants were offered different ways of participation, such as a self-administrated hard-copy or an online questionnaire, or a researcher-administrated hard-copy questionnaire.

Participants who chose a self-administered questionnaire received a document pack enclosed with an information sheet, a consent form (Appendix 13), a copy of the questionnaire and an envelope. They were instructed to read through the information sheet before signing the consent form. After they have signed the consent form and filled out the questionnaire, they were instructed to put the signed consent form and answered questionnaire in the enclosed envelope. The participants sealed the envelope before returning it to the care home manager. Once the care home manager returned the questionnaires, the researcher arranged a meeting with the care home manager to collect the questionnaires. The participants who preferred to complete the questionnaire online were sent a link of the online survey via email. The link of online survey was sent to the care home managers so that they could forward the link to their staff. In order to avoid the possible method effect on data collection, the online survey is identical to the hardcopy questionnaire. Participants were presented with the information regarding the study at the beginning of the survey. After they have read through the information sheet and agreed to participate in the study, they signed the online consent form and completed the online survey.

There were three care home managers who gave their consent for questionnaire to be administered during working hours. Given that a researcher-administered questionnaire might potentially take up care workers' working time or increase other care workers' workload, the researcher (ILY) arranged the visit to the care homes during the less busy

times, such as after breakfast and before lunch, after lunch and before dinner or after dinner and before night shift. Before the participants signed the consent form, the researcher gave the information sheet to the participants and explained the purpose of the study. The participants' rights in taking part in the study were emphasised before they signed the consent form, such as they do not have to take part in the study, they can withdraw from the study without offering any reason and their responses will be removed from the dataset immediately, and their responses will be kept confidential and anonymous. If the participants had any questions regarding the study, the researcher explained and clarified their questions. After the participants fully understood their rights and the study and agreed to take part, they signed the consent form and then filled out the questionnaire. If participants had any questions about the items in the questionnaire, the researcher explained the items to the participants. The duration of the researcher-administered survey was between 20-60 minutes. At the end of the study, participants were thanked and offered contact information if they wish further information regarding the study. The data were collected between November 2016 and October 2017.

7.2.5 Ethical considerations.

Ethical Approval for this study was received from the Faculty Research Ethics Committee (FREC) in the Faculty of Art and Social Sciences at Kingston University (Appendix 9). There are different methods of administering a survey including researcher-administered, self-administered, and group-administered questionnaire and they have different advantages and limitations. A summary of the advantages and limitations of different administrations is presented in table 7.1. The questionnaire used in the current study involves asking care workers to rate their level of satisfaction at work and their thoughts about themselves. The questions are not exceedingly sensitive. However, there is possibility that their rating might be influenced by their colleagues' presence and they might perceive this administration as less anonymous. Therefore, group-administered questionnaire was not considered in the current study. Given that using both self-administered and researcher-administered methods to collect data might allow researcher to benefit from the advantages and reduce the negative impact of the limitations, self-administered and researcher-administered methods were used in the current study.

In the current study, the researcher was aware that inviting care workers to fill in a questionnaire involving them to reflect their experiences and feelings at work might lead care workers to recall unpleasant or distressing memories. Thus, researcher clearly explained

to care workers about the possible risk associated with their participation and encourage them to discuss their feelings with their care home managers or GPs in the information sheet. Moreover, for safety consideration, the researcher administered the questionnaire in the care home. Had any researcher experienced any issues during the questionnaire administration, they would have been discussed with her supervisors.

Table 7. 2 A summary of the advantages and limitations of different administrations.

Administration	Advantages	Limitations
Self-	• No researcher biases • Researcher spend less time on administration • Effective way to collect large sample size • More relax for participants • Participants perceive as more anonymous	• Lower return rate • Higher possibility of missing data or uncompleted questionnaire
Group-	• Researcher spend less time on administration • More effective way to collect large sample size	• Participants may feel strange or uncomfortable answering some questions in the presence of others • Participants perceived as less anonymous
Researcher-	• Participants can receive the clarification for the questions • Less missing data • Higher return rate	• Researcher spend more time on administration • Less effective way to collect large sample

7.2.6 Analytic procedure

Structural equation modelling (SEM) is used to explore the causal relations between care workers' organisational identification, self-esteem, self-efficacy, the compatibility between organisational and personal, motivation, commitment, and job satisfaction. Anderson and Gerbing (1988) suggest a two-step approach to conduct analyses using SEM which involves conducting a confirmatory factor analysis (CFA) to examine the fit of the measurement model prior to examining a structural model that includes both a covariance structure and a mean structure. The analyses were conducted with Lavaan package (Rosseel, 2012) in R using maximum likelihood estimation with robust standard errors and mean adjusted (MLM; Satorra, 2000).

Malone and Lubansky (2012) suggest that data analysis should start with data screening which helps to ensure the data are appropriate and meet the assumptions for conducting structural equation modelling (SEM). In order to ensure that the data quality was appropriate, the accuracy of data, missing data pattern and imputation, the assumption of multivariate normality, multivariate outliers, and the multicollinearity issue were examined prior to conducting a CFA. The percentage of the missing data within the dataset and missing data pattern were examined in order to prevent the possibility of producing biased results led by the missing value imputation. The current study applied 5% of missing data as the cut-off for the missing value imputation (Peng, Harwell, Liou & Ehman, 2006; Schlomer, Bauman & Card, 2010) and implemented Expectation-Maximization (EM) to impute missing values. In addition, to detect whether the data collected in the current study violated the assumption of multivariate normality, the Henze-Zirkler's test (HZ) was conducted (Korkmaz, Goksuluk & Zararsiz, 2014; Zhou, & Shao, 2014). To ensure the results of the current study were not biased by the multivariate outliers, the Cook's distance (Cook, 1977; Cook & Hawkins, 1990) was conducted to examine whether there were any impactful multivariate outliers in the dataset. The threshold of Cook's distance for determining impactful outliers was greater than 1. A check for multicollinearity in SEM was conducted through examining the bivariate correlations between variables (Kline, 2015; Weston & Gore Jr, 2006) and the variance inflation factor (VIF) and tolerance (O'brien, 2007). When the bivariate correlation between variables is higher than 0.85, it suggests the potential problem of multicollinearity (Kline, 2015). On the other hand, when the tolerance of a variable is less than 0.1 or its VIF is greater than 5, it indicates a severe problem of multicollinearity in the variable (O'brien, 2007).

The Chi-Square ($\chi 2$), the relative Chi-Square statistic ($\chi 2/df$), the root mean square error of approximation (RMSE), the standardised root means square residual (SRMR), the comparative fit index (CFI), and the Tucker-Lewis index (TLI) were used in the current study to evaluate the overall goodness-of-fit of models in CFA and SEM (Bagozzi & Yi, 2012; Hooper, Coughlan & Mullen, 2008; Jackson, Gillaspy Jr & Purc-Stephenson, 2009; Kline, 2015; Yuan,2005). For the Chi-Square test, an insignificant result indicates a goodness fit (Hooper, Coughlan & Mullen, 2008; Kline, 2015). However, the Chi-Square test tends to reject the null hypothesis with large sample size and may reject an alternative hypothesis with small sample regardless of whether the model represents the data well or not. The Relative Chi-Square is calculated using the Chi-Square values divided by its degree of freedom ($\chi 2/df$) which is aimed to eliminate the influences of sample size. The acceptable threshold of the relative Chi-Square value for a good model fit is suggested between 2 to 1

and 3 to 1 (Byrne, 1991). An RMSEA or SRMR value within the range of 0.08 and 0.10 suggests a moderate model fit whereas the value below 0.08 indicates a good model fit (Hooper, Coughlan & Mullen, 2008; Hu & Bentler, 1998). For CFI and TLI, values greater than 0.9 suggest a good model fit. Notably, the CFI change was used to examine the differences between two nested models in the measure invariance test (Chen, 2007; Cheung & Rensvold, 2002). The criterion value for the CFI change is .01. Thus, when the change was less than .01, it suggested that there was no significant difference between the two models compared.

A measurement model included all indicators loaded to their latent construct (organisational identification, self-esteem, self-efficacy, the satisfaction of psychological needs, intrinsic motivation, organisational commitment, and job satisfaction). In order to ensure a strong relationship between an indicator and its latent construct, the factor loading of each indicator should be greater than 0.5 and its significance should be less than 0.05 (Hair, Ringle & Sarstedt, 2011). Moreover, indicators with an r-squared value less than 0.2 should be removed from the measurement model as a low r-squared value indicates high levels of error (Hooper, Coughlan & Mullen, 2008). The measure of composite reliability (CR) using coefficient omega was conducted to examine the internal consistency of a measure in a measurement model in the current study (Fornell, & Larcker, 1981; McDonald, 1970; Peterson & Kim, 2013). Notably, CR is an effective estimator for reliability in SEM, yet it is not appropriate to utilise CR as a tool to modify the measurement model (Bacon, Sauer & Young, 1995). Therefore, Cronbach's alpha was used to explore the data before conducting CFA and SEM, while coefficient omega was used to estimate the reliability of the measurement model. Furthermore, in order to test for common method variance (CMV; Bagozzi, Yi & Phillips, 1991; Podsakoff, MacKenzie, Lee & Podsakoff, 2003), Harman's single-factor test was used in the current study. To demonstrate the convergent validity and discriminant validity in the hypothesised measurement mode, the multitrait-multimethod (MTMM) approach was applied to examine the difference between the baseline model and three nested models.

Measurement invariance (MI) tests investigate whether the measure has equivalent psychometric properties and reflects the same construct across different subgroups in the population (Chen, 2007; Chen, Sousa & West, 2005). MI was applied to examine whether the questionnaire used in the current study had equivalent psychometric properties and reflected the same construct between native English-speaking and non-native English-

speaking care workers. Notably, the estimation of MLM used in the hypothesised measurement models may experience difficulties when estimating the measurement invariance model (Satorra, & Bentler, 2010). Thus, MLR was used to the measurement invariance models in the current study (Satorra, & Bentler, 2001; Satorra & Bentler, 2010).

7.3 Results

7.3.1 Data screening.

7.3.1.1 Accuracy.

In order to certify the accuracy of the data and avoid data entry errors, the data were checked by exploring the minimum and maximum value of each variable. In the categorical variables, the values are checked together with their value labels. Most of the data were collected using hard-copy questionnaires. Any values which were not within the expected range among the categorical and manifest variables were referred back to the original questionnaire and replaced with the accurate value. The detailed descriptive statistics for the indicators within each latent construct including valid sample size, the percentage of missing data, mean, SD, skewness, and kurtosis is presented in Appendix 15.

7.3.1.2 Missing value pattern and imputation.

In order to examine whether the pattern of the missing values in the data set was missing completely at random (MCAR), the Little's MCRA test (Little, 1988) was conducted. The results of the Little's MCRA test suggested that the missing values in the data set was missing complete at random (χ^2 = 5200.90, *df*= 10809, *p*=1.000). Moreover, most of the variables had less than 5% of missing values except the variable of value congruence. There was 21.7% of missing values in the variable of value congruence. In order to maintain a sufficient number of participants in the analysis, value congruence was removed from the analysis. To obtain a data set without missing values, the variables with less than 5% of missing values were imputed using expectation maximization (EM; Peng, Harwell, Liou & Ehman, 2006; Schlomer, Bauman & Card, 2010).

7.3.1.3 Multivariate normality.

The assumption of multivariate normality is essential for conducting SEM (Bagozzi & Yi, 2012; Curran, West & Finch, 1996; Lei & Lomax, 2005). The skewness and kurtosis of most of the indicators (Appendix 15) suggested that they had not severely departed from the normal distribution. The Henze-Zirkler's multivariate normality test was conducted to test for multivariate normality. The result showed that data did not meet the assumption of

multivariate normality (HZ = 1, p <.001). Because of the violation of the assumption of multivariate normality, maximum likelihood estimation with robust standard errors (MLM) was used to estimate the parameters in SEM (Freedman, 2006; Li, 2016; Satorra, 2000).

7.3.1.4 Multivariate outliers.

Influential multivariate outliers in the multivariate data set could have a negative impact on the data analysis and produce the biased inferences (Kannan & Manoj, 2015). In order to correctly detect the influential outliers in multivariate data, Cook's distance (Cook, 1977; Cook & Hawkins, 1990) was conducted to explore if there were any influential multivariate outliers in the data set. In order to explore Cook's distance for each participant, the total score of each subscale was calculated. The linear regression model was conducted using organisational commitment as a dependent variable and the other constructs as predictor variables, such as self-esteem, self-efficacy, organisational identification, the satisfaction of psychological needs, intrinsic motivation, and job satisfaction. The results showed that there were no participants whose Cook's distance was greater than 1, suggesting there were no influential multivariate outliers in the data set.

7.3.1.5 Multicollinearity

In order to identify whether there was an issue of multicollinearity, the correlations between latent constructs and a regression model were conducted. The correlations between the latent variables are shown in table 7.3. None of the correlation coefficients were greater than .85 which suggested that multicollinearity might not be an issue in the current study.

Table 7. 3 Means, standard deviations and correlations.

Construct[1]	Mean	SD	Correlation matrix of latent constructs [2]						
			OI	SEs	SEf	SPN	IM	OC	JS
OI	24.37	3.87	1						
SEs	39.99	5.39	.27**	1					
SEf	32.70	4.52	.35**	.49**	1				
SPN	102.53	15.02	.31**	.42**	.32**	1			
IM	121.12	18.63	.34**	.42**	.31**	.60**	1		
OC	79.45	14.11	.42**	.20**	.24**	.57**	.59**	1	
JS	172.31	27.30	.23**	.23**	.29**	.59**	.47**	.60**	1

1: OI = organisational identification, SEs = Self-esteem, SEf = Self-efficacy, SPN = the Satisfaction of Psychological Needs, IM= Intrinsic Motivation, OC= Organisational Commitment, JS= Job Satisfaction. 2: The correlation matrix was conducted using raw data with missing values before missing data imputation.

Furthermore, VIF and tolerance were examined using the same linear regression model used to examine multivariate outliers where organisational commitment was the dependent variable. The results presented in table 7.4 showed that multicollinearity was not an issue in the dataset.

Table 7. 4 Collinearity statistics for constructs

Constructs/predictor variables	Tolerance > 0.2	VIF < 5
Organisational identification	.69	1.45
Self-esteem	.63	1.60
Self-efficacy	.61	1.63
Satisfaction of psychological needs	.56	1.79
Intrinsic motivation	.54	1.84
Job satisfaction	.49	2.04
Dependent variable: Organisational commitment		

7.3.2 Reliability prior to CFA

Cronbach's alpha was conducted before conducting CFA and SEM models. The results showed that all the scales had adequate reliability. A summary of the internal consistency of each scale using Cronbach's reliability estimates is presented in table 7.5.

Table 7. 5.Cronbach's Alpha Reliability Estimates for each scale

Scale	Original α
Organisational identification	.80
Self-esteem	.76
Self-efficacy	.92
Satisfaction of psychological needs	.82
Intrinsic motivation	.88
Organisational commitment	.87
Job satisfaction	.94

7.3.3 Confirmatory factor analysis

The measurement model had an adequate model fit ($\chi2(1290) = 1669.13$, $\chi2/df = 1.29$, $p< .001$, RMSEA= .045, 90% CI [.039, .051], SRMR = .076, CFI= .920, TLI= .914). A summary of the estimate, factor loadings and r-squared of each indicator in the modified measurement model is shown in the Appendix 16. The correlations matrix of the latent constructs in the measurement model is presented in the table 7.6. None of the correlations was higher than .85 which suggested that the additivity remained in the modified measurement model. A summary of the modified measurement model is presented in the table 7.7.

Table 7. 6. Correlation matrix of latent constructs in modified measurement model

	1.	2.	3.	4.	5.	6.	7.
1. Organisational identification	1						
2. Self-esteem	.52	1					
3. Self-efficacy	.45	.61	1				
4. Satisfaction of psychological needs	.45	.28	.40	1			
5. Intrinsic motivation	.44	.32	.38	.51	1		
6. Organisational commitment	.49	.19	.41	.68	.71	1	
7. Job satisfaction	.41	.22	.44	.76	.75	.78	1

7.3.4 Reliability of constructs in CFA

The reliability of each construct within the measurement model was examined using omega reliability. The Omega reliability coefficients are shown in table 7.9.

Table 7. 7.Omega reliability coefficient of each construct in measurement model

Constructs	Omega
Organisational identification	0.83
Self-esteem	0.75
Self-efficacy	0.92
Satisfaction of psychological needs	0.81
Intrinsic motivation	0.87
Commitment	0.90
Job satisfaction	0.78
Total	0.97

7.3.5 Common methods bias test

A one-factor model was built by loading all the indicators into one factor ($\chi^2(1378) = 8245.31$, $\chi^2/df = 5.$, $p<.001$, $RMSEA = .123$, $RMSR = .13$, 90% CI [.112, NA], $CFI = .47$, $TLI = .45$). The variance explained by the one-factor model was 31% which was below the criterion 50%. The result suggested that common methods bias did not affect the data in the current study.

Table 7. 8. The model summary of the measurement models, measure invariance models, multitrait-multimethod models, and structural regression model.

		χ^2(df)	χ^2/df	RMSEA [HI_{90}, LO_{90}]	SRMR	CFI	TLI	CFIΔ
CFA	Model	1669.13 (1290) **	1.29	.045 [.039, .051]	.076	.92	.914	
MTMM	Model one	1866.30 (1248) **	1.50	.058 [.053, .064]	.059	.871	.857	
	Model two	3560.62 (1322) **	2.69	.112 [.107, .116]	.123	.493	.472	.378
	Model three	2801.88 (1269) **	2.20	.092 [.088, .097]	.088	.669	.641	.23
	Model four	1953.77 (1251) **	1.56	.062 [.057, .067]	.08	.852	.837	.019
MI	All group	2167.89 (1290) **	1.68	.060 [.056, .064]	.076	.870	.862	
	Group A (*n*= 105)	2477.62 (1290) **	1.92	.091 [.086, .097]	.099	.756	.74	
	Group B (*n*= 102)	2493.55 (1290) **	1.93	.093 [.087, .098]	.089	.737	.719	
	Configural	4971.09 (4625) **	1.93	.092 [.088, .096]	.094	.747	.73	
	Metric	4983.64 (2636) **	1.89	.091 [.087, .095]	.109	.746	.735	.001
	Scalar	5052.14 (2679) **	1.89	.091 [.087, .095]	.109	.743	.736	.003
	Strict	5222.55 (2732) **	1.91	.094 [.090, .098]	.112	.722	.72	.021
SEM	SR model	1703.42 (1294) **	1.32	.047 [.040, .053]	.084	.914	.908	

7.3.6 Convergent and discriminant validity – MTMM approach

In order to examine the convergent and discriminant validity, four MTMM models were built. Notably, the traits in the MTMM models were uncorrelated with methods factors. Therefore, the constraint on the correlations between traits and methods was imposed in four MTMM models. The first model, which was used as a baseline model, was built by composing latent trait constructs and latent method factors ($\chi 2(1248) = 1866.3$, $\chi^2/df = 1.5$, $p < .001$, *RMSEA*= .058, 90% *CI* [.053, .064], *SRMR* = .059, *CFI*= .871, *TLI*= .857). The second model was built using only latent method factors ($\chi 2(1322) = 3560.62$, $\chi^2/df = 2.69$, $p < .001$, *RMSEA*= .112, 90% *CI* [.107, .116], *SRMR* = .123, *CFI*= .493, *TLI*= .472). The results showed that the fit of the second model was poor. The comparison between model one and model two showed a significant difference ($\chi d^2 = 811.3$, $df_d = 74$, p<.001, *CFI-difference* =.378>.01). The poor fit of the model two suggested that latent method factors were not the best estimate for the data. Moreover, the significant difference between model one and two demonstrated the convergent validity. As the constraint was imposed on the correlations between traits in the model three, the traits in the model three were perfectly correlated (unity), whereas the correlations between method factors were allowed to be freely estimated. The results suggested that the model fit of the model three was inadequate comparing to the model one ($\chi 2(1269) = 2801.88$, $\chi^2/df = 2.2$, $p < .001$, *RMSEA*= .092, 90% *CI* [.088, .097], *SRMR* = .088, *CFI*= .669, *TLI*= .641). The comparison between model one and three showed a significant difference ($\chi d^2 = 358.5$, $df_d = 21$, p<.001, *CFI-difference* =.23>.01). The results suggested that the traits were measuring different constructs and therefore proved the discriminant validity of the trait.

Furthermore, the model four was constructed by setting the correlations between traits to be freely estimated and constraining the correlations between method factors to zero. Thus, the method factors were independent and uncorrelated with other method factors in the model four. This was to demonstrate the discriminant validity of the method factors by testing whether the method factors were measuring different method effects. Therefore, the model four was expected to be equivalent to the model one. The model fit of the model four presented a mixed model fit where the relative chi-square, RMSEA, and SRMR suggested a good model fit, yet CFI and TIL suggested a mediocre model fit ($\chi 2(1251) = 1953.77$, $\chi^2/df = 1.56$, $p < .001$, *RMSEA*= .062, 90% *CI* [.057, .067], *SRMR* = .08, *CFI*= .852, *TLI*= .837). The results of chi-square difference test suggested that there was a significant difference between model one and model four ($\chi d^2 = 39.83$, $df_d = 3$, p<.001, *CFI-difference* =.019>.01).

Therefore, the results of the comparison between model one and four did not demonstrate the discriminant validity of the method factors. However, it is worth noting that method factors measuring the same traits are more likely to be correlated. Therefore, the discriminant validity of method factors has been suggested as difficult to prove in practice (Bagozzi & Yi, 1991; Brown, 2014). A summary of the MTMM models is presented in the table 7.7.

7.3.7 Testing for measure invariance

To conduct the measure invariance tests (configural, metric, scalar, strict, and latent means) the complete questionnaire dataset was separated into different data files based on whether English was their first language. The data from native English-speaking participants were assigned to group A data file (n=105) and non-native English-speaking participants' group B file (n=102). Two measurement models were conducted for Group A ($\chi 2(1290) = 2477.62$, $\chi^2/df = 1.92$, $p < .001$, *RMSEA*= .091, 90% *CI* [.086, .097], *SRMR* = .099, *CFI*= .756, *TLI*= .74) and Group B ($\chi 2(1290) = 2493.552$, $\chi^2/df = 1.93$, $p < .001$, *RMSEA*= .093, 90% *CI* [.087, .098], *SRMR* = .089, *CFI*= .737, *TLI*= .719). A summary of four measure invariance models is presented in the table 6.7. The configural invariance test was conducted to examine whether the data from native and non-native English-speaking care workers showed the same factor structure. In order to test the configuration of these two groups, a model for configural invariance was built using both Group A and Group B ($\chi 2(4625) = 4971.09$, $\chi^2/df = 1.93$, $p < .001$, *RMSEA*= .092, 90% *CI* [.088, .096], *SRMR* = .094, *CFI*= .747, *TLI*= .73). The model fit indices suggested a mixed fit. The relative $\chi 2$ (χ^2/df) and *RMSEA* indicated moderate model fit whereas *CFI* and *TLI* pointed out an unsatisfactory model fit. The effects of a complex model in CFA or SEM has been suggested as influential. Judging the model fit merely based on the generally accepted criteria, such as CFI, might omit the important effects of a complex model whereas RMSEA is less likely to be influenced by the model parameters (Cheung & Rensvold, 2002). Considering the complexity of the model tested together with RMSEA and the relative $\chi 2$, the model fit of the configural invariance model was considered as moderate and confirmed the configural invariance.

Once the configural invariance was achieved, it implied that the patterns shown from the dataset were the same across the group. It is worth noting that the configural invariance model is seen as the baseline model in measure invariance tests. The constraints on the factor loading of the indicators in different groups were added into the configural invariance model to build the metric invariance model. Therefore, the factor loading of each indicator in Group A and Group B were constrained to be equal in the metric invariance model ($\chi 2(2636) = 4983.64$, $\chi^2/df = 1.89$, $p < .001$, *RMSEA*= .091, 90% *CI* [.087, .095], *SRMR* = .109, *CFI*=

.746, *TLI*= .735). In order to examine whether the metric invariance was achieved, the comparison between the configural and metric invariance model was made to determine whether the constraints on the factor loadings made these two models significantly different. The CFI change was used to examine the differences between two nested models in measure invariance test (Chen, 2007; Cheung & Rensvold, 2002). The criterial value for the CFI change is .01. When the change is less than .01, it suggests that there is no significant difference between two models compared. The CFI change between the configural and metric invariance models was .001 which was less than the criterion of .01. The CFI change confirmed the metric invariance which suggested that the questionnaire used to measure the latent constructs had the same meanings to both native and non-native English-speaking care workers.

Furthermore, intercept for each indicator on a scale is suggested as the starting values when participants respond to the item. In order to examine whether the mean comparison between native and non-native English-speaking care workers is justifiable, the scalar invariance test was conducted. The scalar invariance model was based on the metric invariance model but adding the constraints on the indicator intercepts. Therefore, the indicator intercepts were constrained to be equal in two groups in the scalar invariance model ($\chi 2(2679) = 5052.135$, $\chi^2/df = 1.89$, $p < .001$, *RMSEA*= .091, 90% *CI* [.087, .095], *SRMR*= .109, *CFI*= .743, *TLI*= .736). The change CFI between the metric and scalar invariance models was .003 (<.01) which suggested that there was no significant difference in the starting values between native and non-native English-speaking care workers when they responded to the same items. The strict invariance model, built from the scalar invariance model with the constrained factor variances, was used to examine residual error invariance ($\chi 2(2732) = 5222.55$, $\chi^2/df = 1.91$, $p < .001$, *RMSEA*= .094, 90% *CI* [.09, .098], *SRMR*= .112, *CFI*= .722, *TLI*= .72). The change CFI between the strict and scalar invariance models was .021 which was greater than the criterion value (.01). The result suggested that the residual error variances were not equal between native and non-native English-speaking care workers. Notably, the strict invariance has been suggested as unreasonable and difficult to achieve in practice (Widaman & Reise, 1997).

Table 7. 9. A summary of latent mean between native and non-native English-speaking care workers

Constructs[1]	Welch t	df	Sig.	Group A[2]		Group B[3]		Effect size
				Mean	SD	Mean	SD	Cohen's D
OI	-1.70	203.91	.090	2.29	0.43	2.38	0.39	-0.24 (small)
SEs	-2.71	204.84	.007**	2.14	0.32	2.26	0.32	-0.38 (small)
SEf	-3.34	202.75	<.001**	2.09	0.28	2.22	0.30	-0.47 (small)
SPN	-1.61	201.14	.109	4.94	0.91	5.16	1.02	-0.22 (small)
IM	1.49	194.47	.139	5.53	0.88	5.33	1.09	0.21 (small)
OC	-0.60	204.53	.550	5.87	1.16	5.97	1.18	-0.08 (negligible)
JS	<.001	204.08	.999	66.52	10.20	66.52	10.63	0.00 (negligible)

Note: [1] OI = Organisational identification scale, SEs = Self-esteem scale, SEf = Self-efficacy, SPN = Satisfaction of psychological needs scale, IM = Intrinsic motivation scale, OC = Organisational commitment, JS = Job satisfaction scale.

[2] Group A: native English-speaking care workers (n=105).

[3] Group B: non-native English-speaking care workers (n=102).

** significant at .01 level. *significant at .05 level.

After the configural, metric and scalar invariances have been confirmed; the test of latent mean differences was conducted to explore whether there are differences in latent means between native and non-native English-speaking care workers. First, participants' raw scores were transformed into the standardised weighted scores based on their parameter estimates, indicating the degree to which the item related to its latent construct. The standardised weighted scores were used to calculate the latent means of each construct in different groups. A summary of latent mean between native and non-native English-speaking care workers is presented in the Table 7.9. The results showed that there was no significant difference between two groups in most of the latent constructs except self-esteem and self-efficacy. In the construct of self-esteem, native English-speaking care workers (*mean* = 2.142, *SD* = 0.323) had significant low means (*Welch t* = -2.71, *df* = 204.83, *p* = .007, *Cohen's D* = -0.377) comparing to non-native English-speaking care workers (*mean* = 2.264, *SD* = 0.323). Moreover, non-native English-speaking care workers (*mean* = 2.222, *SD* = 0.302) had significant higher mean in self-efficacy scale (*Welch t* = -3.341, *df* = 202.75, *p* < .001, *Cohen's D* = -0.465) comparing to native English-speaking care workers (*mean* = 2.087, *SD* = 0.279).

7.3.8 Structural equation modelling – Structural regression analysis (SR)

The results showed that the SR model has an adequate model fit ($\chi 2(1294) = 1703.42$, $\chi^2/df = 1.32$, $p<.001$, *RMSEA*= .047, 90%*CI* [.040, .053], *CFI*= .914, *TLI*= .908). The matrix indicating the correlations between latent constructs in the SR model is presented in table 6.10. The significant path coefficients are presented in figure 7.3, whereas the non-significant path coefficients are omitted.

Table 7. 10. The correlation matrix of the latent constructs in the SR model

	OI	SEs	SEf	SPN	IM	C	JS
OI	1						
SEs	.55	1					
SEf	.50	.29	1				
SPN	.48	.30	.24	1			
IM	.33	.29	.34	.50	1		
C	.46	.15	.40	.66	.70	1	
JS	.39	.16	.41	.74	.75	.77	1

OI= Organisational identification, SEs= Self-esteem, SEf= Self-efficacy, SPN= Satisfaction of psychological needs, IM= Intrinsic motivation, C= Commitment, JS= Job satisfaction.

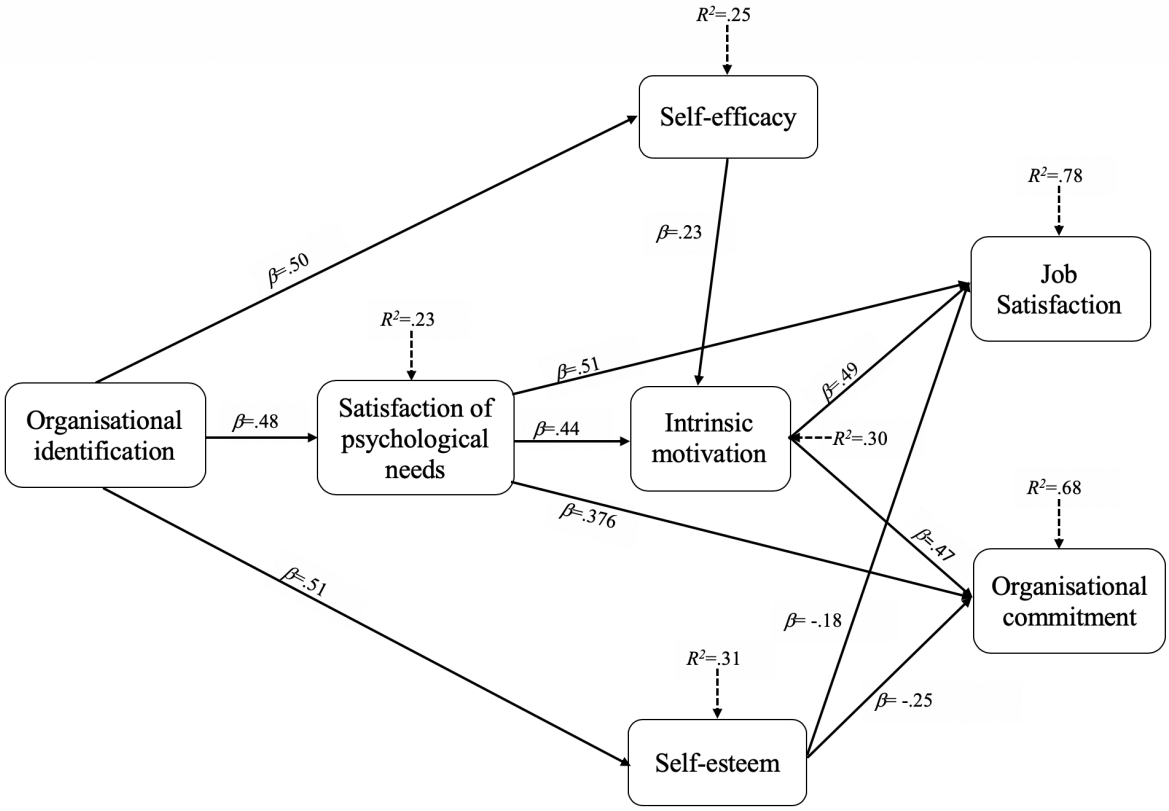

Figure 7. 3. The hypothesised structural regression model with standardised path coefficients (β) and r-square.

Note. The significant directional relationship between latent constructs was presented, whereas the non-significant standardised path coefficients were omitted.
Note. Value congruency was removed because it had more than 20% of missing data.

7.3.8.1 Effects of latent constructs on job satisfaction.

The results showed that care workers' self-esteem (β= -.18), satisfaction of psychological needs (β=.51), and intrinsic motivation (β= .49) had significant direct contributions to the prediction of job satisfaction. The latent constructs in the SR model accounted for 77.9% of the variability in job satisfaction. Moreover, the results indicated that neither organisational identification nor self-efficacy had a significant direct contribution on the prediction of job satisfaction. Nevertheless, organisational identification had significant indirect effects on job satisfaction through self-esteem, the satisfaction of psychological needs (β= .25), the combined path of the satisfaction of psychological needs and intrinsic motivation (β= .13), and a significant total effect on job satisfaction (β= .35). The results showed that the effect of organisational identification on predicting job satisfaction was significantly mediated by self-esteem, the satisfaction of psychological needs and intrinsic motivation. In addition, the satisfaction of psychological needs had a significant indirect contribution to predicting job satisfaction through intrinsic motivation (β= .26) and a significant total effect on job

satisfaction (β=.77). Furthermore, intrinsic motivation did not have any significant indirect effect but a significant total effect on job satisfaction (β=.49). A summary of the direct, indirect, and total effect of latent constructs on job satisfaction is presented in the table 7.11.

Table 7. 11. A summary of direct, indirect and total effect of latent constructs on job satisfaction

Effect	Direct (β)	Sig.	Indirect (β)	Sig.	Total (β)	Sig.
On job satisfaction						
Of OI (b)	-.01	.921			.39	.002*
Via SEf (a*k)			.09	.044*		
Via SEf &IM (a*i*m)			.06	.076		
Via SEf, IM, & SEs (a*i*j*o)			-.003	.434		
Via SPN (c*f)			.25	.01**		
Via SPN & IM (c*g*m)			.10	.005**		
Via SPN, IM & SEs (c*g*j*0)			-.01	.349		
Via SEs (e*0)			-.09	.038*		
Of SEs (o)	-.18	.034*				
Of SEf (k)	.18	.069			.29	.005**
Via IM (i*m)			.11	.043*		
Via IM & SEs (i*j*o)			-.01	.426		
Of SPN (f)	.51	.012*			.72	.001**
Via IM (g*m)			.22	.003**		
Via IM & SEs (g*j*o)			-.01	.364		
Of IM (m)	.49	.003*			.47	.003*
Via SEs (j*0)			-.02	.363		

Note: OI = Organisational identification, SEs = Self-esteem, SEf = Self-efficacy, SPN = Satisfaction of psychological needs, IM = Intrinsic motivation.

7.3.8.2 Effects of latent constructs on organisational commitment.

Results showed that self-esteem (β= -.25), satisfaction of psychological needs (β= .38), and intrinsic motivation (β= .47) had significant direct effects on commitment. In addition, the satisfaction of psychological needs had a significant total effect on commitment (β= .63) and a significant indirect effect on commitment through intrinsic motivation (β= .25). A summary of the direct, indirect, and total effect of latent constructs on commitment in the SR model is presented in the table 7.12.

It is worth noting that organisational identification did not have a significant direct effect on commitment but a significant total effect (β= .43) and indirect effects on commitment via

self-esteem (β= -.12), satisfaction of psychological needs (β= .18) and the combined path of satisfaction of psychological needs and intrinsic motivation (β= .12). Thus, the results suggest a relationship between organisational identification and organisational commitment is mediated by self-esteem, the satisfaction of psychological needs and intrinsic motivation. The SR model explained 68.7% of the variability in commitment.

Table 7. 12. A summary of direct, indirect and total effect of latent constructs on commitment.

Effect	Direct (β)	Sig.	Indirect (β)	Sig.	Total (β)	Sig.
On commitment						
Of OI (d)	.20	.132			.46	<.001**
Via SEf (a*l)			.06	.138		
Via SEf & IM (a*i*n)			.06	.038*		
Via SEf, IM & SEs (a*i*j*p)			-.003	.358		
Via SPN (c*h)			.18	.002**		
Via SPN & IM (c*g*n)			.10	.007**		
Via SPN, IM & SEs (c*g*j*p)			-.01	.281		
Via SEs (e*p)			-.13	.028*		
Of SEs (p)	-.25	.012*				
Of SEf (l)	.12	.146			.23	.006**
Via IM (i*n)			.11	.011*		
Via IM & SEs (i*j*p)			-.01	.345		
Of SPN (h)	.38	<.001**			.57	<.001**
Via IM (g*n)			.21	<.001**		
Via IM & SEs (g*j*p)			-.01	.27		
Of IM (n)	.47	<.001**			.44	<.001**
Via SEs (j*p)			-.03	.267		

Note: OI = Organisational identification, SEs = Self-esteem, SEf = Self-efficacy, SPN = Satisfaction of psychological needs, IM = Intrinsic motivation.

7.3.8.3 Effects of latent constructs on self-concept, psychological needs, and motivation.

A summary of the direct, indirect, and total effect of latent constructs on self-esteem, self-efficacy, the satisfaction of psychological needs, and intrinsic motivation is presented in table 7.13. The results show that organisational identification was the only latent construct contributing to the prediction of self-esteem including a significant direct effect (β= .50) and a significant total effect (β= .53) on self-esteem. The latent constructs in the SR model accounted for 30.1 % of the variability in self-esteem. On the other hand, organisational identification (β= .40) and intrinsic motivation (β=.23) had significant direct contributions

on predicting self-efficacy. Notably, there was a significant indirect effect of psychological needs on self-efficacy through intrinsic motivation (β= .13). The SR model accounted for 25% of the variability in self-efficacy. Furthermore, organisational identification has a significant direct contribution to predicting satisfaction of psychological needs (β= .49). The SR model explained 23.9% of the variability in satisfaction of psychological needs. Lastly, intrinsic motivation was significantly predicted by the direct contribution of satisfaction of psychological needs (β= .54) and the indirect effect of organisational identification through the satisfaction of psychological needs (β=.26). The latent constructs in the SR model account for 29.2 % of the variability in intrinsic motivation.

Table 7. 13. A summary of direct, indirect and total effect of latent constructs on self-esteem, self-efficacy, the satisfaction of psychological needs, and intrinsic motivation

Effect	Direct (β)	Sig.	Indirect (β)	Sig.	Total (β)	Sig.
On Self-esteem						
Of OI (e)	.51	<.001**			.55	<.001**
Via SPN & IM (c*g*j)			.03	.194		
Via SEf & IM (a*i*j)			.01	.314		
Of IM (j)	.12	.193				
Of SPN via IM (g*j)			.05	.198		
On OI						
Of SEs(a)	.50	<.001**				
On Self-efficacy						
Of OI (a)	.50	<.001**				
On psychological needs						
Of OI (c)	.48	<.001**				
On intrinsic motivation						
Of OI					.33	<001**
Via SPN (c*g)			.21	.001**		
Via SEf (a*i)			.12	.015*		
Of SEf (i)	.23	.001**				
Of SPN (g)	.44	<001**				

OI = Organisational identification, SEs = Self-esteem, SEf = Self-efficacy, IM = Intrinsic motivation, SPN = the satisfaction of psychological needs.

7.4 Discussion

This study aimed to examine the extent to which care workers' organisational identification, self-esteem, self-efficacy, satisfaction of psychological needs, and intrinsic motivation predict or influence their organisational commitment and job satisfaction. In the current study, a hypothesised model with the directional relationships between care workers' organisational identification, self-esteem, self-efficacy, satisfaction of psychological needs, intrinsic motivation, organisational commitment and job satisfaction was examined using confirmatory factor analysis (CFA) and structural equation modelling (SEM). Measurement invariance tests were conducted to examine whether the measures used in the current study had equivalent psychometric properties to reflect the constructs from the participants regardless whether they are native and non-native English-speaking care workers. The results of the measurement invariance tests demonstrate that participants' response pattern, the strength of each item within the measures, and the baseline value for each item were equivalent between native and non-native English-speaking care workers. Therefore, the questionnaire did not measure constructs differently or was understood differently regardless of whether participants were native or non-native English-speakers. It is worth noting that the measurement error variances between native and non-native English-speaking care workers were different. Furthermore, the weighted latent means between native and non-native English-speaking care workers were compared and the results showed that non-native English-speaking care workers reported significantly higher self-esteem and self-efficacy than native English-speaking care workers.

The findings of the current study contribute to the knowledge on the effect of care workers satisfying psychological needs in a care home context where care workers' organisational identification influences their organisational commitment and job satisfaction through psychological need satisfaction and intrinsic motivation. The findings suggest that care workers' satisfaction of psychological needs facilitates them to experience a higher degree of intrinsic motivation. Intrinsic motivation in the current study refers to the extent to which care workers internalised the care home regulation and expectation into their self-concept (Gagné & Deci, 2005; Hagger et al., 2014). Whereas the satisfaction of psychological needs involves the extent to which care workers' autonomy, competence, and relatedness needs are satisfied at work. The satisfaction of psychological needs has been suggested as a nutriment that helps individuals to internalise the external regulations and actualise intrinsic motivation (Deci & Ryan, 2000; Gagné & Deci, 2005; Ryan & Deci, 2000). The current findings demonstrate that a higher level of satisfaction of psychological needs leads care workers to

experience more intrinsic motivation. It may be understood that care workers' satisfaction of psychological needs facilitated them to internalis the regulations in the care homes into their self-concept and this then led them to reach a sense where they volitionally execute their caring role in the care home. Moreover, the current findings are consonant with previous research (Deci & Ryan, 2000; Gagné & Deci, 2005; Hodgins, Brown & Carver, 2007) which also suggest that individuals' satisfaction of psychological needs and autonomous motivation are strong predictors of their commitment and job satisfaction. In other words, care workers who are more intrinsically motivated are more willing to commit to the care work in the care home and to consider care home interests as their own. Such findings can be understood to mean that care workers are more likely to execute organisational expectations and adhere to fulfil the same expectation over time when they are motivated autonomously (Deci & Ryan, 2000; Gorin et al., 2014).

These findings also suggest that care workers' well-developed organisational identification enhances their self-esteem and self-efficacy. The results of the current study are consistent with previous research on organisational studies (e.g. Bartel et al., 2001; Dutton, Dukerich, & Harquail, 1994; Fuller et al., 2006; Vignoles et al., 2006) which suggest that affiliating with the organisations and receiving training enhance employees' self-esteem and self-efficacy. Moreover, the current results demonstrate the directional linkages between care workers' organisational identification, the satisfaction of psychological needs, and intrinsic motivation. This may suggest the contextual significance of the nutriment that care workers receive. It is possible that care workers who do not identify themselves with the care home may respond less well to the nutriment in the care home or find it less important. Thus, care workers with higher organisational identification might perceive the nutriment in the care home as significant in satisfying their psychological needs

The current study points out that the relationships between care workers' organisational identification and their organisational commitment and job satisfaction are mediated by their satisfaction of psychological needs, self-esteem, and intrinsic motivation. These findings indicate that the satisfaction of psychological needs and intrinsic motivation functions as a positive mediator of organisation identification in both job satisfaction and organisational commitment. This is similar to the findings of Van Knippenberg (2000) where individuals' perception of being a member of an organisation has a weak association with individuals' adherence to fulfil the organisational expectations. SDT also suggests that the nutriment with a social environment facilitates individuals' enactment of the identity-relevant behaviours

(Ryan & Deci, 2003). The current findings further suggest that care workers receiving nutriment in care homes allows their relationships with their care homes to move from a 'self-definitional' perspective (Van Knippenberg & Sleebos, 2006) to being willing to devote efforts in support of the organisation (Coopey, 1995; Mowday, Steers & Porter, 1979).Thus, care home workers might be more likely to adhere to providing quality care for residents, to contribute to the care homes and have a higher job satisfaction when they reach a stronger sense of organisational identification and experience the nutriment and intrinsic motivation at work. In addition, according to identity theory, individuals are more likely to act in accord with the role expectations when the identity is perceived as salient (Burke & Stets, 2009; Stryker & Burke, 2000). The findings of the current study suggest that experiencing the satisfaction of psychological needs and autonomous motivation helps care workers, who have assumed the membership of the care home, to reach a higher level of satisfaction at work and to be willing to commit to the care work. In other words, these findings suggest that the satisfaction of psychological needs and experiencing autonomous motivation are significant for care workers to evaluate the identity of being a care worker in the care home as essential and valuable. Such positive evaluations may subsequently facilitate care workers in conducting their care practice in accordance with the role expectations in the care home and experience better job satisfaction.

The current findings reveal that self-esteem as a negative predictor of job satisfaction and organisational commitment. Self-esteem in the current study refers to care workers' emotional judgement towards whether they are worthy and valuable. The current findings indicate that care workers who evaluate their own worth highly and positively are more likely to have lower organisational commitment and experience less satisfaction at work. These findings are contrary to previous research which suggests that individuals with higher self-esteem are more likely to experience better job satisfaction and have higher organisational commitment (Johnson, Morgeson, Ilgen, Meyer & Lloyd, 2006; Pratt, 1998; Van Knippenberg & Van Schie, 2000). Such unexpected findings may be explained by considering statistical and theoretical perspectives. The negative sign between self-esteem and job satisfaction and organisational commitment may indicate the suppression effect which refers to the appearance of suppressor variables in the analysis. Researchers point out that there are a number of different types of suppressor variables, including the classical suppression, negative suppression, and reciprocal suppression (Cheung & Lau, 2008; Hadi, Abdullah & Sentosa, 2016; Maassen & Bakker, 2001; MacKinnon, Krull & Lockwood, 2000; Paulhus, Robins, Trzesniewski & Tracy, 2004). It is worth noting that the variance of

a latent construct includes the criterion-relevant and criterion-irrelevant components. In the classical form of suppression, a latent construct is correlated more with the criterion-irrelevant components of the dependent variable and the criterion-relevant components of other latent constructs in the model (Maassen & Bakker, 2001). In other words, a classical suppressor is an independent variable which does not correct with the dependent variable but is correlated with other independent variables. In addition, the negative suppression refers to two independent variables positively correlating with the dependent variable but one of the independent variables has a negative path coefficient in a simple path model. In this case, the independent variable shares more criterion-irrelevant components than the criterion-relevant components with dependent variable. Furthermore, the reciprocal suppression refers to two significant predictors sharing the criterion-irrelevant components of the dependent variable and supressing the criterion-irrelevant components of each other in a regression model (Maassen & Bakker, 2001; Paulhus, Robins, Trzesniewski & Tracy, 2004).

There might be a possibility that self-esteem acted as a negative predictor of job satisfaction and organisational commitment because of the negative suppression. According to the definition of negative suppression, the unexpected findings might be because self-esteem shared more criterion-irrelevant variance than the criterion-relevant variance with job satisfaction and organisational commitment. Cheung & Lau (2008) point out that exploring suppressor variables may contribute to theoretical development in research. It has been suggested that the inclusion of a suppressor variable in the analysis helps to suppress or partial out the criterion-irrelevant components (Burton, Lee & Holtom, 2002; Henik & Tzelgov, 1985; Tzelgov & Henik, 1991). For instance, Burton, Lee and Holtom (2002) include a variable “age” in the analysis of investigating the relationship between employees’ motivation to attend and their absence behaviours. Their findings suggest that the weak relationship between motivation to attend and absence behaviours found by previous research may be the results of failing to include suppressor variables in the model. In the current study, two constructs might have the potential to be the suppressor variables to partial out the criterion-irrelevant variance shared by self-esteem and job satisfaction and organisational commitment. They are the concepts of perceived external prestige (Dutton, Dukerich & Harquail, 1994) and role stress fit (Bacharach, Bamberger & Conley, 1991; LeRouge, Nelson & Blanton, 2006; Nelson & LeRouge, 2001).

Perceived external prestige (PEP), which is also known as constructed external image, refers to individuals' perception regarding the thoughts of outsiders have toward the organisation. Thus, PEP involves individuals' understanding of the reputation of the organisation or the work group (Dutton & Dukerich, 1991; Dutton, Dukerich & Harquail, 1994). It is important to note that research on organisation suggests that individuals are likely to see themselves as the affiliation with the organisation and reflect the external organisation reputation on their performance (Carmeli, Gilat & Weisberg, 2006; Podnar, 2011). Internalising organisational regulations and values is likely to influence employees' perceptions regarding their value and their behaviour (Ibarra, 1999; Slay & Smith, 2011) which then influences their self-esteem (Bartel, Dutton, Hogg & Terry, 2001; Riketta, 2005; Smidts, Pruyn & Van Riel, 2001). Thus, it is possible that the affiliation with an organisation with greater reputation encourages employees to develop their organisation identification, enhancing their self-esteem and organisational commitment (Carmeli, Gilat & Weisberg, 2006; Fuller et al., 2006; Riketta, 2005; Smidts, Pruyn & Van Riel, 2001). However, the negative media coverage in the UK argues that the quality of the care provided for older people might be inadequate, or that care workers may not receive adequate training, or the reporting of incidents of neglect and abuse in care homes. It is possible that the negative media portray of care homes in the UK might translate to care workers experiencing care work related stigma (Pfefferle & Weinberg, 2008) and negative media representation (Miller, Tyler & Mor, 2013) and this might in turn influence their self-esteem, which further influences their organisational commitment and job satisfaction. Therefore, PEP might have the possibility to supress the criterion-irrelevant variance in the analysis.

Moreover, role stress fit has been found as a negative predictor of self-esteem, job satisfaction in many different fields, such as IT industry (LeRouge, Nelson & Blanton, 2006; Nelson & LeRouge, 2001), health care professionals (Moore, Lindquist & Katz, 1997), and education settings (Reilly, Dhingra & Boduszek, 2014). Job stress, which is also referred to as role stress or work-related stress, can be seen as a form of organisational stress where employees experience distress evoked by the demands and expectations of the job role they undertake (Cooper, Dewe & O'Driscoll, 2001; LeRouge, Nelson & Blanton, 2006; Manning & Preston, 2003). Bacharach, Bamberger and Conley (1991) discuss the concept of role stress which involves a number of job-related stressors such as role conflicts, role ambiguity, and work overload. Role conflict in role stress research refers to individuals' challenging experience at work induced by the lack of resources and the demand of completion, while

role ambiguity involves a blur boundary between individuals' goals and responsibilities (LeRouge, Nelson & Blanton, 2006).

It is important to note that the presence of role stressors do not directly associate with the negative effect. Nevertheless, it has been found that the negative effects of role stressors are induced when individuals perceive it in a situation where role stressors are unexpected or unmanageable (Ivancevich, Matteson & Konopaske, 1990; LeRouge, Nelson & Blanton, 2006). Scholars use the concept of role stress fit to describe the difference of individuals' perceptions regarding the extent to which they perceive their role stress as preferable and manageable comparing to the level of role stress they actually experience at work (Edwards, 1996; LeRouge, Nelson & Blanton, 2006). In organisational studies, experiencing work-related distress has been related to the negative effects on productivity, employees' health, self-esteem and well-being (Bacharach, Bamberger & Conley, 1991; Ivancevich, Matteson & Preston, 1982; LeRouge, Nelson & Blanton, 2006).

Previous research suggests that care home workers are likely to experience stress and pressure at work (Shinan-Altman & Cohen 2009; Pitfield, Shahriyarmolki & Livingston, 2011; Räikkönen, Perälä & Kahanpää, 2007). When care workers work under staff shortages, their workload is likely to increase and the time they have to meet residents' care needs is more likely to be insufficient. Care workers with additional workload or demanding schedule at work may perceive the demands and expectations of their job role as unmanageable and subsequently experience the negative effects of job stress (e.g. job dissatisfaction and burnout). Moreover, researchers state that care workers are likely to experience difficulties navigating care worker-resident relationship boundaries, especially care workers who are emotionally engage in their care practices (Carr 2014; Hudson & Moore, 2009). It is possible that care workers perceive the levels of their role stress as unmanageable. Thus, role stress fit might have the potential to be a suppressor variable in the proposed model in the current study.

It is worth noting that PEP and work stress were not included in the analysis as potential suppressor variables and therefore whether PEP and/or work stress would help to partial out the criterion-irrelevant variance shared by self-esteem and job satisfaction and organisational commitment remains unclear. Future studies may investigate the influences of the inclusion of PEP and work stress on care workers' work identities, work motivation, organisational commitment and job satisfaction.

7.5 Implication

The current study implies the important role of social interaction in providing care workers with the nutriment to satisfy their psychological needs, shaping their motivation in carrying out their role and increasing their organisational commitment and job satisfaction. This may then enhance care workers' retention intention and subsequently reduce turnover in care homes. Social interaction has been suggested as a method for individuals to learn about the role expectation within the social structure (Stryker & Burke, 2000) and as a facilitator for forming individuals' organisational identification (Sluss & Ashforth, 2007; Stryker & Burke, 2000). Moreover, the supports and feedback from care workers' significant others in care home settings via social interaction have been indicated as valuable in enhancing their self-concept (Dutton, Dukerich & Harquail, 1994; Field, Duffy & Huggins, 2013) and the satisfaction of psychological needs (Ashforth, Harrison & Corley, 2008; Ibarra, 1999; Mael & Ashforth, 1992; Pratt, 1998; Slay & Smith, 2011). Thus, care workers are more likely to have better development and optimal functioning when they are in a work environment which encourages their independency, recognises their contribution, offers supervisory support, and fosters the development of relationships with residents. This might then have positive effects on their organisational commitment and job satisfaction. Thus, care home managers should foster a positive care home culture which allows sufficient time for care workers to interact with residents and encourages a) care workers to form relationships with residents; b) peer support among care workers; and c) care workers' independence at work. Moreover, additional workshops or meetings may be arranged for care workers to share their work experiences with their colleagues. This may provide care workers with opportunities to showcase their care work skills and knowledge and to support their colleagues.

7.6 Limitations

There are various limitations to the current study. First, some participants commented on the length of the survey. However, it was difficult to gauge whether the length of the survey was the reason for non-completion or non-participation. Understandably, a long questionnaire may demotivate or tire the participants that may subsequently affect the validity of the data. Therefore, the alternative scales measuring the same constructs with fewer items should be considered to ensure that this did not demotivate or tire participants and to avoid the adverse effects on the validity of the data. Second, the participants were recruited from care homes where the managers expressed support for their care workers' participation. It is possible that participants may have been protective of their care homes when filling the questionnaire.

7.7 Recommendation for future research

Managers are suggested as having influential roles in many aspects, such as employee's emotional health (Kemp, Leila Borders & Ricks, 2013), turnover (Kuvaas, & Dysvik, 2010; Tymon Jr, Stumpf & Smith, 2011), organisational commitment (Richard, Ismail, Bhuian & Taylor, 2009), and job satisfaction (Babin & Boles, 1996; McNeese-Smith, 1997). The future study may look into how care home managers provide a need-supportive environment, what the effective managerial support are, and what limitations and restrictions managers work under in supporting the staff. Moreover, the current study adopts the universal approach of the satisfaction of psychological needs rather than investigating the strength of the psychological needs separately. Recent studies on psychological need satisfaction discuss the individual difference in need strength where individuals may perceive a particular psychological as more important than other (Chen et al., 2015; Hofer & Busch, 2011). Future studies may explore care home workers' individual difference in needs strength which may help to develop interventions for providing effective psychological resources to satisfy their particular psychological needs. In addition, care workers' high stress level has been suggested in prior research and suggested to have negative impacts on job-related performance, turnover, and wellbeing (Brodaty, Draper & Low, 2003; Ejaz, Noelker, Menne & Bagaka's, 2008; Zimmerman et al., 2005). However, care workers' stress levels are not taken into consideration in the current study. It may be worthy to investigate the influences of care workers' distress in relation to the organisational identification, self-concept, the satisfaction of psychological needs, and motivation.

7.8 Conclusion

The current study investigates how care workers organisational identification, self-esteem, self-efficacy, satisfaction of psychological needs, and intrinsic motivations influence their job satisfaction and organisational commitment. The findings suggest a directional linkage from care workers' organisational identification to the satisfaction of psychological needs, to intrinsic motivation and to organisational commitment and job satisfaction. Care workers' satisfaction of psychological needs and intrinsic motivation are two strong predictors of organisational commitment and job satisfaction. They are also the significant mediators of organisational identification in their job satisfaction and organisational commitment. Unexpectedly, self-esteem, was as a negative predictor of organisational commitment and job satisfaction and a negative mediator of organisational identification in organisational commitment and job satisfaction. This study suggests the significance of social interaction in enhancing care workers' organisational commitment and job satisfaction. This study also

implies the contextual significance in satisfying care workers' psychological needs which then shapes their motivation in carrying out their role and impacts on organisational commitment and job satisfaction. The future study may investigate care home manager's input in providing support for care workers, enhancing social interaction in the care home, and creating a positive work environment.

CHAPTER 8
CARE HOME MAMAGERS' PERSPECTIVES OF SUPPORTING THEIR CARE WORKERS: A QUALITATIVE STUDY

8.1 Introduction / background

Managers have significant influences on the employees' organisational behaviour and performance (Kemp, Leila Borders & Ricks, 2013; Kuvaas, & Dysvik, 2010). The role of care home managers involves facilitating care workers' development at work, enhancing their care practices and promoting their wellbeing. Care workers' development requires managers to convey care home expectations and values to their care workers (Lopez, 2006; Pfefferle & Weinberg, 2008), provide training and ensuring care workers implement the training into the care practices (Coogle, Head & Parham, 2006; Lawrence et al., 2012; Stolee et al., 2005). Enhancing care workers' care practices involves managers empowering care workers to work independently (Kuo, Yin & Li, 2008), promoting care workers' self-esteem (Bishop et al., 2009), and reducing turnover rate (Coogle, Head & Parham, 2006; Menne et al., 2007). Ensuring care workers' wellbeing requires care home managers to create a positive work environment (Bishop, et al., 2009; Castle & Engberg, 2005; McGilton et al., 2007), reduce care workers' stress levels (Harrisson et al., 2002; Lawrence et al., 2012; McGilton, et al., 2007), and enhance job satisfaction (Coogle, Head & Parham, 2006; Decker, Harris-Kojetin & Bercovitz, 2009).

Moreover, the findings of study 1 (chapter 6) revealed that many participants struggled with meeting their role expectations in the care home. In many cases, participants in study 1 seemed to struggle between offering social and emotional support to residents and maintaining a feeling of not being emotionally involved with residents. The findings of study 1 also imply that care workers would have to go through the process of negotiating, examining and constructing their own boundaries based on their social interaction with others and the care home culture. Given that the literature review in chapter 2 emphasised that care home managers have a significant role in conveying care home values to their care worker, it appears to be important to understand care home managers' role and experiences in facilitating care workers' motivations and care practices and the ways in which they conceptualised care workers' role, responsibilities, and boundaries. In addition, the findings of 2 (Chapter 7) suggest that the level of care workers' intrinsic motivation and satisfaction of psychological needs were strong predicators of their job satisfaction and organisational commitment. Care workers' intrinsic motivation and the satisfaction of psychological needs

were demonstrated to be significant mediators of the effect of organisational identification on organisational commitment and job satisfaction. Notably, organisational identification, intrinsic motivation, and satisfaction of psychological needs is suggested as being developed or fostered in a social environment through social interaction with others. (Deci & Ryan, 2000; Gagné & Deci, 2005; Sluss & Ashforth, 2007; Stryker & Burke, 2000). Thus, the findings of the previous study raised the possibility that the social environment in the care homes and the support care workers receive through social interaction have an impact on their organisational commitment and job satisfaction.

The rationale of the current study is to further investigate under what social environment, circumstances or management the motivators for encouraging care workers staying in their current position may be more effective or significant. Given that managers have an important role in creating the work environment, training, and supporting care workers, learning form their perspective may provide insightful understandings about the effective motivators for encouraging care workers to continuing working as care workers.

8.1.1 Aim of the current study.

The aim of this study was to understand the perspective of care home managers on the ways in which they facilitate their care workers in the care homes. More specifically, this study aimed to understand:

- What do care home managers perceive their care workers' support needs and barriers to carry out their role?
- How do care home managers facilitate their care workers to cope with the barriers and difficulties at work?
- What do care home managers do to facilitate their care workers to develop work identities and organisational commitment?

8.2 Methods

8.2.1 Research design.

In order to understand care home managers' perceptions of their care workers' support needs, their subjective experience of management in care homes, and the ways in which they facilitate care workers to develop work identities, organisational commitment, and coping strategies, a qualitative approach was conducted. Individual face-to-face interviews were conducted using a semi-structured interview guide which contained open-ended questions (Appendix 22).

8.2.1.1 Inclusion criteria for care home settings.

The inclusion criteria for care home settings were a) nursing homes or residential care homes, b) care homes providing care for older people aged 65 years old and over, c) care homes not providing care for individuals with learning disability or other mental illness, and d) located in South East England and Greater Landon.

8.2.1.2 Inclusion criteria for care home managers.

Eligibility for participation were, a) working in a care home which meets the aforementioned inclusion criteria, b) managers, c) being fully conversant in English, and d) willingness to share their experiences regarding their management practice.

8.2.2 Participants.

Ten care home managers participated in this study, nine of whom were female, and one was male. Four managers worked in residential care homes and 6 managers worked in a nursing home. Participants had various lengths of care home management experience, ranging from 2 months to 35 years (*M*=14.75 years; SD=11.9). The majority of participants had similar work experience before taking positions as care home managers. Participants' demographic information is presented in Table 8.1.

Table 8. 1 Participants' demographic information

Participants		N= 10
Care home setting	Residential care home	N= 4
	Nursing home	N= 6
Gender	Female	N= 9
	Male	N= 1
Age	M=54.8; SD=11.65; range [36-71]	
Ethnicity	White	N= 8
	Mixed/multiple	N= 1
	Asian/Asian British	N= 1
Years of managing experience	M=14.75; SD=11.9; Range [2 months – 35years]	
Education background	Secondary school	N= 1
	Undergraduate degree	N= 4
	Postgraduate degree	N= 3
	Others	N= 2

8.2.3 Semi-structural interview guide.

In order to ensure the trustworthiness of the data, open-ended questions were used in the interview guide (Appendix 22). The use of an interview guide provided a structure to the interview and encouraged participants to freely discuss their management experience in the

care homes. This interview guide was developed based on the literature review in chapter 2 and the findings of first two studies in this thesis (chapter 6 & 7). A grand tour question (Leech, 2002) was used in the beginning to understand care home managers' role in the care homes "Please can you tell me about your role as a care home manager?". This question acted not only as the icebreaker but also allowed the researcher to learn about participants' previous experience, their views of their job, the values they attached to role and the work, and their perceptions of their role as a care home manager. Prompts were used to encourage participants to further illustrate their experience and role. If participants mentioned interactions of care workers with residents, they were encouraged to elaborate.

The findings of the first qualitative study on care workers' work experiences (see chapter 6) pointed out that many participants expressed their struggling with meeting their role expectation in the care homes. According to the literature reviews in chapter 2, care home managers have a significant role in conveying care home values to their care worker. It was therefore important to understand the way in which participants conceptualise their care workers' role and care practice: "Please can you tell me about your expectations towards care workers?". This broad and direct question may lead to a broad and vague answer. Thus, prompts were used to focus on the areas where care workers found themselves struggling to meet expectations including care practice, interactions with others in the care homes, teamwork, and new care workers adjusting to the care home (see chapter 6). If any noteworthy interactions with care workers were mentioned, the participant's reactions and strategies were further explored.

In order to explore the ways in which managers conceptualise and facilitate care workers' motivation. The interview explored participants' strategies in motivating care workers: "Please can you tell me how you motivate staff to provide care in the care home?". It is worth noting that the findings of the first qualitative study (see chapter 6 in section 6.3) suggested that care workers' motivation in continuing their role as a care worker may be positively influenced by the work satisfaction, appreciation of their work value, and sense of belongingness. It is negatively impeded by work barriers, such as struggling with meeting role expectation and attachment. Thus, to understand the ways in which managers motivate their care workers, questions should reflect on what care workers expressed in chapter 6. Participants were asked about their perceptions of care workers' work barriers, their support to the care workers, their ways of motivating the care workers, their ways of conveying the

expectations, and their ways to ensure the care workers are in line with the expectations and care home values.

Furthermore, the findings of the first qualitative study on care workers' work experiences (see chapter 6) pointed out that care workers may struggle between offering social and emotional support to residents and maintaining an adequate working relationship with residents. Thus, during the interview, any mention of scenarios in relation to care workers' boundaries or responsibilities were further explored. Alternatively, participants were asked about their views about care workers' boundaries or responsibilities: "Please can you tell me about your thoughts regarding professional boundaries?". This question was aimed to understand the ways in which they facilitated their care workers in navigating boundaries at work. At the end of the interview, participants were asked if they would like to share anything else with the researcher which was not covered by the interview guide.

8.2.4 Ethical consideration.

The detailed ethical consideration in relation to the research process, including research planning, data collection, data analysis, and findings dissemination, has been presented in chapter 5 (section 5.6). In the current study, the researcher was aware that discussing past managerial issues or support of their care workers might lead care home managers recalling unpleasant or distressing memories. Thus, prior to the interview, each participant was explained that if they felt upset or distressed, the interview would be stopped. If they did not wish to continue the interview, they could withdraw immediately from the study. If participants felt distress after the interview, they would be encouraged to discuss their feelings with their line managers or GP. Furthermore, in order to ensure the safety of the researcher, the interviews were conducted with participants in the care home during work hours. The current study received ethical approval (Appendix 17) from the Faculty Research Ethics Committee (FREC) in the Faculty of Art and Social Sciences at Kingston University.

8.2.5 Procedure.

Care home managers working in the eligible care homes were contacted with an invitation letter (Appendix 18) and information sheet (Appendix 19) to explain the purpose of the study. Nine of the participants were managers of the care homes participating in study 1 and 2. Once care home managers agreed to take part, the researcher arranged an interview time convenient for the care home manager. Before the interview started, the researcher explained the purpose of the study, their right of withdrawal from the study, and the researcher's responsibility for ensuring their anonymity and confidentiality. After participants fully

understood what the study involved and gave their verbal consent to the participation and audio recording during the interview, they signed a consent form (see appendix 20) prior to the start of the interview. The care home managers completed a demographic questionnaire (see appendix 21) before the interview commenced. The duration of the interview lasted between 1 hour and 2.5 hours. At the end of the interview, participants were thanked and invited to contact the researcher if they had any further questions about the study. In order to avoid participants being recognized or identified by their personal information or their responses, each participant was given an identification number, and all the names mentioned in the interviews were replaced with an alias to ensure the data remained anonymous.

8.2.6 Data analysis.

In order to understand the care home managers' perspective concerning the ways in which they facilitated their care workers in the care homes, the three qualitative analyses considered were interpretative phenomenological analysis (IPA; Smith & Osborm, 2003), grounded theory (GT; Corbin & Strauss 2008), and thematic analysis (TA; Braun & Clarke, 2006; Clarke & Braun, 2013).

A detailed discussion of IPA, GT and TA was provided in chapter 6 (see Section 6.2.6). This section expands on the reasons for choosing TA to analyse the qualitative data in this study. The aim of this study was to understand the ways in which care home managers facilitate their care workers in the care homes. This included the understanding of managers' views and perceptions of their care workers' support needs, their ways and methods to provide support for their staff, and their practices in fostering the development and maintenance of care workers' work identities and organisational commitment. It is very likely that managers would have different perceptions and methods in providing support to their staff. It is also likely that they might have similar and effective ways to facilitate their staff. Although this study was not to evaluate the managerial practices of participants, it would be valuable to learn about the differences and similarities between participants' accounts in relation to facilitating their care workers in care homes. Thus, IPA emphasising participants' subjective experiences is considered as less suitable than TA. Moreover, this study had a small sample size, specific research questions and a time constraint. GT often requires a large sample size and involves developing, defining, testing the categories from the data and a process of on-going data collection. Thus, GT is not considered as a suitable analysis in this study. On the other hand, TA has the flexibility in allowing the researcher to search the patterns within the data based on the research questions and can also be used in a research project with a small

sample size. Considering the strengths previously discussed, TA was chosen to analyse participants' accounts in this study to understand care home managers' perspectives on the ways in which they facilitate their care workers in the care homes

Participants' responses were transcribed verbatim and repeatedly read through so that the researcher became familiarised the content of each interview before commencing the initial coding throughout all the data. Most of the initial codes were short phrases indicating the basic elements or meanings within the data in relation to how the participants perceived care workers' work barriers and support needs, how the participants supported care workers to manage the work barriers and navigate the boundaries, and what participants did to facilitate care workers to develop their work identities and organisational commitment. The initial coding process was done using the qualitative research software, NVivo 11. Once the initial code was generated, the patterns were searched and identified within the clustered codes based on whether the clustered codes represented the meanings from the data relating to the research questions.

After examining the relationship between the patterned codes, candidate themes and subthemes, the researcher started adding the extracted coded data to examine whether the candidate themes and subthemes were supported by the data. If it was evident that any candidate themes and subthemes were not adequately reflecting the meaning of the data, they would be refined or removed. Each theme was then defined and named based on the 'essence of what each theme is about.' (Braun & Clarke, 2006, p.92). Moreover, the identified themes and subthemes were considered in regard to whether they reflected the meanings of the data to ensure their validity. After the refinement, the candidate themes and subthemes were defined and then discussed with the researcher's supervisors in order to ensure that the themes, subthemes, and extracted data were organised in a coherent and consistent manner and fit into the narrative of the whole dataset. Three master themes with their subthemes were identified from the data that related to participants' perspective on care workers' support needs, work barriers, and the ways in which they support care workers in the care homes will be presented.

8.3 Findings and discussion

Participant accounts reflect that their role involved ensuring residents received quality care and recruiting, providing training, and supporting care workers. This study focused on the care home managers' perspectives surrounding their support of care workers in the care

homes. Findings from participants' accounts reflected their role in establishing supporting structure and care home culture, their perceptions of care workers' support needs, and their support of care workers coping with work barriers and developing work identities and organisational commitment. Three master themes were identified from the data. The first master theme described participants' values of the care work, management practices and style which facilitated the establishment and maintenance of the care home culture and provided a foundation for care workers to conduct the care practice. The second master theme illustrated participants' perceptions of their care workers' support needs in meeting the role expectations while maintaining the boundaries. The third master theme depicted care home managers' support in meeting care workers' support needs. An overview of four master themes and their subthemes is presented in table 7.3. The findings are presented with illustrated quotes from the interviews.

Please note that some participants used the term 'carer' or 'carers' to refer to their care staff or employees in the care homes. In order to maintain the integrity of the direct quotes from participants and the consistency in the use of language referring to care workers, '(care worker)' or '(care workers)' will be added to the participants' quotes where 'carer' or 'carers' were used.

Table 8. 2 An overview of themes and subthemes

Master theme	Subtheme
Managers' role in facilitating care home culture	1. Managers' management practices 2. Collective responsibilities and trust 3. Productive and cohesive work environment
Managers' perceptions of boundaries for care workers	1. Managers' supervision model informing care workers' responsibilities and practices 2. Conceptualising care workers' boundaries 3. Dilemmas associated with maintaining boundaries 4. Helping care workers navigate and maintain boundaries 5. The consequences of crossing the boundaries
Managers' support for their care workers	1. Facilitating care workers' career advancement 2. Fostering effective communication 3. Giving recognition and ensuring staff's wellbeing 4. Mangers' perceived limitations in supporting their staff

8.3.1 Managers' role in facilitating care home culture.

Participants discussed their views and experiences of managing their care homes. Their accounts reflected that their role influenced the ways in which care home culture was formed and maintained in their care homes. It seemed that the organisational structure and care home

culture functioned as a foundation for the care workers to carry out the care work. Participants depicted the ways in which they planned and organised the care work that provided a framework and guide for their care workers to follow and grasp the care home expectations. Participants addressed different levels of expectations towards care workers' responsibilities that were conveyed in their management practices to their care workers. Participants felt that the trust between care home managers and care workers was the key to enable care workers to assume more responsibilities at work and to help managers to conduct effective communication with care workers. In addition, participants expressed the significance of care workers having shared understanding of care work, attitudes, and values within the work environment.

8.3.1.1 Managers' management practices.

Many participants expressed that, being a care home manager, they had the duty of implement their own values and standards into the care provided in the care home and shape the care home culture. It may be understood that care home managers' perceptions towards care quality, their values, and views of the care work exerted influences on the ways in which care provision was planned and organised in the care homes (André, Sjøvold, Rannestad & Ringdal, 2014; Jeon, Merlyn & Chenoweth, 2010; Toles & Anderson, 2011).

> *"I think I can bring my values and my standards. I can implement them, which does please me. Over the years, I have been very unhappy off and on both in the NHS and in independent sector where I felt standards weren't being maintained, so in my position, I can do that to the best of my ability. I don't always succeed, but certainly, that is my vision that I will provide a high quality of care."* (M01, female, nursing home manager, 20 years' work experience)

Participants used a number of different analogies to describe their role, including the mother of a big family, a manager keeping the care home running, a manager tracing and correcting faults, a person with privilege implementing their own values, and a leader to achieve the goal. Given that participants had very similar perceptions of what their role entailed, these different analogies may be understood as reflecting participants' management style and practice as well as emphasising the cooperation between care home managers and care workers. Many participants pointed out that care workers have an essential role in providing care to residents and executing the goals and plans that the managers laid out.

> *"I don't see myself a manager, I see myself as a leader, we all have got a common course in this home, we just do different job to achieve it, to achieve our outcome, we have to have a leader, and I suppose I'm that leader, but I couldn't do it without them, and they probably couldn't do it without me."* (M08, female, residential care home manager, 30 years' management experience)

It might be understood that care home managers acknowledged the role of care workers as collaborators who implemented the managers' views, visions, and values in their care practice. This also suggests that care home managers provide the vision for the values underpinning the care home culture. Some participants expressed that explaining and conveying their plans or values of the care work to their care workers can sometimes be difficult. One participant articulated her struggles to convey her values to the care workers and alter their attitudes to those she would prefer in her care workers. This account seemed to suggest that it is desirable to have care workers who shared similar understandings, ethos, attitude and values of care work as those of the care home manager. This may imply that the lack of consensus on how care work is expected to be carried out can lead to adverse effects on care quality and tensions between care workers and the manager.

> *"The manager's strength completely depends on the staff. Okay? I cannot run this business myself. My biggest strength and my major strength is my staff. So if my staffs are perfect, if my staff does what they are supposed to do, if my staff maintains all what we were talking about, …, turn up on shifts, according to what they are supposed to do, then I have achieved everything …, Then my residents will be well looked after. I'll be able to maintain a good standard of care in this home. So my staffing will be my biggest thing. If I could change their attitude, yeah. That is the biggest thing.* (M10, female, nursing home manager, 5.3 years' management experience)

It is worth noting that some participants felt that involving care workers in the planning and organising of care work was a more effective way to convey the managers' views and values to the care staff. It seemed that this method allowed care home managers to learn about care workers' views of care work and helped care home managers to convey their own values by providing feedback on care workers' views. Some participants felt that going through this communication process helped them and care workers to reach a mutual understanding and an agreed method of conducting the care practices to ensure care quality.

> *"I'm not autocratic or bombastic, I'm always very diplomatic in my management style, I believe in democracy, and things got to be done, they got to be done properly, and I want to get everyone's views on how they should be done, because if I get their views on something should be done, then I know if I put that in place, they are going to do it coz they actually give their input of how it should be done, but with the guideline that ensure they follow the legislation and CQC requirement."* (M09, male, residential care home manager, 4 years' management experience)

This suggested that some participants recognised the significance of reciprocal communication in their management practices. Encouraging care worker input in the planning and organisation of care provision seemed to have a number of advantages, including ensuring their care practices being in line with regulation, enhancing their sense of competence, and encouraging them taking ownership over their work situation. According

to self-determination theory (SDT), need for autonomy refers to individuals needing to have a sense of taking ownership of their behaviour in the action (Deci & Ryan, 2000). It is suggested that experiencing the satisfaction of autonomous needs leads individuals to have a higher level of intrinsic motivation and better performance (Baard, Deci & Ryan, 2004; De Cooman, Stynen, Van den Broeck, Sels & De Witte, 2013). In care home context, it can be assumed that care workers would benefit when they experienced the sense of taking the ownership of their care practice. Care home managers encouraging the care workers' involvement in planning and organising care work seemed to satisfy care workers' need for autonomy as well as to enhance the effectiveness of communication between care home managers and care workers.

The majority of the participants expressed that one of their roles was a gatekeeper filtering out unsatisfactory care practice. Many participants pointed out that as a care home manager, it is important for them to pay close attention to the care workers' care practice. It seemed that care home managers' responsibilities did not conclude after providing adequate training courses to equip their care workers to provide care to their residents. Some participants felt that observing or paying close attention to care workers' care practices was a crucial part in their management practice. Moreover, some participants pointed out that knowing care workers' strength, limitations, and work performance helped managers to plan and organise care work for the care workers. This may be understood that care home managers' management practices were influenced not only by their own views and values of care work, but also the competence of their personnel. One participant expressed that witnessing care workers' unacceptable or unsatisfactory care practices without giving immediate feedback or correction was considered as a flaw in her management practices. She felt that a manager's management practices could have a significance impact on care home culture, regardless of whether the practices were activity and positively resolving the issues or passively allowing negative care home culture to form and last.

> *"If you know your staff team well enough …, You know what they would be capable and what they won't be capable of doing. …, The more you get to know, you know well, that (care worker) doesn't fit that (care work). How have you got staff members that have been there for years that are abusive …, It can't just fall on their shoulders, can it? That is where actually I would be like, 'I'm culpable to that because I have not changed that. I've allowed that. Whether it's been me not acting or not seeing, but I have allowed that kind of culture to be in that home'."* (M02, female, residential care home manager, 10 years' management experience)

According to identity theory (Stryker & Burke, 2000), an identity is viewed as a framework that provides meanings to guide an individual's behaviour and to fulfil the expectations. This

framework is established through an individual continuously interpreting their experience and negotiating and adjusting their personal knowledge and understanding of the social structure. In a care home context, care home managers giving immediate feedback or correction to care workers' care practices may be seen as a means of negotiating the expectations attached to the role of care workers. This may subsequently facilitate care workers to grasp the meanings of being a care worker and form their work identities. Moreover, one participant who had previously been a care worker and has recently taken the position of manager described her frustrated feelings when she found one of her senior care workers provided poor quality of care to a resident. She further illustrated her ways of managing the incident where she immediately intervened and demonstrated the appropriate and expected care practices to the care worker.

> *"I was so frustrated to the standard of care that senior carer (care worker), Level 3 carer (care workers) gave to that resident, and the resident started to get unsettled and I felt so bad. At some point I said to the carer (care worker) 'Would you mind to stop?' '..., I turned back to the resident and said 'Would you mind me to give you the personal care?' and he turned back, he has the capacity and he laughed and said 'Yeah, of course' and then I explained to him what I'm going to do, ..., I washed him without him making any complaint, and I always communicate with him. When I finished, I called the carer (care worker) to the side room, and I said 'You said you are a Level 3 carer (care worker), the standard you gave wasn't good. I expect you to improve."* (M04, female, nursing home manager, 24 years' management experience)

In this context, it may be understood as a means of demonstrating this care home manager's understanding of care work and competence of conducting satisfactory care practice. This demonstration may also be considered as a means of giving additional information of this manager (M04) to the care workers and informing them of her management style. At the end of the demonstration, this participant (M04) asked the care worker to improve the care practice to meet the care home standard for care in a private conversation. This may be considered as a means of providing a clear feedback on care workers' unsatisfactory care practices and focusing on the improvement which was required.

Ensuring care workers receive clear feedback and instructions seemed to be a crucial part of care home managers' management practices. Many participants emphasised the significance of being consistent in their management practice. Ensuring consistency in management practices seemed to provide a stable structure and framework for care workers to conduct their care practice. Some participants managing the care homes with multiple units pointed out that the consistency throughout the management teams (e.g. care team leader, unit leader,

or deputy managers) was required in order to avoid confusion and misunderstandings between management and care workers.

> *"There is a line of management, but if they (line managers) were having a problem with a member of staff, that they won't be able to deal with it, then I will step in. But if a member staff came to me now, 'This is a problem for me'. I will say 'Have you spoken to your line manager? Have you spoken to the team leader?' and if they say 'No', I will say, 'You need to do that.' Because it's not right, it would be like me jumping over my manager and going higher for the problem. So, I will see that as bypassing the manager, which is not nice."* (M08, female, residential care home manager, 30 years' management experience)

It seemed that a hierarchical organisational structure was applied to manage a sizeable care home and the consistency in management may be viewed as a means of showing a unified and well-informed management team. It is worth noting that care home managers' attitudes in maintaining a cohesive and unified management team seemed to be important. This attitude may leave middle managers feeling like they were supported, trusted and recognised as competent in dealing with the issues by care home momagers.

Many participants stated that they often spent time on "*troubleshooting*" or resolving complaints and the disagreements between residents, residents' families and care workers, which were an important part of care home managers' management practice. Many participants pointed out that being objective and effective in dealing with the issues raised in care work or complaints made by residents or residents' families was crucial. One participant expressed that avoiding dealing with the issues and complaints or managing the incidents without supporting evidence might exacerbate the incidents and undermine the reputation of the care home manager and care home.

> *"I can receive a complaint from a resident about a certain member of staff and I might think, that's not like her to do that. She is very aware and she's very caring and she's very sensible. ..., I will go and ask her, take me through what happened. 'I have just had this complaint. Take me through it'. She will take me through it. It sounds reasonable, but I don't take her word for it. Even though I know she's good. I still don't take her word for it. I will go and check. Is that what happened. I am not doing that to protect her or whatever to substantiate the complaint or not to substantiate it. I am doing it to protect myself. That is my responsibility*." (M01, female, nursing home manager, 20 years' management experience)

It seemed that managers resolving issues or disagreements could not merely rely on their understandings of care workers' personal characteristics or general care practices and performance. Instead, resolving issues seemed to require specific and detailed information and evidence from the resident and the care worker involved. Resolving issues with evidence may be understood as an ethos of management practices and a means of establishing and

maintaining positive reputation. Moreover, it may be understood that a care home manager's management practices includes fulfilling their managerial responsibilities and ensuring fairness and justice being implemented throughout the process of managing the incidents. Care home managers actively managing the problems, issues and incidents in a consistent manner and attitude may be understood as a means of maintaining care home culture (Killett et al., 2016).

In this subtheme, care home managers may have different management styles. Nevertheless, there were a number of shared characteristics within participants' management practices, such as implementing their views and values of the care work, being a gatekeeper to ensuring the care quality, assuming the responsibilities to deal with the issues and complaints raised in care work, and valuing the reciprocal communication and mutual understanding with their care workers. A consistent management practice may facilitate the maintenance of the care home culture and give care workers a stable fundamental framework to guide their care practice.

8.3.1.2 Collective responsibilities and trust.

Many participants expressed their efforts in establishing a cohesive care work team. It seemed that in order to form a cohesive team, care home managers were required to ensure that care workers fully understood the care home goals, that care workers work well together, and that care workers had a sense of contributing to the care home goals. Many participants felt that some of their care workers might not be aware of their fellow care workers' work, which could impede them working together as a team. Some mentioned the concept of collective responsibilities where they expressed that they expected their care workers to assume the responsibilities in a broader sense rather than narrowing to the completion of their assigned work. One participant raised her care workers' awareness of teamwork by rearranging the allocations and clarifying the work and responsibilities assigned to each care worker. The participant (M06) stressed that rearranging the allocations meant that care workers would have to work with different colleagues rather than just the colleagues they were friends with. As a result, the participant (M06) noticed her care workers had a better sense of teamwork and achieved a better working outcome.

> *"You have to make people responsible because otherwise, you tend to get people say, 'It wasn't me, I did my job okay'. They have to work together as a team, and what we found, when we put those allocations together, it kind of pull the team together, because they started working better, you know, they kind understood about how everybody has to work together, because it's not about just you are doing individually,*

it's what your colleagues also doing." (M06, female, nursing home manager, 6 years' management experience)

This may also point out the significant influences care home managers have on care workers' social interactions and the social environment in the care homes.

It is worth noting that participants seemed to have different views regarding the extent to which their care workers were expected to assume the responsibilities when communicating or interacting with residents and residents' families. Many participants expressed that part of their responsibility as managers was communication with residents' families, registered nurse if it was a nursing home, or senior care worker if it was a residential care home. Therefore, many participants expected their care workers to direct resident's families to them or registered nurses if resident's families had any concerns about residents' health condition or medical needs. These participants further illustrated their views that care workers did not have sufficient medical knowledge, training and/or were given the limited access to the information of residents' conditions and medical needs. In order to avoid confusion and misunderstanding, these participants actively discouraged or forbade their care workers to discuss residents' condition with residents' families.

"Sometimes there is no point asking a carer (care worker) what the doctor said. Some families don't see it that way. 'You are a member of staff and you are supposed to know'[what families have said]. … when this happens what you need to do is say to them, the nurse is on duty. Tell them the nurse that is on duty and if they would like to talk to them, they have got all the information because they spoke to the doctor today." (M03, female, nursing home manager, 13 years' management experience)

"What I say to them is um you always show family you have interests, but don't speak about anything medical, because often you get mixed messages, …, I say to staff 'senior and myself will deal with that'." (M05, female, residential care home manager, 35 years' management experience)

These participants' accounts may be understood that care workers assuming the responsibilities of communication with resident's families may be perceived as overstepping their role and boundaries in the care homes. In this instance, care home managers' discouraging their care workers from discussing residents' health conditions with residents' families may be viewed as a form of control and exercising managerial authority or a means of safeguarding the care homes. On the other hand, one participant managing a residential care home had an opposite view – residents' families can learn about their loved ones by communicating with the care workers. It seemed that conveying the precise and accurate information of a resident's condition was the purpose of the communication between care workers and a resident's family. She pointed out that she actively encouraged care workers

to communicate with other health professionals to obtain sufficient information about residents because she felt this promoted the direct communication between care workers and residents' families.

> *"They are the person that has seen that resident on a daily basis and seen the changes. ... if the resident has an injury or a fall, they (care workers) will be the ones that phone them (residents' families) and let them (residents' families) know what happened. They (care workers) are the ones that see them (residents' families) when the family members visit. And yes, I don't have this, 'No, you can't talk to the carers (care workers)'. I change the culture of the families when I started it. It's the same with the healthcare professionals. I expect the staff team to talk to the district nurses and it's the team leaders that take the district nurses round. It's the team leader that takes the doctor round and knows exactly what's going on. Not me."* (M02, female, residential care home manager, 10 years' management experience)

The differences between participants' views and attitudes regarding whether care workers should be encouraged or forbidden to communicate with residents' families may be understood as relating to the extent to which they would like to relinquish their control over the matters. It is worth noting that the participant M02 mentioned that she changed the culture in the care home. This may be assumed that she had gone through the process of preparation to equip her care workers to have the confidence, knowledge, understanding, and information in order to conduct the effective and direct communication with residents' families. It may be understood that the preparation process that care home managers employ facilitated the care workers' capability to assume responsibilities as well as foster trust between manager and care workers.

The concept of trust was mentioned by many other participants. They felt that their trust towards their care workers was established or '*earned*' through care workers demonstrating adequate care practice, compliance with the care homes' regulation, schedule, and values, and active correction of the mistakes in care provision.

> *"If someone's going to let me down, you know, cancel shifts and that, you've lost my trust, you know. ..., I can't trust that you're going to be here for the forty hours because I know you're going to cancel half of them. So, trust is earned, ..., Yeah, you know, you don't hire someone, 'Ah, I trust that person implicitly, you don't know them'. So over time, you get to know them and the more you get to know them the more you can trust them. That is earned, and I think you can lose it very quickly."* (M09, male residential care home manager, 4 years' management experience)

It seemed that care home managers perceived the concept of trust as a dynamic process where care workers were expected to maintain credibility in their care practice. On the other hand, some participants expressed that their care workers' credibility encouraged them to

relinquish certain levels of control over care work and to provide higher levels of autonomy to their care workers.

> *"When I go home at night, I don't worry about what is happening, trust the staff, if they know what is expected. We have regular residents' meetings; I get no complaint from my residents.* (M05, female residential care home manager, 35 years' management experience)

This may be understood that care workers' quality of care practices established care home managers' trust which then led to more autonomy for care workers and positive work outcome in the care homes. It is worth noting that trust between participants and their care workers seemed to be perceived as a reciprocal relationship between them and the care workers. Many participants felt that it was important that care workers' trust them. It seemed that if care workers trusted their managers, they would experience more effective communication with managers and feel reassured when encountering obstacles at work. Some participants pointed out that gaining a care worker's trust required them to be perceived as approachable, willing to offer support, and effective resolving issues.

> *"I think they um know what is expected of them, they know if there is anything new, no one would expect them to just be given a piece of new equipment to use or whatever. There is training available for that and help."* (M05, female residential care home manager, 35 years' management experience)

> *"Everybody knows what they are doing, coz if anything happened, the first thing they used to call me, someone would come '(Name of the manager),, come quickly'. 'Why are you calling me for? You are handling it.' They just want my approval sometimes you know, but it's all good fun."* (M09, male residential care home manager, 4 years' management experience)

On the other hand, a lack of trust between managers and care workers may be perceived as a significant challenge in management. One participant felt that she had to gather written evidence when dealing with the issues with her care workers as a means of protecting her reputation and avoiding the possible future dispute.

> *"Get more evidences before we do anything to them like a suspension or a discipline or an anything. We need to collect enough and more evidence …, That is one of the biggest challenge on the manager is because we can't because we can't touch anything. Because the tribunals and everything, so we have to have a trail of papers, evidence, before we do anything because if they come and shout at us today, or if you shout at me, you can turn it back and say I shouted at you. Because you don't have any witness. So, what you says it might be that 'when I went to manager she shouted at me', then you will go to the GP, I'm at stress at work because the manager shouted at me. GP will say, 'stress at work, off the record, or not to fit to work. Because a manager was very rude'. That's their evidence. So, we have to be, it has to be tackled in a proper way, that no one is being hurt*". (M10, female nursing home manager, 5.3 years' management experience)

The mistrust between managers and care workers was perceived to be a significant obstacle in conducting productive management practices and effective communication. It is worth noting that the communication in organisations involves creating or exchanging the information and understanding between senders and receivers (De Ridder, 2004; Forbes-Thompson et al., 2006). Ineffective communication between managers and care workers can cause a negative impact on care quality (Berta et al., 2010; Scott-Cawiezell et al., 2006; Zheng & Temkin-Greener, 2010) and a lack of trust might have adverse effects on the work atmosphere as well as the care provision. It is worth noting that managers requesting a care worker's compliance at work can blur the line between providing support and imposing a punishment. Notably, the findings of the current study show that a punitive management style may lead managers to experience difficulties in establishing trust with care workers, fostering a positive work environment, and retaining care workers. This supports previous research suggesting that top-down or punitive management style has an adverse effect on the relationship between care home managers and care workers which then impacts the quality of care (Colón-Emeric et al., 2006; Scott-Cawiezell et al., 2006; Swagerty, Lee, Smith & Taunton, 2005).

In this subtheme, participants were endeavouring to encourage care workers to work as a team and assume collective responsibilities. Nevertheless, participants had different views regarding the extent to which their care workers were expected to assume the responsibilities of communication residents' families. This difference seemed to relate to managers' trust in care workers, managerial control over certain matters, and care workers' autonomy at work. Trust seemed to be conceptualised as a reciprocal relationship between care home managers and care workers. The trust between managers and care workers seemed to be viewed as a dynamic process where trust might be assumed implicitly through the interaction and understanding between managers and care workers. It also might require nurturing to establish the trust. Established trust seemed to lead to positive work outcome whereas the lack of trust led to the struggles in management.

8.3.1.3 Productive and cohesive work environment.

Most participants expressed that care worker teamwork, understanding of care home values, and conducting care practices in accordance with care home values were key elements of establishing a positive work atmosphere in the care homes. It seemed that participants preferred to recruit care workers with certain personality characteristics that were perceived as compatible to their care home values or care work team. For instance, many participants

felt that recruiting "*compassionate*" care workers was key to promoting a positive work atmosphere in the care homes. One participant stressed that she invested a considerable amount of effort in recruiting care workers who have compassion to help others and a strong ethos about being a care worker. She felt that the care workers she recruited exerted a significant influence on the care home culture.

> *"Most of my team have built really strong relationships with each other and therefore the delivery, the care they give is pretty much as good as it is ever going to get, because their communication is excellent with each other and they believe that you come to work, and you come to work to do the best for the resident. …, They get pissed off if people are sick all the time. The team have certain beliefs that you are supposed to work, and you are supposed to work to the best of your ability."* (M02, female, residential care home manager, 10 years' management experience)

It may be understood that managers established or fostered a care home culture through management practices and the recruitment process. Recruiting care workers with certain personality characteristics may be understood as a means of developing a cohesive care work team with compatible values with care home managers.

Furthermore, many participants expressed that care workers' attitude of "*learning from mistakes*" was crucial in developing their care practice. Some participants pointed out that care workers were likely to make mistakes when implementing new skills or knowledge into their care practice. Nevertheless, many participants felt that it was important and productive to help care workers to rectify the mistakes and improve the care practice. It may be assumed that care home managers felt a blame culture in the care homes as counterproductive as it did not have positive influences on providing quality care or enhancing care workers' care practice. However, a care worker's repetitive mistakes were perceived by managers as unacceptable. Many participants pointed out that care workers who kept making the same mistake could have adverse effect on the care quality and residents' wellbeing. They also expressed that care workers making the same mistake in the care practices suggested that the care workers were reluctant to improve their care practice.

> *"I feel it was allowed to make mistakes, so if you made a mistake, it's fine, but you know, be honest, and you will be shown the correct way to do it. you can make the same mistake for the second time, I won't have a problem with that. Then I will say you have done that before, this is the final time, you've just done that again. Then I know you're just not interested. The third time, I will fire you now. that's not a mistake, it's just you are just not interested*." (M09, male, residential care home manager, 4 years' management experience)

It may be understood that care home managers were required to ensure care workers being supported to improve their care practice. However, they had to prioritise maintaining the

care quality and residents' wellbeing when care workers seemed to be reluctant to improve their care practice. In addition, many participants felt that showing care workers their efforts to "*dissipate the blame culture*" was a key to fostering a positive culture in the care home, one where care workers were more likely to be honest about their mistake and focusing on improvement.

> *"I think this goes well with the staff, you know, because they are not afraid to say 'listen, I made a mistake' ..., because no one is perfect, they can make mistake, and I think that's the way you learn by making mistake*." (M04, female, nursing home manager, 2 months' management experience)

Care home managers' efforts on dissipating the blame culture in the care homes may be understood as a means of fostering a productive care work environment. It seems that the efforts may help change care workers' views and attitude toward the management and convey the message that managers were there to support and develop the care workers rather than punishing them for mistakes.

In this master theme, care home managers' perceptions, views, and values of the care work seemed to influence and embed in their management style, management practices, and recruitment strategies. Their management practices then shape, direct and foster the care home culture and the organisational structure of the care homes. This provided care workers with a foundation in which to carry out the care work in the care homes. Care home managers seemed to perceive that care workers having compatible values with the care homes or sharing the understanding, attitude, and values of care work with managers was a crucial element to establish a cohesive, trusting, effective and productive work environment.

Stryker and Burke (2000) suggest that individuals internalise role expectations attached to their social structure. The role expectation provides individuals with meanings and directs them to perform their role behaviour. When individuals are performing their role behaviour, they may also compare their internalised meanings (also known as self-meaning) with others feedback. A congruent outcome of this comparison would lead individuals to experience positive emotions while an incongruent outcome would lead individuals to feel negative emotions. Negative emotions are suggested as a form of pressure that drives individuals to modify the situation or adjust their role behaviour in order enhance the compatibility between their self-meaning and their received feedback. In a care home context, a cohesive care work team may help care workers to receive consistent feedbacks from other care workers and subsequently facilitate those care workers to conduct care practices that is in line with the expectations and values of the care homes. In addition, previous research suggests that employees perceiving a congruence between their personal values and

organisational values are more likely to experience higher job satisfaction and a sense of belongingness within the organisation (Edwards & Cable, 2009; Ren, 2013) and have better organisational performance (Dobni, Ritchie & Zerbe, 2000; Ostroff & Judge, 2007). The findings of the current study imply that recruiting care workers with compatible values with those of the care home could help to establish a cohesive work environment and facilitate their care workers to develop the work identities.

8.3.2 Managers' perceptions of boundaries for care workers.

In this master theme, participants' accounts reflected on their perceptions of their care workers' struggles to fulfil the responsibilities, meet the care home expectations, and maintain boundaries at work. Participants stated the ways in which they impressed on their care workers the meanings of the care work and their expectations towards care workers' role. These meanings and expectations seem to imply the responsibilities and boundaries that care workers were expected to assume and maintain in their care practice. Participants expressed that they perceived and recognised care workers' struggles when care workers experienced dilemmas in relation to meeting the care home expectations, fulfilling the responsibilities, and maintaining the boundaries in the care practice. Participants stressed their concerns and the consequences of care workers stepping over or crossing the boundaries. Furthermore, participants shared their experiences where they helped care workers to navigate the boundaries or prevent care workers from stepping over or crossing the boundaries.

8.3.2.1 Managers' supervision model informing care workers' responsibilities and practices.

Many participants seemed to conceptualise boundaries as job descriptions, principles, or guidelines, which inform their care workers about their responsibilities and roles in the care homes. *"We know what our guidelines are. ..., It's in policies and procedures and it is made abundantly clear to everybody as part of their job role."* (M03, nursing home manager, 13 years' management experience). It seemed that providing training courses to care workers was a means of introducing guideline and job descriptions as well as to reassure care workers that they were supported in conducting the care practice. Participants felt that it was important to provide training courses to their care workers so that care workers could understand what care work entailed and provide care to residents in a correct and safe manner. It may be understood that training courses allow care workers to learn about the skills and knowledge of the care work as well as the meanings of care work and a care worker's responsibilities. The training that participants provided to their care workers seemed to vary

from one to another. Some participants employed both eLearning and face-to-face training to equip their care workers for care provision, whereas other participants felt that eLearning was not an ideal method to deliver training. It is worth noting that eLearning and face-to-face training did not seem to be perceived by care home managers as sufficient to prepare their new care workers. The majority of participants mentioned that peer-led mentoring was put in place to assist newly recruited care workers to learn about care work, and the routine, values, and care practices of the care homes. Some participants stated that the mentoring might last one to two weeks depending on a new care worker's progress with care provision. In some cases, the mentoring was provided to new care workers before they received face-to-face training.

> *"I arrange for them to have what we call, a buddy or a mentor. …, They will work with that same person, ideally for a minimum of a week and sometimes two weeks, …, They would also do what we do here is eLearning. They learn electronically and they have to go through that so that they can show evidence that they have an understanding of what's expected of them and health and safety fire, safeguarding, all these things that they have to do, electronically. And they also have to do them face-to-face, but not in the first few weeks, but within, at least, three months, they have had all that training face-to-face."* (M01, female, nursing home manager, 20 years' work experience)

It seemed that some new care workers may learn about care work while working with other experienced care workers and then supplement their learning through face-to-face training or eLearning. Thus, new care workers may develop the concept of care responsibility through implicitly interpreting other care workers' care practices and understanding of care work. In many cases, peer-led mentoring may be considered an effective way to help new care workers grasp the meaning of care work and their work responsibilities. In identity theory, many scholars emphasise the significance of social interaction. For instance, Stryker and Burke (2000) suggest that individuals internalise meanings attached to the social structure they are in through the processes of social interaction. Internalising meanings is suggested as a means of establishing individuals' identity in a given social structure. Thus, managers employing peer-led mentoring to new care workers may not only facilitate them grasping the meaning of care work in general but also help develop their identities of being a care worker in that care home through the social interaction with both new and experienced care workers.

It is worth noting that peer-led mentoring may involve new care workers learning about care work through other experienced care workers' understanding or implicitly interpreting others' care practice. This may lead to subtle differences between a new care worker's perception

of their responsibilities and a care home manager's expectation. In some cases, some care workers did not reach a mutual understanding of care work with their managers in relation to the job responsibilities and boundaries. Participants felt that it was important to provide feedback or a reminder to their care workers in order to clarify the misunderstanding that their care workers might have towards the responsibilities and to enhance their care workers' care practice. Many participants often used '*there is a limit',* '*you need to know your limitations*', '*draw a line*', *'we have regulation and policy'*, or '*it is not acceptable*' to address a care worker's care practices and responsibilities in the care homes. It seemed that it was unrealistic to list every possible instance that a care worker might encounter in a care practice and explain the accepted and/or expected attitude and behaviours. Participants seem to provide their care workers with the principles or guidelines which were used to guide or inform their care workers the meaning of the care work, the responsibilities and the expected work attitude in care work. For instance, many participants emphasised the importance of care workers promoting residents' autonomy in the care practice. This may be considered as one of the principles directing a care worker's care practice. One participant discussed the concept of promoting residents' autonomy by describing some care tasks and what he expected from the care workers' care practice.

> *"Your duty of care is not to do anything with them (residents) that they don't want you to do with'. So if they don't want to wear a particular jumper, they don't have to wear that particular jumper, not forced on them, whatever, so whenever you provide care, you know, what is the best for that residents? Give them what they want. You know, and that's part of our basic training, is never doing anything with a resident without asking them first"* (M09, male, residential care home manager, 4 years' work experience)

It may be understood that the example instances were used to illustrate the principle of respecting residents' autonomy to care workers. Moreover, this participant's account suggested that the care workers were required to adopt the principle and generally apply it into their care practice. It is worth noting that this participant's account reflected that care workers might be required to make decisions based on their own evaluation of whether their care practices was in a resident's best interest. Deci and Ryan (2000) suggest that individuals have a need to experience a sense of volition, freedom, willingness to make decisions while performing an activity. Care home managers introducing the principles of care work to care workers might be understood as a means of encouraging care workers to take the ownership of their care practices and fulfilling their autonomous need.

8.3.2.2 Conceptualising care workers' boundaries.

Many participants stressed that they often encourage their care workers to spend time with residents to learn about their life histories, preferences, and needs so that the care workers could establish a trusting relationship with the residents. Many participants expressed that it was important for their care workers to demonstrate their understanding of where the boundaries of interacting with residents lay and to maintain the boundaries throughout the care practice. Some participants pointed out that care workers behaving or interacting with others beyond their role and responsibilities was considered unacceptable. They stressed that a care worker's care practice, behaviour and social interaction with others should be consistent with their role and responsibilities.

> *"Obviously they (care workers) are friendly, they're getting to know the residents and the stuff like that. but there is a line you draw, and you know this. I mean we had, one of our residents actually is quite flirtatious with one of our care staff, and obviously that's, that wasn't the member staff who was crossing, pushing the boundary, that was a resident obviously toward the member staff, …, they (care staff) know the limitation, what is acceptable and what isn't."* (M07, nursing home manager, 24 years' management experience)

It seemed that care home managers expected care workers to fulfil the job responsibilities while being aware of the appropriateness of their care practice. It may be assumed that the concept of the appropriateness within the care practice is associated with the meanings of the care work, and care home culture and values. Therefore, care workers may be required to learn about what the care practice appropriateness entailed in that care home through interpreting others' care practice, and care home culture and exceptions. For instance, some participants felt that having physical contact with residents was only considered acceptable when the residents actively expressed their needs for comfort. It may be understood that having physical contact with residents was perceived by these participants as a means of offering emotional reassurance to residents. Thus, it is likely that their care workers would perceive that it is inappropriate to initiate physical touch or contact with residents who have not indicated a need for it.

> *"We don't encourage people to hug or kiss or anything like that. But if um if someone says I need a hug, give them a hug, you know, you can see they are upset. 'Are you okay? Do you need a hug or something' and then they will hug you, you know?'* (M09, male, residential care home manager, 4 years' work experience)

On the other hand, some other participants felt that physical contact was a way to emotionally engage or connect with residents in these settings. Thus, they felt that it was appropriate for their care workers to have physical contact with residents as a means of expressing care workers' emotional engagement in their care practice. It may be assumed

that their care workers are likely to perceive having physical contact with residents to express their emotional engagement as a part of the care practice.

> *"We hug our residents. We hold their hands. We get to know them as people. They become part of our family so that they feel included. The family members love the fact that they are cared for in that way, because that is care, yeah. This whole idea, have you had a not touch policy. Could you imagine we are social human beings, yeah, who need social engagement? That is why isolation is seen as a kind of prison sentence or a punishment"* (M02, female, residential care home manager, 10 years' management experience)

It may be assumed that care workers working in different care homes may internalise different cultural meanings of a care worker's role. Thus, they might conceptualise a slightly different set of roles, responsibilities and boundaries depending on the culture of care homes in which they work. This may particularly influence care workers who have left a previous care home and joined another, because they will be required to adjust the ways in which they conceptualised their role, responsibilities, and boundaries in care practice.

Care home managers perceived a care worker handling a resident's money as inappropriate. Some participants felt that any money which did not go through care home administration could potentially cause misunderstandings between the care workers and residents.

> *"Someone's got dementia, they will rely on a person in particular, and sometimes they ask you to do things like shopping or whatever for them, and afterwards they say 'I gave you £100, and where is it?' this kind of thing, so (care workers) has to be very very certain that there are limitations to what they can do.* (M07, female, residential care home manager, 30 years' management experience)

It seemed that misunderstanding between care workers and residents could be detrimental to the interests of the residents and the reputation of the care workers and the care homes. Thus, avoiding this area of misunderstanding seemed a priority by care home managers. In addition, some participants stated that some residents or residents' families gave expensive gifts or money to their care workers as a means of expressing the gratitude for care workers' care provision and support. It seemed that care workers accepting any expensive gifts or money from residents or residents' families might create a potential misunderstanding or undue expectations between care workers, residents, and residents; families. Many participants expressed that it was important to raise care workers' awareness of the possible misunderstanding of accepting gifts or money from residents and residents' families.

> *"We've got the policy on it, …, they are not allowed to accept any monetary gifts or anything like that, staff know this, you know, care staff know this from their interview and various type of professional boundaries."* (M08, female, residential care home manager, 30 years' management experience)

It may be understood that care workers established their concept of boundaries through learning the meanings of the care work and implicitly interpreting others' care work experiences, and explicitly being informed by care home managers.

Implementing the principles of care work also required care workers to make active decisions in their care practices by taking the residents' best interests and boundaries into consideration. This may imply that care workers experience dilemmas when trying to fulfil their responsibilities and the care home expectations while promote residents' best interests.

8.3.2.3 Dilemmas associated with maintaining boundaries.

Participants discussed their observations where care workers experienced dilemmas in the care practice, especially when care workers tried to implement the principles of care work while considering residents' social and emotional needs. It seemed that working in a care home may lead care workers to blur the line between the public and private spheres, especially as a care home is often conceptualised by care workers as the residents' home (see chapter 5). In order to convey the values of care homes in making the environment more homely for residents to care workers, some participants used the care workers' parents as analogies to convey the caring attitude expected towards residents.

> *"We believe in the mom treatment…, would you do anything to your mother that you would do to the residents, would you put the arm? Would you talk to her in the bed, you know, whatever you want for your mother, I want you to have for your residents, so if you love your mother, the resident is just like your mother,* (M09, male, residential care home manager, 4 years' management experience)

The majority of participants expressed that it was important for their care workers to establish a close relationship with residents. It seemed that care home managers perceived a close relationship between the care workers and residents as an indication of quality care. Many participants stressed that they encouraged the care workers to form relationships with residents. However, they later emphasised that care workers' relationships with residents should be built based on trust and respect. It seemed that the relationship which care home managers encouraged the care workers to established with the residents had a purpose in enabling care workers to provide quality care to the residents.

> *"They need to build a relationship because that's how the residents will respond to you, because they trust you. You need to have that relationship with them. There is a limit. Like I say, you wouldn't take a resident home with you. You wouldn't build a relationship with their family. You wouldn't be texting the family on your personal mobile phone.* (M03, female, nursing home manager, 13 years' management experience)

It may be understood that care home managers expect care workers to care for residents as if residents are care workers' own parents and develop a close trusting relationship with residents. However, managers seemed to expect care workers to not to go beyond their role or develop a personal relationship with residents.

Many participants felt that the care workers had better care practices and higher satisfaction at work when they had close relationships with residents. Those participants also expressed that they understood that the care workers with close relationships with the residents might be more likely to emotionally attach to the residents. Some participants stressed that they valued the fact that some care workers were intrinsically motivated to provide care and emotional support for residents but worried when the care workers became overly emotionally engaged at work.

> *"We have some carers (care workers) that got so emotionally involved with the residents, that they will come in here in their own time, because there is a bad deteriorating and one of them sit with them for hours and hours and hours, and I said that's wonderful that you're doing that, that's really delegation, but don't make yourself in, don't burn yourself out, coz you need to be there for your family, and you need to be there for us as a member of staff, and you are not expected to be here 24/7"* (M06, female, nursing home manager, 6 years' management experience)

It may be understood that managers acknowledged residents and care workers' social needs in the care homes and might view care workers forming close relationships with residents as a means of fulfilling residents' and care workers' social needs. Self-determination theory suggests that individuals have a tendency to interact, to connect with others, to reach a sense of belongingness (Deci & Vansteenkiste, 2004), and to build meaningful interpersonal relationships with others in a social group (Moller, Deci, & Elliot, 2010). Experiencing meaningful and reciprocal relationships with others in that social group allows individuals to experience a sense of trust and intimacy and to fulfil their need for relatedness (Moller, Deci, & Elliot, 2010). The findings of the current study draw attention to the importance of a manager's encouragement of care workers forming close relationships with residents as these relationships may establish the trust between care workers and residents. This may then lead care workers to perceive residents akin to a friend or an older relative rather than a client. Care workers are then caught in a dilemma between trying to implement the care home values in caring for residents and forming close relationships with residents and also maintaining a boundary. Many participants acknowledged that it could be difficult for care workers to have a clear boundary while maintaining their close relationship with the residents.

> *"You want to feel that you are compassionate and you are listening to individual at the same time you have to have distance, you have to professional distance, so it can be incredibly difficult to know where to draw that line, because you want to able to be almost like a friend to people who obviously come into the home, but you know you cannot be that, they (care workers) have to have that line in there."* (M06, female, nursing home manager, 6 years' management experience)

Many participants stated that they encouraged and expected their care workers to communicate and interact with residents. Some participants emphasised that care workers should abstain from discussing their personal affairs with residents. They felt that it was irresponsible for care workers to discuss personal problems with residents because it can invoke negative emotions from residents.

> *"Staff, they shouldn't go and talk about their problem, the private problem with residents, because the residents are in the position of vulnerability. And even if it's nothing, but you like 'oh, I just had a fight with my husband last night.' And you go to tell the residents, they will be sorry for you, they will cry for you.* (M04, Nursing home manager, 2 months' management experience)

However, some residents were reportedly interested in learning about their care workers. It may be assumed that a reciprocal communication between care workers and residents helped the development of their relationship. Many participants acknowledged that it could be difficult for care workers to avoid revealing any personal matters when interacting with residents. However, those participants felt that it would justifiable or practicable for care workers to share a few positive and joyful personal matters.

> *"You are not gonna come in and work and put your personal problems onto a resident, staff know that, just common sense, and there is crossover boundary here, obviously if we got some residents who know member staff better, coz they might just say, they might take interest maybe, or how many children you got, or are you married? Or your habit or your interest, but any personal issues that you have or anything like that, then they are not, they are not discussing with the residents, and the staff know that not to discuss with residents. So, there is no personal friendship made up."* (M07, nursing home manager, 24 years' management experience)

It seemed that care workers sharing a few positive and joyful personal matters with residents might be perceived as a means of establishing a reciprocal communication without invoking a resident's negative feelings. This may be understood that the boundaries in care work are not clearly defined principles or issues. Instead, managers might conceptualise the care workers' boundaries as blurred and circumstantial and care workers might require managers' guidance to navigate the boundaries.

8.3.2.4 Helping care workers navigate and maintain boundaries.

Many participants expressed that care workers may sometimes push on or step on boundaries without intentionally doing so. They felt that it is important to pay close attention to their care workers' care practices so that they could facilitate their care workers in maintaining the boundaries or intervene to prevent care workers crossing boundaries.

> *"It will be one of the situations where, if the need of role we notice somebody is getting too emotional involved, we will then step in, and we will say 'right, this is not right you know what's happening.' Sometimes they might not even know it's happening to them. You know, get completely caught out with it, they don't know it's happening. You just need to have a little chat and say, 'this is too much you need to cut it out or step it out."* (M06, female, nursing home manager, 6 years' management experience)

> *"You came close to boundaries, when you kiss him on the cheek without asking and thing like that you know, so it's part of observation, and monitory and as I said all day watching, you know, there is always someone watching, senior is always down there, the other manager is always down there during the day, so there is always someone seeing something."* (M09, male, residential care home manager, 4 years' work experience)

Moreover, some participants encouraged their staff to use physical contact to offer emotional reassurance to residents whereas some participants discouraged physical contact between staff and residents. It was clear that participants had different views about care workers using physical contact to reassure or offer emotional support to residents. Nevertheless, many participants expressed that it is important to impress on care workers the appropriate extent of a care workers' physical contact with residents.

> *"There are boundaries, okay, you don't kiss people on the lips, or things like that, you give them a kiss on the cheek, fine, you put your arm around them while walking or give them a little bit of hug. Who doesn't like a hug? Um, put your hand on their leg? No, when you sit there and put your hand on their hand, that type of thing, there is a boundary."* (M09, male, residential care home manager, 4 years' work experience)

It seemed that many participants felt that care workers might inevitably have some physical contact with residents when offering them emotional reassurance. Thus, introducing or explaining the appropriate extent of a care workers' physical contact with residents may help care workers to have a clear notion of navigating the boundaries in relation to offering emotional reassurance and having physical contact with residents. Most of the participants stated that they impressed upon their care workers the appropriateness of social interaction with residents and residents through training, supervision, and feedback. Yet, they acknowledged that some practical issues may not be fully covered or conveyed and felt that some issues required care workers to learn through observation at work.

> *"If you don't see somebody else doing it in the building, you shouldn't be doing it either…, you will see it in the building then you know that it is a normal behaviour. We have had residents in the past that have been sexually disinhibited and so we have had to manage that in a way. It's interesting, because our staff then become very very less tactile with them. They don't encourage it. They don't give them anything to believe that this is what this behaviour is normal. We work with it."* (M03, nursing home manager, 13 years' management experience)

According to social identity theory, the norms and values within the group can act as guidance for an individual's appropriate behaviour (Ashforth & Mael, 1989). When individuals perceive their membership of the group as meaningful, they are more likely to act in accordance with what is considered as appropriate in the group (Tajfel, 1981). The findings of the current study draw attention to the importance of care workers learning via observations. It may be understood that each care home has its own culture and norms which contain the information in relation to the acceptable standard, behaviour, and adequate ways of conducting care practice. It may not be possible to verbally convey the norms in the care homes. Care workers learning via observations may be understood as a means of learning the appropriateness of care practices and interaction with residents in that care home. This could then guide or direct care workers to navigate the boundaries.

One participant pointed out that care workers were sometimes less experienced in managing situations where monetary gifts were offered. She felt care workers need to be shown the way in which care workers could manage the situation without crossing boundaries or inducing a resident's negative feelings. One participant shared that she told her care workers that accepting a box of chocolate was fine and offered an alternative for residents and families who would like to offer monetary gifts to care workers or the care home. In some cases, she also showed and explained the appropriate way to manage the situation to the care worker.

> *"Care assistant came to me not that long ago said 'look, [resident] gave me this money, and she said I shouldn't tell anyone'. And I said 'well, you have done the right thing, and we will put it back to her personal account, rather than upsetting her, we recorded it, and she has a personal account, and we will put it in there.'* (M08, female, residential care home manager, 30 years' management experience).

It may be understood that managers not only acknowledged the dilemmas care workers may experience when maintaining the boundaries at work but also help care workers navigate the boundaries.

8.3.2.5 The consequences of crossing the boundaries.

Many participants felt that it is essential for care workers to utilise the correct methods in care so that they can avoid causing harm to the residents. When care workers "*cut corners*" or did not utilise the correct techniques, it was considered breaking the boundaries. One participant used the term "*abuse*" to describe the negative consequences care workers might cause to residents.

> *"What is abuse? It's by grabbing someone and not using correct moving and handling techniques. So, if I grab your arm there and pull you out, you can end up big bruises, …, Because their skin is so thin, and they are so brutal, and bruises are so easily, or you get skin tear, or something like that, so you got to be so careful, and that's why you have to use proper moving techniques." (*M09, Residential care home manager, 4 years' work experience)

It seemed that care workers conducting unsatisfactory care practices or providing care in an unsafe manner was conceptualised as crossing their boundaries. This could lead to harmful care outcomes and negatively affect residents. Moreover, it seemed that the purpose of providing feedback for care workers in order to improve their care practices was to ensure residents received appropriate quality care. Some participants expressed that correcting mistakes and improving care practices were part of a care worker's role and responsibilities. In some cases, when care workers made a mistake in their care practice, they would be given an opportunity so that they can improve at work. However, some participants stressed that when care workers failed to demonstrate improvement at work, they would be removed from the care home.

> *"I am not someone that's not going to tell you if you are doing something wrong. I will tell you. I don't shout at them. I do tell them. But I expect to see improvement. If it doesn't happen then it doesn't happen. They will know that I have disciplined, and I have sacked some of the loveliest people that I really liked. Even my best friend's daughter who is working here. But actually, it's the way in which you do it."* (M02, female, residential care home manager, 10 years' management experience)

It may be understood that that care workers failing to improve their care practices is perceived as crossing the boundaries which would require a care home manager's immediate intervention. Furthermore, many participants expressed that when care worker behaviour involved violence towards residents or other fellow care workers, they are immediately removed and liable for abuse. One participant describes how one care worker's abusive behaviour impacted residents, her fellow care workers and the care home.

> *"A couple of years ago, I have a care assistant that kicked residents, she actually went to court, she lost her job, of course, quite a long time, there was a full investigation, and she went to court and found guilty, that again, you see, it's very difficult for, another difficult thing for managers and to the care staff reported it.*

> *They reported that their colleague, that was a hard event, they saw her do it, so they felt awful, they felt it's very very hard"* (M08, residential care home manager, xx years' management experience)

In this master theme, participants applied various methods to convey the meaning of care work, care workers' responsibilities, and boundaries to their staff. Participants expressed that their staff's care practices were required to meet the residents' best interests and the staff's responsibilities, including maintaining boundaries. Participants expected their care workers to form a trusting relationship with residents, be compassion in meeting residents' emotional support needs, while rejecting residents' gifts. They acknowledged the dilemma that care workers are asked to form trusting relationships and yet not get too close. Participants discussed the feedback and guidance that they offered to help their care workers to negative the boundaries. Appropriateness seems to be a key concept to apply when navigating the boundaries and required care workers' careful observation of others' practice and interaction in the care home. This implied that the meanings of appropriateness might be slightly different from one care home to another due to different care home cultures. Care workers failing to provide adequate care or improve care practices or behaving violently towards residents or other care workers were considered as crossing the boundaries. This could have adverse or harmful effects on residents' care, safety and wellbeing and work atmosphere in the care homes. In this case, immediate interventions were required to prevent the adverse effects.

8.3.3 Managers' support for their care workers

In meeting care workers' support needs, the participants' accounts reflected their perceptions that care workers' support needs included career advancement, effective communication at work, recognition and wellbeing. Participants expressed that their understanding of care work and staff helped them to recognise care workers' support needs. Some stressed that they modified their management practices in order to better work with their care workers. Many participants felt that it was important to express their acknowledgment of care workers' effort at work and to promote care workers' wellbeing. Furthermore, participants shared their experiences where they perceived the limitations and obstacles in meeting their care workers' support needs.

8.3.3.1 Facilitating care workers' career advancement.

The majority of the participants felt that they played a key role in advancing career development for their staff. Many participants believed that care worker progression had the potential to enhance the quality of care provided for residents. One participant suggested

that all the care workers had the potential to take on a manager's role in the future and wanted to support staff in advancing their career.

> *"They (care workers) are the future managers. If you have got to get them thinking like a manager, If you train them to be a manager, whilst they are on the floor, that care delivery to that person is spot on. They are the ones that are effectively managing the resident's care. They are the ones that deliver every part of that service to the resident. If you develop them and give them the autonomy, if you give it to develop the staff, give them autonomy to actually understand how they make decisions, how they have worked in the resident's best interest, how to improve that and what they want the team to do it, you train them to be managers of their care, because that is what they are."* (M02, female, residential care home manager, 10 years' management experience)

Facilitating care workers' career advancement may be seen as a means of motivating their care practices and work performance. According to goal-setting theory (Locke & Latham, 1990), individuals who have a specific and challenging goal are more likely to achieve a higher level of performance at work and to adjust their efforts in order to achieve the goal. It is worth noting that the participants emphasised the significance of providing training and support to care workers to achieve the goal. Although the managerial support is widely discussed in goal-setting theory, the participants' account pointed out the importance of providing managerial support and meeting care workers' autonomous needs in facilitating care workers to achieve the goal.

On the other hand, some participants felt that the care workers with different career motivations development might require different support. One participant stressed the importance of him supporting his staff in accordance with their own goals.

> *"I don't know what's your career prospects are, …, but you must tell me what do you want, what you are aiming for? 'I just want to be a carer (care worker)'. I say 'well, then NVQ2 is fine, if you worry about the residents'. So for her, her thing is NVQ2, isn't it? so my thing for her would be NVQ2 at that moment."* (M09, male, residential care home manager, 4 years' management experience)

This may be understood as a means of meeting care workers' autonomous needs where they were encouraged to take the ownership of their career advancement. Many participants in the study stated that learning about their staff's goal at work enabled them to provide effective support for their staff. In some cases, participants might find some care workers who were less ambitious in career advancement and willing to accept the goals that mangers set for them.

> *"We have our own objectives, so home objectives, and we will have team objectives, and in the appraisal they will set their objectives, so we discuss where we want them to be, where they want to be, where I can see them going, basically how they are*

> *going to get there, and what support we are going to give them to do that, some people very motivated, they will come up with a lot of objectives of what they want to achieve, what they want to be in a year's time. Other people, just not, 'you tell me, you tell me what you want me to do.'"* (M07, female, nursing home manager, 24 years' management experience)

Some participants felt that it was about a care worker's choice and decision about their career advancement rather than a care worker's capability to deliver quality care to residents. When care home managers value care workers' autonomy and foster care workers' career development, it seems that care workers are more likely to feel empowered and to take on more responsibilities (Barry, Brannon & Mor, 2005; Colón-Emeric et al., 2006; Corazzini et al., 2014). It may be understood that care workers' sense of empowerment is fostered by care home managers' trust and shared responsibilities which involve care home managers relinquishing some extent of their control over care work. Moreover, self-determination theory argues that individuals have a need to experience volition, a sense of freedom, and allowed to make decisions while performing an activity (Deci & Ryan, 2000; Deci & Vansteenkiste, 2004). The satisfaction of autonomous needs helps individuals to internalise extrinsic values and regulations which subsequently enhance individuals' intrinsic motivation and performance (Baard, Deci & Ryan, 2004; De Cooman, Stynen, Van den Broeck, Sels & De Witte, 2013).

8.3.3.2 Fostering effective communication.

Most of the participants discussed issues that arise from ineffective communication among care workers, residents, residents' families and care home management. In some cases, participants perceived that care workers' ineffective communication could negatively impact the teamwork and work atmosphere. Some participants indicated that having a sufficient understanding of their care workers was a key to helping care workers improve their communication with their colleagues and residents in the care homes.

> *"He is a very good carer (care worker), he loves his residents, he cares for them very very well. But he has this tendency to completely blow his top and shout at other staff, um because he got crossed, because he has a certain high standard, he felt other staff didn't. But he didn't stop to think about anything else, he will just literally say what he thought. ..., so I told him about that technique for calming him down first, ..., he still got that high bar, but he, obviously then can escalate his knowledge to whoever he got the problem with, and obviously he generally resolve it and I have to say his last appraisal he got really really good feedback, because he has done really well*."(M06, female, nursing home manager, 6 years' management experience)

Previous research draws attention to the negative impact of ineffective communication and the quality of care that residents receive in the care home (Berta et al., 2010; Scott-Cawiezell

et al., 2006; Zheng & Temkin-Greener, 2010). Managers' interventions, including addressing issues associated with ineffective communication and offering care workers practical strategies to improve, seemed to improve the effectiveness of the care team.

Many participants acknowledged that their care home employed migrant care workers and therefore it was important to take the cultural differences into consideration when assigning work to their staff.

> *"We had one, …, she was strictly no men, but she had worked here for 5 years, she was an excellent carer (care worker), excellent, excellent carer (care worker), …, But she was strictly no men and she worked here for 5 years, never worked with a man.* (M09, male, residential care home manager, 4 years' management experience)

Participants expressed that the adjustments were made in accordance with care workers' needs. Nevertheless, this required care workers to communicate with managers and inform them about their support needs. Some participants expressed that some care workers were not aware of their needs for establishing an effective communication with others. In some cases, the lack of this awareness could lead to conflicts between care workers and managers. It seemed that the lack of effective communication may exacerbate the misunderstanding between managers and the care workers, and further increase the tension between them. One participant shared her experience of communicating with a care staff from a different cultural background where she modified her communication style and reached a better communication outcome.

> *"We have a gentleman here that is a bit of concern. Him being told what to do by a woman is very difficult for him to accept. He is the most amazing carer (care worker), but he and I have come to loggerheads. …, I did a training course with our HR manager and she made me think, well, actually, it is his culture. If you change your position when talking to him, maybe you will get a better response. If I go to him and say, I need your help, this is what we need to do, how do you suggest we get there? I am not telling him what to do, but I still get the desired result.* (M03, female, nursing home manager, 13 years' management experience)

One participant noted that it can be difficult for the care workers from different cultural backgrounds to work together. Thus, he introduced clear guidance to all the care workers so that they would know their job as well as their other colleagues' job. It seems that the guidance served as common ground for care workers to communicate, interact, and work together.

> *"You got 31 staff, everyone is different, they all have different nationalities, got different customs, things like that, you know, if we all work on the same set of rules and regulations and our policy and procedure, they will all do the same thing, we don't step on each other's toe and respect the culture, and things like that, and*

> *everyone is treated equally."* (M09, male, residential care home manager, 4 years' management experience)

In addition, many participants felt that many interpersonal issues were caused by ineffective communication between care workers and residents. In order to facilitate the communication in the care home, some participants felt that they were required to brief or relay messages to care workers and residents and emphasised the importance of promoting positive messages.

> *"Last week a resident made a complaint about a member of staff, so I feedback to the member staff, um, then they, this member of staff went into this resident again on another occasion, I got feedback from the resident, and the resident said absolutely brilliant, no problem at all, whatever you said to them is worked. So, it's feeding that back to the member staff as well, …, everybody feels demoralised a bit and like demotivated. Once they get that positive, kind of like well done, you know, …, then you can just totally see that lifts them and motivated again."* (M06, female, nursing home manager, 6 years' management experience)

Some participants found that care workers with effective communication skills seem to work better with their fellow care workers and have a closer relationship with their colleagues. A mutual understanding between care home managers and care workers may be essential, especially if they are from the different cultural background. Identity theory scholars argue that individuals occupy a number of different roles in society. Within a given social structure, an individual's experience will be influenced by their interactions with others and the meanings that are attached, such as ethnicity, nationality, and religion (Burke & Stets 2009; Stryker & Burke, 2000). Thus, understanding how others interpret their experiences in the care homes may be essential in the development of effective communication. It is likely that care workers with different cultural backgrounds may interpret their experiences differently. When care home managers do not have the awareness of the possible interpretations a care worker might experience, the misunderstanding may intensify and subsequently impact on management practices, work environment and atmosphere, care workers' support, the support provided to care workers, commitment, and job satisfaction (Berta et al., 2010; Bowers, Esmond & Jacobson, 2000; Scott-Cawiezell et al., 2006; Postmes, 2003; Postmes, Tanis & De Wit, 2001; Zheng & Temkin-Greener, 2010)

8.3.3.2 Giving recognition and ensuring staff's wellbeing.

Many participants mentioned that many of their staff felt under-appreciated or under-valued. Care home managers emphasised the importance of giving positive feedback to their care staff.

> *"You have to give people praise to appreciate what they are doing, and to recognise for people, to comment when they do something good, obviously, to be very truthful with them, be to approachable, because they will know there are somebody who are*

there to support them, um to be valued, to feel valued as individuals and as a worker (M04, female, nursing home manager, 2 months' management experience)

One participant working in a private care home described his ways of showing the appreciation to the care workers by verbally thanking them and providing financial incentives to them. However, this participant also mentioned that the owner of that particular private care home did not fully agree his ways of motivating the care workers.

> *"If he does a good job, I will say '[care worker's name], well done, it was hard work today, I will put extra hours on your pay' which I also do as well with my staff. you know, £7.5 an hour, I put 2 hours on, that's £15, you know, so (laugh) it's not gonna break the bank, so you know. Specifically, they have gone out their way, they came in specifically coz someone's cancelled the shift, they come in and work really hard, they stayed extra next hour or two hours, I will definitely put some extra on, I will show my appreciation for that. But that's my management style, I have been corrected by the owner for that, you know, I said 'well, you want them to work here, then I got to motivate them'. (laugh)"* (M09, male, residential care home manager, 4 years' management experience)

Other participants felt that attending to care workers' care needs was an effective way to support the staff and to show her appreciation for their efforts at work.

> *"I know how difficult it's going to be, (after a long shift), then you damn well do get them food, don't you. You get them small food and you get them a taxi home, so they don't have to go home on public transport and then lug themselves up a hill when it's pissing down. That is how you value the people you are working with. If they are going to spend 14 hours here, you are going to feed them. You are going to make sure they get home safe. You are going to make sure that you have done that bit for them, so that when they can go home, they can just collapse. You are going to make sure they have regular respite, so they have got the time to be able to do the crap that we've all got to do when we get out of work." (*M02, female, residential care home manager, 10 years' work experience)

Furthermore, the issue of understaffing was frequently mentioned by participants. Many participants stated that they sometimes used an agency to cover shifts. This may be understood as care home managers' efforts in ensuring that sufficient resources were in place to facilitate care workers' care practice. A few participants expressed their willingness do the care work themselves in order to alleviate their staff's workload or enable staff to concentrate on their current tasks.

> *"If I see you interacting with a resident, but I know you are going to that resident's room to change a pad, I will go down to that resident and change her pad, so you have that interaction time. I was a carer (care worker) before I was a manager. I know how to care. I know how to do the job they are doing. It does frighten them sometimes when I go in and say, I will give you a hand.* (M03, nursing home manager, 13 years' management experience)

Some participants felt that they had to ensure their care workers reach a balance between caring for residents and the care workers' own self-care, especially if they found that some care workers may have unconsciously neglected their own care needs.

> *"They have got the innate need to care. They sometimes don't value themselves very highly because they do everything else for everyone else, but they won't look after themselves, which means you will see people that will go the extra mile that would want to work ridiculous hours and you manage that, because actually they need to have time out. They need to look after themselves. So, you support them in their own self-care and development and actually what happens is the care quality just gets even better."* (M02, female, residential care home manager, 10 years' work experience)

Most of the participants indicated that it is important for care workers to avoid the negative influence of their personal problems on their care practice. Yet, it can be difficult for care workers to maintain a neutral expression when they are experiencing emotional distress. Thus, a number of participants stated that they would actively express their concern and their willingness in offering support for the care worker.

> *"If I see the long face, sadness or anger, or whatever, I always 'are you okay? Do you want a chat?' you know, generally, they, what I like is they will come to knock my door, they will come to sit and talk to me, and ... that means I must do something right, you know, they do respect my opinion of what they should do. And I will take action if they come to me and talk to me, then I will take action."* (M09, male, residential care home manager, 4 years' management experience)

It seemed that participants perceived the negative impact of care workers' distress and the positive influences of care workers' wellbeing on the care quality. Participants seemed to perceive care workers' needs for the enhancement of their self-esteem and self-care. According to Collins (2005), self-care is defined as "an integral part of multiple aspects of a person's life, including health and wellness" (p. 264). Care workers who assume the role for supporting residents often experience distress and challenging circumstances. However, there is limited understanding of the issues relating to care workers' self-care and its influences on their work experience and care practice.

Care workers often experience care work related stigma (Jervis, 2002; Pfefferle & Weinberg, 2008) and negative media representation (Kadri et al., 2018; Miller, Tyler & Mor, 2013) outside the care home. Inside the care home, they often feel their work is undervalued and underpaid (Bjerregaard, Haslam, Mewse & Morton, 2017; Himmelweit, 2007). Giving positive feedback to care workers, verbally thanking them, providing financial incentives, and expressing appreciation for their work efforts may be seen as a means of enhancing care workers positive appraisal towards themselves and subsequently increasing their self-esteem.

According to previous research, the enhancement of a care worker's self-esteem may lead them experiencing a better job satisfaction and a stronger organisational commitment (Podsakoff, MacKenzie, Paine & Bachrach, 2000; Van Knippenberg & Sleebos, 2006).

8.3.3.4 Mangers' perceived limitations in supporting their staff.

Many participants stated that their job involved complying with the numerous government regulations, policies and procedures, and expressed overwhelming feelings towards policy changes and the evaluations. On the other hand, some participants used the term "*bureaucracy*" and "*come full circle*" to describe some changes and policies. They also pointed out the counter-productive effect of *"bureaucracy"* on their care workers.

> *"They (care workers) were very disappointed, because they work very hard, you know, if you read, I would advise you to go on the internet and read about (CQC) requite improvement inspection, and read someone have got outstanding, they read exactly the same, they rate exactly the same."* (M09, male, residential care home manager, 4 years' management experience)

> *"There has been a lot of changes now, lately, very much more paper work, very much now, because we're living in a blame culture, aren't we? There is a lot of investigations and suing. If a district nurse found a bruise on one of the residents and reported it, and we have to do huge among of paperwork informing the social care services, investigation. And I can give myself a bruise now, just like that, you know, that's life, that's what happened. But you have to make sure people who are not being abused, so it's kind of turn full circle, and we've gone completely off the top now, so huge amount of time, every time we spend on paper work, making sure that every avenue every step away is documented, it's time consuming, the time you spend away from the residents."* (M05, female residential care home manager, 35 years' management experience)

Many participants expressed their enthusiasm for helping their care workers with career development. Yet, some managers discussed their concerns about retaining care workers due to the limited available positions for care workers to be promoted or to utilise advanced knowledge and skills.

> *"A lot of time, when they (care workers) gained the experience and then they moved on to NHS or somewhere else. We lost a lot of staff as well. You trained them and you give them the qualification and put them on the courses, and then they go to the NHS."* (M07, female, nursing home manager, 24 years' management experience)

> *"For the home, I would like everyone to be NVQ3, but that's being, there is not enough room for promotion. If I was a care company that has 100 homes where I can transfer people around. ..., We are one home, I cannot have that, you know, so I have to be realistic with them as well and say, you know, when you reach NVQ3 and you haven't reached senior, then maybe it's better for you to look another home where you can actually progress farther."* (M09, male, residential care home manager, 4 years' management experience)

When considering the importance of providing financial incentives to care workers, one participant stated that "*The financial bonus, no, no one likes financial bonuses"* (M07, nursing home manager, 24 years' management experience). However, many participants acknowledged that their staff often felt their income is incompatible with their work efforts and input. Some participants stated they do not have the authority to offer care workers a material incentive or a pay rise.

> *"What I think, to be honest, money is always a motivator, always, it always is, especially in this profession, because it's quite poorly paid for what they do, ..., I think the people that administer medication should get that a little bit more hourly rate, if you get somebody the wrong medication that can be very dangerous, I think they should be rewarded for doing that task, so maybe giving them a bit incentives for different tasks they do."* (M08, female, residential care home manager, 30 years' management experience)

Furthermore, the majority of the participants discuss the importance of supporting their care workers, with some even supporting their staff outside the care home. Yet, many care home managers felt that their support did not always achieve their support goals, especially when care workers' support needs were invoked by care workers' personal problems.

> *"If they (care staff) have any personal problems, I will try to help them, I will advise them to see people, ..., we have noticed a down-turning this person, the standard of her work, the tardiness, things like that, called her in, wrote it done here, she told us all about it, and we write to the doctor, say 'we worry about it', it's not like she is going to do anything, you know, but we have notified them she needs help and she needs help now, not 6 months' time, ..., so we have done whatever we can*." (M09, male, residential care home manager, 4 years' management experience)

It seemed that participants did not hesitate to provide to the care workers but needed to be aware of the limitations of their support. This awareness could help managers focus on care workers' support needs and prevent managers feeling frustrated when their support does not achieve their goals. On the other hand, one participant expressed a sense of helplessness in supporting her care workers, especially care workers who were not naturally compassionate.

> *"If you're compassionate for your caring ... if you like to be as a carer (care worker), loves caring for residents, that will be your satisfaction. That you feel that you have done something good for your residents, that will be your biggest satisfaction. ..., They (care workers without compassion) will never be satisfied with anything. ..., because there will always be something that's off, we won't be able to provide, we can't provide, we can't please everyone. That's the right answer.* (M10, female, nursing home manager, 5.3 years' management experience)

It seems that the care home manager experienced difficulties in helping her care workers to internalise the value of the home when the care workers had very different values from the care home values.

8.4 Limitation

There are various limitations to the current study. First, this study conducted a qualitative research to understand how care home managers help their staff to deliver quality care for residents and support their staff at work. It is apparent that the care home managers participated in the current study were generally supportive of the research project. Yet, there is a possibility that they may present themselves positively or be protective of their care homes. Future studies may focus on filed observation to explore care home managers' management style, care home culture, and effective communication. Second, the findings of this study suggest that managers with different values or management practices seem to perceive their care workers' support needs differently. Thus, effective supports seem to differ slightly from one care home to another. However, the ways in which care workers perceive managers' support and how such perceptions influence care workers' motivations of remaining employed remain unclear. Future studies may explore care workers' views and perceptions of managers' management practices and supports in relation to care workers' motivation of continuing their role.

8.5 Conclusion

The current study reveals that care home managers' perceptions, views, and values of the care work seem to influence their management practices and recruitment strategies. Their management practices shaped, directed and fostered the care home culture that provided care workers with a foundation to carry out the care work in the care homes. Moreover, managers acknowledged the dilemma their care workers might experience at work when the needs of intimate care conflicted with boundaries and felt they needed to help their care workers negative boundaries and avoid the adverse effects of crossing the boundaries.

The findings of the current study reveal that managers' values and management practices seem to influence the ways in which they provide support, convey their expectations, and foster the work environment for their care workers. It is worth noting that care home managers in the current study seem to differ in their perception of what are care workers' support needs and what is adequate support. The care home managers who emphasised care workers' empowerment seemed to describe adequate support for the care workers as fostering the care workers' career development, sharing information with care workers, encouraging care workers' autonomy and involvement in managerial issues. The findings of the current study show that the effective supports for care workers in continuing their role include facilitating career advancement, meeting their autonomous needs, fostering effective

communication, the enhancement of their self-esteem, and promoting their self-care and wellbeing.

This revealed the significant role managers had in facilitating care home culture, informing care workers' role, responsibilities and boundaries, and meeting care workers' support needs. However, the findings did not suggest that care home managers should be entirely responsible for the unmet care workers' support needs or staff turnover. Considering the limitations participants perceived and revealed in the current study, this may point to managers' support needs in managing the unmet care workers' support needs.

CHAPTER 9
GENERAL DISCUSSION AND CONCLUSIONS

9.1 Discussion

The aim of this thesis is to investigate care workers' perceptions, experiences, and motivations of continuing their role as a care worker. The objectives of this thesis are to further our understanding of care workers' perceptions and experiences at work, adding to the theoretical knowledge on care workers' motivations to continue working as a care worker. This is particularly relevant topic in the light of an ageing population in the UK and the chronic issues of high turnover and understaffing in the care homes. Three research questions were postulated at the beginning of this thesis and in this chapter, I will address the extent to which these questions were answered and gaps which future research can address.

1. What are the care workers' perceptions and experiences in providing care for residents from the admission to the care home up to the end of life?
2. What are the influences or relationships between care workers' perceptions towards their work roles in the care homes, psychosocial attributes, psychological needs, and motivation, and the care workers' organisational commitment and job satisfaction?
3. What are the care home managers' perceptions on the ways in which they facilitate their care workers in the care homes?

Through acquiring a better understanding of care workers' work identities and motivations in regard to continuing their role, this thesis seeks to inform future interventions and contribute to efforts to enhance retention, care practice and care home workers' wellbeing. The following sections highlight contributions made by this thesis, such as understanding the impact of incompatibilities between care workers' work identities and care practice, exploring how to foster effective care home cultures, predicting care workers' job satisfaction and organisational commitment, and better understanding the value of social interaction and social environment in promoting care workers' work identities and motivations of staying employed.

9.1.1 Understanding the impact of incompatibilities between care workers' work identities and care practice.

Study 1 reveals the barriers and challenges care workers encountered at work impeding them from fulfilling their role. The difficulties include feeling obliged to meet the expectations of residents' families which may compromise residents' sense of autonomy or best interests, encounter emotional labour of caring, and experience ineffective teamwork. The findings of study 1 suggest that the difficulties care workers experience at work may result from the incongruences between their work identities and care practice. Care workers learn and internalise the regulations, expectations and values of the care work in the care homes which facilitates their development of meanings of being a care worker. According to participants' accounts, these meanings may be understood as respecting residents' autonomy, working with colleagues, residents' families, and other healthcare professionals to provide care to residents in a consistent and fair manner, avoiding harm to residents, and ensuring the best interests of the residents. Interestingly, these meanings are almost identical to the ethical principles defined in ethical research (Bollig et al., 2015; Hosseinabadi et al., 2019; Preshaw, Brazil, McLaughlin & Frolic, 2016; Tønnessen, Solvoll & Brinchmann, 2016). It has been suggested that the ethical principles function as guidance for the care providers' implementation of ethical values in their care practice. This thesis further suggests that the ethical principles have an important role in the development of care workers' work identities. Moreover, the difficulties care workers discussed in study 1 might reveal that they experienced clashing ethical principles. Tønnessen et al. (2016) stress that nurses found reaching an appropriate balance between the conflicted ethical principles challenging and difficult. Study 1 also reveals similar struggles experienced by care workers between their work identities and their day-to-day care practices. This implies that care work per se does not directly impose difficulties on care workers or barriers on their care practice. The difficulties and barriers may be led by the incongruences between the real job of caring and care workers' capacity for exercising their work identities. These findings may be related to the work of Burke and Stets (2009), suggesting that when individuals experience an incongruency between their self-meanings and perceived situational meanings, or between self-meanings and the feedback from others in a given social structure, they will modify their behaviour in order to reach a sense of identity verification. However, on failing to reach identity verification, individuals are more likely to experience depression and distress. Our findings suggest that when care workers experienced a significant incompatibility between their personal values and self-meanings of care work and the actual care practices in care homes, they were likely to leave the position. The findings imply that the value congruence

between care workers' personal values and care homes' values and the consistent care home culture may eliminate care workers' distress at work and facilitation their retention intention. Reflecting on the issues of inconsistency and consistency in care workers' care practice, our findings also draw attention to managers' consistent management practices that facilitate the maintenance of care home cultures and provides care workers with a stable fundamental framework in which to guide care practices (Killett et al., 2016). Our findings suggested that consistent management practices seemed to heavily rely on managers' attitude and determination and might require them to: a) actively manage the issues, problems, and incidents in the care home in a consistent manner, b) ensure fairness and justice in the handling of issues, c) provide feedback in accordance with the meanings and values of care work, and d) maintain an unified and cohesive management team. Our findings reveal that the consistency of a manager's practice may help to provide care workers with consistent feedback for their care practices. The consistent management practices may also help to eliminate incongruences that care workers may experience when exercising the work identities in real job of caring. To eliminate the incongruences, management practices might need to be characterised by consistent meanings and values of care work. It might be anticipated that implementing consistency in management practices would facilitate the development and maintenance of a stable and positive care home culture.

9.1.2 Exploring how to foster effective care home cultures.

Our findings reveal that managers applied various methods to inform and educate their care workers about the meanings of care work, care workers' role, responsibilities and boundaries, including eLearning, face-to-face training and peer-led mentoring. Peer-led mentoring seemed to be considered an effective way to help new care workers to grasp the meaning of care work. This implies that new care workers develop the concept of care responsibility and boundaries through implicitly interpreting other care workers' practices and understanding of care work.

The findings of study 3 revealed that managers arrange a peer-led mentoring for newly recruited care workers which often lasted for a limited period of time whereas the findings of study 1 revealed that care workers value the support their colleagues offered to them throughout their care practice. Offering peer-led mentoring and peer support may be understood as a means of meeting care workers' support needs and a form of nutriment. According to self-determination theory, individuals tend to interact and connect with others in order to reach a sense of belongingness (Deci & Vansteenkiste, 2004) and to build

meaningful interpersonal relationships with others in a social group (Moller, Deci, & Elliot, 2010). Thus, the findings of study 1 and 3 imply that the required nutriment care workers receive in care homes needs to be consistently provided. It might be anticipated that care workers receiving consistent nutriment are more likely to reach a strong sense of belongness and to embrace the meaning of care work in the care homes.

Our findings suggest that care works revise their meanings of being a care worker and improve the efficacy of their care practices through receiving continuous training, learning from experienced colleagues, and interacting with residents. Care workers in our study frequently mentioned the support they received from their colleagues and infrequently mentioned the direct support from their managers. Social network analysis (SNA), which concerns the relationships among a group of individuals who are connected or interdependent in a given social system, has been applied to investigate the effectiveness of communication and organisational performance in organisations (Sabot, Wickremasinghe, Blanchet, Avan & Schellenberg, 2017). Given that the findings of study 1 imply that care workers have different social distances with their fellow care workers than with their managers, future studies may explore the communication channels and information flow between care workers and managers and how these may facilitate care workers' support needs and encourage their retention intention using SNA.

Furthermore, findings from empirical study 3 emphasised the influence of care home managers' over care workers' care practices and work identities, suggesting that managers' management practices shaped, directed and fostered the care home culture that provided care workers with a foundation to carry out the care work in the care homes. However, care workers' accounts in study 1 reflect the significant influences of peer support and social interaction with residents on the development and maintenance of their work identities. Given that the care home managers' role has been suggested as influential in forming care home culture (e.g. Lopez, 2006; Pfefferle & Weinberg, 2008), the differences between the findings of empirical study 1 and 3 reflect different perceptions between care workers and managers in relation to care workers' support needs and development of work identities. Future studies may explore care workers' perceptions of managerial support in relation to their care practice, the development of their work identities, and their job satisfaction and organisational commitment.

9.1.3 Predicting care workers' organisational commitment and job satisfaction.

The results of Study 2 demonstrate a directional linkage from care workers' organisational identification to the satisfaction of psychological needs. This directional linkage suggests a contextual significance of the nutriment care workers receive. It is possible that care workers who do not identify themselves with the care home may respond less well to the nutriment in the care home or find it less important. Thus, care workers with higher organisational identification might perceive the nutriment in the care home as significant in satisfying their psychological needs. The findings of study 2 show that the effects of care workers' organisational identification on their organisational commitment and job satisfaction were positively mediated by the satisfaction of psychological needs and intrinsic motivation. Ryan and Deci (2003) suggest that the nutriment with the social environment facilitates the formation of individuals' identities and enactment of the identity-relevant behaviours.

The findings of study 2 were consonant with SDT research (e.g. Gagné & Deci, 2005; Hodgins, Brown & Carver, 2007). It may be assumed that care workers with a higher level of satisfaction of psychological needs and intrinsic motivation are more likely to have a higher organisational commitment and better job satisfaction. The findings of study 2 further suggest that experiencing satisfaction of psychological needs allow the care workers' relationships with their care home to move from 'self-definitional' perspectives to forming reciprocal bonds with their organisations and being willing to devote effort in support of their organisations. The findings of study 2 also confirmed the work of Van Knippenberg (2000) where an employee's perception of being a member of an organisation has a weak association with that individual's adherence to fulfil the organisational expectations. Moreover, the findings of study 2 further suggest that experiencing the satisfaction of psychological needs may facilitate care workers, who identified themselves with their care homes, to adhere meeting the care home expectations and promote their job satisfaction and organisational commitment.

Contrary to expectations and previous research (e.g. Johnson et al., 2006; Van Knippenberg & Van Schie, 2000), study 2 reveals that care workers who evaluated their own worth highly and positively had lower organisational commitment and job satisfaction. Such unexpected findings may be caused by negative suppression. The inclusion of an additional suppressor variable in the analysis might help to partial out or suppress the criterion-irrelevant variance that shared by self-esteem and job satisfaction and organisational commitment. Based on the findings of this thesis and the literature review of care work, the perceived external prestige

(Dutton, Dukerich and Harquail, 1994) and role stress fit (Bacharach, Bamberger & Conley, 1991; LeRouge, Nelson & Blanton, 2006) might act as a suppressor variable in the proposed model. The findings of study 2 also imply the negative influences of the care work related stigma and negative media representation that care workers often experience outside the care home. Such negative influences may also be observed from the findings of study 2, where native care workers had significant lower self-esteem and self-efficacy in comparison with the migrant care workers. Future study may explore the ways in which a care workers' role, care work, and care homes are perceived by individuals outside social care sectors (e.g. general public). Future studies may also investigate under what circumstances individuals' perceptions of care workers and care homes might be modified or whether their perceptions of care workers and care homes would positively or negatively affect their decision to relocate their loved ones in a care home. Furthermore, the findings of study 2 also imply that role stress has a negative impact on care workers when they perceived the role stressor as unexpected or unmanageable in a situation (LeRouge, Nelson & Blanton, 2006). Taking the findings of study 1 into consideration, the role stress in care home context may be associated with care workers' work identities where their self-meanings prepare them for the demands and expectations of the job role they undertake. However, when care workers perceived their work as overload and struggled with to meet their role expectations, they may experience the negative effects on their care practice, self-esteem, and well-being.

9.1.4 Understanding the value of social interaction and social environment for promoting care workers' work identities and work motivations.

Considered as a whole, the findings of empirical studies 1 and 2 support the significant influences of social interaction and social environment in the care homes on care workers' work identities and motivation to continue their role. Our findings suggest that care workers' work identities might exert influences on the ways in which they perceive the facilitators for continuing their role as a care worker. Furthermore, these findings imply that the incongruences care workers experience between their work identities and actual care practice, or self-meanings and the feedback from others in the care homes, can have negative influences on care workers distress, retention intention, and self-esteem. The findings of study 1 and 2 point to a need for creating a work environment which provides care workers with nutriment and management practices consistent with the meanings of care work conveyed to the care workers.

Moreover, the findings of study 3 revealed that care home managers' perceptions and values of care work were embedded in their management styles and management practices which then shaped, directed, fostered, and maintained the care home culture (André, Sjøvold, Rannestad & Ringdal, 2014; Jeon, Merlyn & Chenoweth, 2010; Toles & Anderson, 2011) and established a fundamental framework to guide care workers' care practices (Kemp, Leila Borders & Ricks, 2013; Kuvaas, & Dysvik, 2010). The findings of study 3 suggest that it is essential that managers facilitate care workers to reach a mutual understanding of the meanings of care work. Managers conveying their vision and values of care work to care workers might be understood as a means of establishing a cohesive, trusting, effective and productive work environment. It may be assumed that having effective communication and reaching a mutual understanding between managers and care workers might be perceived as a key to establishing a productive work environment. To ensure care workers comprehend the meanings of care work, most managers paid close attention to care workers' care practices while some managers encouraged care workers' involvement in the planning and organisation of care work. Encouraging care workers' involvement and utilising reciprocal communication seemed to meet care workers' need for autonomy (Baard, Deci & Ryan, 2004; De Cooman et al., 2013) as well as to enhance the effectiveness of communication between care home managers and care workers.

Previous research suggests that managers and care workers often have different perceptions about the efficiency of the communication between managers and care workers (Forbes-Thompson et al., 2006; Scott-Cawiezell et al., 2004). Our findings suggest a feasible way to improve communication efficiency between managers and care workers involves encouraging care workers' involvement in managerial issues and establishing reciprocal communication to affirm a mutual understanding. Our findings contribute to evidence on effective communication improving care workers' care practice, teamwork and work atmosphere in the care homes. Effective communication may require managers to have sufficient understanding of care workers' cultural differences and personal characteristics and to equip their care workers with effective communication skills. The findings of study 3 showed that managers viewed effective communication as significant in conveying care home values and the meanings of care work to care workers, fostering a positive work environment, avoiding misunderstanding, and improving teamwork. Nevertheless, study 1 demonstrates care workers emphasising the role of the emotional support and peer learning on fostering a positive work environment and a teamwork atmosphere. The different emphases between two studies may imply the different perceptions of the facilitator for

fostering a positive work environment and improving teamwork between managers and care workers.

The findings of study 3 revealed that managers expected the care workers to form trusting relationships with residents and to be compassionate in meeting residents' emotional support needs. According to SDT, satisfying individuals' relatedness need and establishing reciprocal relationships with others in the given social group or social environment allows them to experience a sense of trust and intimacy (Moller, Deci, & Elliot, 2010). SDT also links the satisfaction of relatedness needs to social support and the management of loneliness issues (Van den Broeck et al., 2010). On the other hand, managers acknowledge that care workers might experience a dilemma when emotionally engaging with patients for care purposes while at the same time keeping the boundaries in place. The concept of appropriateness, which was applied to help care workers navigate boundaries, required a care worker's careful observation on others' practice and interaction in the care home. The findings of study 3 point out that the meanings of appropriateness might be different from one care home to another due to different care home cultures. Given that previous research on boundaries often focus on employees' responsibilities and porfessional performance (e.g. Brown, Crawford & Darongkamas, 2000; McCullough, 2004; Peternelj-Taylor & Yonge, 2003), these findings may offer a different perspective to understand care workers' boundaries in care work. Future studies may explore the ways in which care workers conceptualise the boundaries in care practice and to what extent care home culture influences care workers' conceptualisation and maintenance of the boundaries.

As noted in chapter 2, previous research points out that care workers often feel their work is undervalued and underpaid in the care homes (Bjerregaard, Haslam, Mewse & Morton, 2017; Himmelweit, 2007. Study 3 suggests care managers recognise that care workers need recognition at work. Managers utilised various methods to express their recognition, including providing consistent, positive and immediate feedback to care workers, expressing appreciation for their work efforts, and offering limited financial incentives. These methods may be seen as a means of enhancing care workers' positive appraisal towards themselves which may lead to increased self-esteem. It can be assumed that the enhancement of care workers' self-esteem leads them to experience a higher level of organisational commitment and job satisfaction (e.g. Podsakoff, MacKenzie, Paine & Bachrach, 2000; Van Knippenberg & Sleebos, 2006). Managers also see acknowledging care workers' work efforts and care

practices may also meet care workers' need for competence (Deci & Ryan, 2000; Van den Broeck et al., 2010).

It is worth noting that the findings of study 1 reveal that care workers had some congruent views with care home managers in study 3 in relation to care workers' support needs, motivation, and facilitators for continuing work as a care worker, such as being valued, the enhancement of self-esteem and self-efficacy, and sense of pride in care work. They also show that care workers who were empowered and encouraged by care home values and culture to take on more responsibilities often experienced a greater sense of autonomy (Barry, Brannon & Mor, 2005; Colón-Emeric et al., 2006; Corazzini et al., 2014), independency, and belongingness. The results of study 2 demonstrate that care workers' satisfaction of psychological needs had a positive and significant influence on their job satisfaction and organisational commitment. Both studies indicate the significance of meeting care workers' needs for autonomy, competence and relatedness. Nevertheless, the findings of study 3 indicate managers may have limited resources and authority to encourage care workers' career advancement or offer care workers material incentives or pay rises. These limitations may be perceived as managers' reluctance to meet care workers' support needs or provide facilitation for encouraging care workers' care practice. In terms of meeting care workers' support needs, the findings of this thesis imply the significance of care workers learning about the manager's role and the limitations of the manager's resources and authority. This could help to avoid the misunderstanding of managers' management practice between care workers and managers.

9.2 Practical implications

The overall practical goal of the research was to assist care homes to create an atmosphere conducive to increasing care worker retention, while increasing the quality of care work. These findings have implications for care workers, their managers, care home providers, and other stakeholders. Specifically, this research gives us some important insights on designing future interventions which may help care workers to internalise the role expectations and the meanings of care work in the care home, and to experience a better organisational commitment and job satisfaction. In this section, some practical implications of this research are discussed.

Care home management should ensure that the meanings of care work and care home values conveyed to care workers are practical and achievable. This thesis suggests managers

emphasise consistent management practices as it can help eliminate the incongruences care workers experience between their work identities and the real job of caring and facilitate the development and maintenance of a stable and positive care home culture. In psychological terms consistent management practice includes a) conducting their management practices in accordance with the meanings and values of care work conveyed to care workers, b) actively manage the unresolved issues in a consistent, fair, and justice manner, c) provide feedback in accordance with the meanings and values of care work, and d) maintain a unified and cohesive management team. It might be helpful if care home management presents a clear vision of how care workers are expected to implement these values and meanings in the care practice. Moreover, managers are likely to benefit from paying attention to effective communication as it fosters a positive work environment and care home culture. Managers could adopt the practices that involve care workers' participation in planning care work and encouraging care workers' input in the improvement of care provision. Furthermore, taking care workers' feedback on the care work and support needs into consideration may help managers to plan for an effective care provision.

The findings of this thesis demonstrate the significant influences of social interaction and social environment in the care homes on the development of care workers' work identities (Stryker & Burke, 2000), the encouragement of continuing their role, and the enactment of their work identities-relevant performances and behaviours (Ryan & Deci, 2003). According to SDT, care workers' satisfaction of psychological needs may encourage their care practices and retention. Therefore, care home managers should focus on fulfilling care workers' psychological needs to encourage them to commit to the care work and stay in their current position. Fulfilling care workers' psychological needs may involve managers encouraging care workers' independency in care practice, providing consistent, positive and immediate feedback for care workers' care practice, assigning sufficient time and affordable workload to care workers to encourage social interaction, and fostering a positive work environment to facilitate the development of relationships between care workers, their colleagues and residents.

The unexpected findings of this thesis suggested that care workers may be influenced by the care work related stigma and negative media representation where care workers who evaluate their own worth highly and positively had lower organisational commitment and job satisfaction. Further, native care workers had significantly lower self-esteem and self-efficacy in comparison with the migrant care workers. Care workers have a need to

experience recognition and appreciation for their work. Given that cultural differences may influence care workers perceived recognition, managers may need to plan different recognition strategies for different cultures. Managers could apply various media (e.g. official website, newsletter, group page on social media, noticeboard) to announce care workers' contribution, to celebrate their achievement, or to convey residents' positive feedback or appreciation towards care workers. This may help to remind and re-emphasise care workers' achievement at work.

Managers could also devise a sustainable and practical intervention incorporating peer-led mentoring and peer support into day-to-day practices in the care homes. For instance, care worker duty handovers in care homes allow care workers coming on duty to learn about their allocated work of the day and residents' care needs and conditions. Handovers could also be a good opportunity for care workers to express their concerns or to share their work experiences and skills with their colleagues. Managers could arrange a slightly longer handover where there is time for care workers' support needs to be expressed and discussed. This may help care workers to be surrounded with a supportive group.

On the other hand, our findings reveal that managers have limited resources and authority to offer care workers a material incentive or a pay rise. Care home stakeholders' inputs for the development of sustainable and practical interventions and the provision of resources to ensure sufficient staffing and financial incentives might help to promote care workers' sense of pride, work efforts, and contributions in the care home.

Our findings reveal that there are differences between care workers and managers perceptions, including their respective perceptions towards facilitators that foster a positive work environment, support needs, and the role of managers. However, these perception differences of managers' role in meeting care workers' support needs might lead care workers to view managers' limitations in meeting care workers' support needs as being reluctant and uncaring. It might help care workers and managers to reach a mutual understanding if care workers would be offered the opportunities to comprehend managers' role, resources and authority as well as the ways in which the care work and management is organised and planned in the care homes. Care workers' learning about managers' role may help them to avoid the misunderstanding of managers' management practice as well as prepare them for further career advancement. Whereas learning about strategies to establish an effective communication and a trust relationship with care workers might help care home

managers to reach a mutual understanding with care workers and to foster a positive work environment in the care homes.

Moreover, this research reveals how care home workers perceive role expectations at work and how their perceptions influence the ways in which they construct their work identities and conduct their care practices. The findings may be particularly informative for new care workers with no previous care work experience or experienced care workers who have recently joined a new care home. A new care worker has to adjust to their new role, to learn about residents and their care needs, and to adapt to the social environment in the care home while taking on the responsibilities for meeting residents' care needs. This thesis provides comprehensive descriptions of the difficulties and barriers care workers may experience in providing care to residents, as well as the facilitators and coping strategies they had to manage the difficulties and barriers. New care workers are likely to experience significant changes after starting to work in a care home and these changes may influence their self-concept, personal values, physical and psychological status, and social network. These changes may be positive or negative. When new care workers perceive these changes as negative, it is important to know that their colleagues likely had similar experiences when they started. The advantage of seeking other care workers' support and advice and learning from colleagues shared experiences have been suggested in this thesis. Care workers can actively express their support needs and signify their willingness to support their colleagues. This could potentially lead to a peer-led support system and enhance care workers' involvement and sense of belongingness in the care home.

9.3 Theoretical implication

In this thesis, self-determination theory was a valuable and comprehensive framework and adopting this theory helped aide our understanding of care workers' motivation, care practice, and job satisfaction. The significance of social interaction and social environment emerged from the findings of this thesis suggests the importance of satisfying care workers' psychological needs on the internalisation of external regulations and the enactment of identity-relevant behaviours and performances. It is worth noting that the care workers who are considered as individuals with lower socioeconomic status (SES) and limited power at work. There might be some critiques in relation to the applicability of SDT to further the understanding of care workers' motivations to stay employed. However, previous research has stated that SDT conceptualises self-determination as an individual's need to experience intrinsic motivation when engaging in an activity (Deci & Ryan, 1985) and that the

satisfaction of psychological needs is essential to individuals regardless their cultural backgrounds and SES (González. et al., 2016; Rouse et al., 2019). In chapter 4, it was stressed that SDT was considered as an adequate theoretical framework for advancing our understanding of care workers' motivations of continuing their work role The accounts of care workers and managers in the current research revealed that care workers' satisfaction of psychological needs plays a significant role in creating meaningful work experiences in care. This can result in higher organisational commitment and job satisfaction for care workers. The model developed based on SDT also demonstrated its validity in understanding the relationships between care workers' organisational identification, satisfaction of psychological needs, motivation, organisational commitment and job satisfaction. Participants' accounts and the findings in this thesis seem to demonstrate that SDT is a suitable motivation theory to further our understanding of care workers' need satisfaction at work, care practices and motivations of continuing their role in the care homes.

Note that this thesis adopts the universal approach of the satisfaction of psychological needs and viewed care workers' psychological need satisfactions as an integral unit – nutriment within social environment. More recent perspectives on psychological need satisfactions in SDT have also explore the strength of the psychological needs separately. Recent studies suggest that there is an individual difference in need strength where individuals may perceive one psychological need as more important than others (Chen et al., 2015; Hofer & Busch, 2011). Given that the participants in this thesis had discussions of different extents in relation to the psychological need satisfaction, this may provide some evidence to support the significance of exploring care workers' individual differences in need strength. In addition, SDT emphasises the significance and the source of nutriment in individuals' internalisation and motivated behaviour. However, SDT does not provide accounts for the scenario where an individual has different social distances with others in a social environment. Thus, whether there are any differences between care workers receiving nutriment from residents with whom they have closer relationships and residents who just moved into the care homes remains unclear.

An important theoretical implication of adopting SDT in this thesis is that it does not provide an account for the difficulties and barriers care workers experience that are induced by incongruences between the real job of caring and care workers' capacity for exercising their work identities. SDT suggests that a lack of nutriment within the social environment would thwart the positive processes and outcomes and lead to individuals' maladaptive functioning,

passivity and ill-being (Deci & Vansteenkiste, 2004; Huyghebaert et al., 2018; Vansteenkiste & Ryan, 2013). However, the lack of nutriment provides little explanation for the difficulties and barriers care workers experienced when they were struggling to meet their role expectations. On the other hand, identity theory suggests the concept of identity verification where individuals compare their self-meaning (also known as their internalised meanings of the role) with others' feedback (known as perceptual input meaning) in a social structure. When the outcome of the comparison between individuals' self-meaning and others' feedback was compatible, individuals would experience identity verification and positive emotions (Burke & Stets, 2009) while incompatible outcome leads individuals to experience negative emotions. It is worth noting that negative emotions are suggested as a form of pressure that drives individuals to enhance the compatibility between self-meaning and others' feedback by either strengthening their role behaviour to convince others or adjusting their role behaviour. Thus, identity theory is included in the theoretical framework of this thesis to supplement the understanding of care workers' work identities, care practices and motivation.

9.4 Contribution of this thesis

9.4.1 Methodological contribution

The methods and research design applied in this thesis contribute to the social care workforce literature in a number of different ways. First, using mixed methods allows the researcher to reach a comprehensive understanding of care workers' work experiences and perceptions of their role in relation to their motivations of retention and examine hypothesised relationships based on care workers' accounts. This is a significant contribution considering there is limited research on care workers' work experiences and perceptions, particularly in the area of qualitative data on care workers' work identities and quantitative data on care workers' motivation of remaining in their current position. Second, using mixed methods provides valuable insights into the psychosocial aspects of care workers' work identities and motivations at work, which may not be possible to generate by conducting only qualitative or quantitative studies. This thesis contributes to demonstrating the applicability and significance of using mixed methods to further our understanding of care workers' work experiences and motivations of retention in care home settings. Third, recruiting both care workers and care home managers in this thesis allows the researcher to explore care workers' perceptions, experiences, and motivations of continuing their care worker role from different perspectives. This also allows the researcher to obtain more information in relation to the social environment in the care homes and how this may influence care workers at work or

be influenced by care workers and managers. It is worth noting that the methodological contributions may be also viewed as empirical contributions. However, these contributions are perceived as resulting from the choice of methods and research of this thesis.

9.4.2 Contributions of empirical studies

The literature review in chapter 2 explored the role of care home workers in providing care for residents from the admission to the care home up to the end of life and the impact of high care home staff turnover on residents, care workers, and care homes. The literature revealed that care workers have an important role in providing person-centre care and incorporating the ethical values into care practices, such as personhood, autonomy, respect, and dignity. However, care workers' personhood, identities, intrinsic values, and contributions are often overlooked and/or unnoticed. Such a gap may hinder our understanding of care workers' care practices, experiences and motivations of retention and may impede the development of effective interventions to support care workers at work. Moreover, previous research on ethical issues in the care home contexts stresses that care providers (e.g. nurses and care workers) may experience ethical principles conflicts which can lead care providers experiencing a higher level of burden and distress (Bollig et al., 2015; Hem et al., 2018; Muldrew et al., 2018). However, the impact of care home workers experiencing ethical issues and the ways in which they manage the ethical issues remain unclear. Furthermore, a number of models have been developed to explore the relationships between care home worker turnover, its predictors and/or antecedents, and care workers' motivation of retention (e.g. Grødal et al., 2019; Karsh et al., 2005; Ravenswood et al., 2017; Yasin et al., 2018). Although these models provide insightful accounts for care worker turnover, their limitations imply that the development of a new theory-based model incorporating care workers' psychosocial factors may be needed. This thesis contributes to the gaps in the literature and investigates care workers' work identities, psychosocial attributes, and motivations of continuing their role as a care worker, as well as developing a valid theory-based model incorporating care workers' psychosocial factors to understand care workers' job satisfaction and organisational commitment.

There are a number oardwf contributions made by the empirical studies that have been discussed above. Here are the summaries of empirical contributions. First, this thesis may contribute to uncover care home workers' work identities, the development and maintenance of their work identities and how the work identities influence their care practice and motivation of continuing their care worker role. This thesis may also uncover the role of

ethical principles in the development of care workers' work identities. Second, this thesis may contribute to furthering our understanding of care workers' perceptions, barriers, and motivations at work and identifying self-determination theory as a valuable and comprehensive framework for understanding care workers' motivation, care practice, and job satisfaction. Third, this thesis may contribute to reveal the facilitators for care workers' internalisation of the care home regulations, the enactment of their work identity-relevant practices and behaviours, and the encouragement of their care practices and retention. Fourth, given that there is limited research focusing on care workers' work identities and the facilitators for care workers assuming their role, this thesis may contribute to further our understanding of care workers' work identities. This thesis also contributes to make care workers' voice, opinion, and story heard. This has the potential to enhance the understanding of general public regarding care home workers' roles and responsibilities and to reduce negative care work-related stereotypes and stigmas. Moreover, this thesis develops a model incorporating organisational identification, self-evaluation processes and self-determination theory to predict care workers' organisational commitment and job satisfaction. This thesis and its hypothesised model contribute to providing evidence-based information which may be used in designing interventions to enhance care worker retention and contribute to care quality and the care workers' wellbeing.

9.5 Limitations and recommendation for future research

This thesis applied different methods and combines qualitative and quantitative methods to explore care workers' work identities, work experiences, care practices and motivations. The application of both qualitative and quantitative methods contributes to the validity, reliability, credibility, trustworthiness, transferability, and dependability of the findings. Nevertheless, there are a few limitations in sampling, methods, research questions, and methodological strategies.

The first limitation is the sampling. This thesis was to investigate and to further our understanding of care workers' perceptions, experiences, and motivations of carrying on their role as a care worker. The participants recruited in this research project were working in a care home at the time that the empirical studies were conducted. It is possible that participants might wish to present themselves positively or be protective of their care home, residents, and colleagues. This could constrain the findings of thesis which largely relied on participants' accounts to understand care workers' experiences of doing care work and managers' experience in supporting care workers. The recruiting procedure limited access to

the care workers or managers who worked in less research-supportive care homes or to those care workers who had left the social care sector. The decision to restrict the sample was made in order to learn about the facilitators for care workers staying in their job role and to understand the support managers provide to encourage their staff's care practices and motivations for continuing the care worker role. The findings provide some understandings as to why care workers might decide to leave the previous care home and to work for the current care home. Given that all the participants were working in care homes, the findings of care workers' motivations and the barriers they experienced in care practices may not apply to former care workers. Thus, the understanding of former care workers' difficulties and motivations to leave the social care sectors remains unclear. A future study may investigate ex-care workers' experiences, perceptions, and decisions for career change and leaving the social care workforce.

The second limitation is the sample size in the study 2, the quantitative survey study. Collecting quantitative data was extremely challenging in South West England and London area and the process of recruiting care homes and care workers was time-consuming and difficult. Two hundred and seventy-one care homes were approached, and 19 care homes agreed to participate in the study before three of 19 care homes withdrew from the study. In the end, there were 207 participants in study 2. Considering the advantages and limitations of different administration methods, both self-administered and researcher-administered methods were used in collecting data. Three-quarters of the participants were self-administered. Inevitably, there were missing values in the dataset. Data screening was conducted to ensure that the missing value imputation would not lead to biased results. Unfortunately, one construct – value congruency had more than 20% of missing values which was not adequate for missing value imputation because it could produce biased outcomes. Given that conducting structural equation modelling (SEM) required large sample size (>200), the construct of value congruency was excluded from the analysis. Thus, to what extent value congruency might influence or associate with other constructs in the proposed model in study 2 remained unclear.

The third limitation concerns the application of SEM in analysing the quantitative data in this thesis. SEM is considered a powerful and flexible statistical method that allows the exploration of relationships between latent constructs without measurement error (Nachtigall, Kroehne, Funke & Steyer, 2003). Moreover, SEM is theory driven and it is used in a confirmatory manner which allows researchers to examine the theoretical relationships

between latent constructs. However, this advantage may increase the chance that researchers exclude or omit important constructs in a proposed model. The omission or exclusion of important constructs may impact on the model's estimated parameters (Tarka, 2018; Tomarken & Waller, 2005).

On the other hand, SEM can be used to provide evidence that a proposed model fits the data. However, SEM cannot be used to demonstrate the proposed model being completely correct. This is because that alternative models may also fit the data well and in some cases the fit of the alternative model may be better than the proposed model (Tomarken & Waller, 2003; Tomarken & Waller, 2005). In addition, SEM requires large sample size, especially when researchers are dealing with complex models. Without sufficient sample size, the calculation of path coefficient and the model fit are likely to be affected. It is worth noting that in recent years, researchers are seeking and developing the alternatives of SEM in dealing with estimating model fit and path coefficient (Croon, 2014; Devlieger, Mayer & Rosseel, 2016; Devlieger & Rosseel, 2017).

Factor Score Regression (FSR) has been suggested as an adequate alternative for SEM as it provides correct path coefficients for the model (Devlieger, Mayer & Rosseel, 2016; Devlieger & Rosseel, 2017). FSR approach involves two steps of the analysis. First, a factor analysis is conducted to calculate the factors scores of the latent constructs. The factor scores are then used in conducting a linear regression. This method does not require large sample size or simple model. Considering the difficulties of recruitment in care home settings, FSR may be a suitable alternative for exploring the relationships between care workers' work identities, psychosocial factors, work motivations, organisational commitment and job satisfaction.

The fourth limitation is the effective measurement which can be used to quantitatively investigate the compatibility between care workers' personal values and care home values. In this research, the compatibility between care workers' personal values and care home values was measured using two scales with an identical list of values. The list of values was mostly adopted from the value survey (Liedtka, 1989) together with other values addressed by the care workers listed in Chapter 5. However, the two identical scales with different introductions seemed to confuse participants. Moreover, some items from the value survey (Liedtka, 1989) were found difficult to consider in care home settings. Given that the existing scale for measuring value congruence is not adequate or effective, this points to a need to

start with a qualitative research exploring value congruence in care home settings and develop an adequate and effective scale. This might subsequently enable the researcher to quantitatively investigate the directional linkage between care workers' value congruence and other constructs measured in study 2.

The fifth limitation is that due to the difficulties in data collection, this thesis did not investigate the influences of extrinsic motivation on care workers' work identities, care practices and motivation for continuing their care worker role. Self-determination theory scholars emphasise the essential role of intrinsic motivation and suggest that salient reward can have a negative influence on ones' satisfaction of psychological needs (Ryan, & Deci, 2000a; Ryan, & Deci, 2000). Nevertheless, recent studies suggest that extrinsic reward does not undermine ones' satisfaction of psychological needs but facilitate individuals to be more creative and motivated (Jovanovic & Matejevic, 2014; Malik, Butt & Choi, 2015). Therefore, exploring extrinsic motivation may supplement our understanding of care workers' care practice, work identities, and motivation. The researcher tried to include the extrinsic motivation into the analysis by asking participants about their hourly pay rate, their perceptions of the salary, and the satisfaction of the extrinsic motivation in relation to their daily needs. Nevertheless, the data collected did not allow the researcher to include the extrinsic motivation into the analysis due to a high missing data percentage in those questions. This points to a need to have a different strategy in exploring the influences of extrinsic material incentive on care workers' work identities, and motivation.

9.6 Personal reflexivity

9.6.1 Approaching care homes.

As I complete data analysis and writing my thesis, I still remember the struggles I had when I was about to approach care home managers. Reflecting on my struggles, there were a few considerations or presumptions I had which may or may not be true. First, I often assumed that care home managers were always busy. Contacting them for a research project in which they may not be interested seemed to be a waste of their time. Second, I often view no immediate reply from the managers contacted as a form of rejection. Therefore, I often felt rejected after sending the invitation letters to care home managers. Third, I often assumed that managers may change their mind about participating in the research. Therefore, I felt pressure from the presumptions that I had made about engaging with care homes

From this experience, I offer the following advice for researchers who have no previous research experience in care home settings. First, care home managers are indeed very busy. However, the assumptions of managers being too busy to learn about your research often arises from fear and lack of confidence. Inviting care home managers to participate in a well-thought-out research initiative does not bother them or waste their time. Thus, a more important consideration should be whether the researchers have given sufficient attention and effort to devise an interesting and useful research project and avoid any harmful effects on participants and care homes. Second, no immediate reply is not necessarily equivalent to a rejection. Sometimes, I had sent the invitation letter to a wrong email address. I often found out when I did the follow-up phone calls. The advice here is to determine the reason for the silence before assuming a rejection. Third, it is important to note that receiving rejections to the research project is as normal as receiving managers' support to participation when approaching care home managers. From my experience, many care home managers are supportive of the research. In some cases, care homes have to reject research projects because they may have already participated, or are still participating, in other research projects. The key here is to be patient and persevere. Data collection in care homes can take a considerable length of time. Therefore, it is important for researchers be realistic about the period of time that may be required to collect data in care homes when planning for the research schedule.

9.6.2 Conducting research in care homes.

I have conducted two qualitative and one quantitative study in care homes. My research experience taught me an important thing - be prepared. It is extremely important to minimise distraction or disruption to care practices in the care homes. It is very likely that unexpected incidents or situations may occur during researchers' visit to a care home. Thus, it would be better for researchers to arrange a time where participants could participate in the research without creating substantial pressure on other care workers. I used to bring a book or some articles with me while collecting data in care homes. Reading while waiting for participants was conceptualised by myself as a means of reassuring them that I was not wasting my time waiting. Moreover, I remembered once I was waiting in the dining area in a care home, suddenly a resident fell on the floor and was immediately attended to. However, I was there waiting and feeling slightly shook up and awkward being there. I remembered thinking that it might make others feeling uncomfortable or awkward if I showed any signs of awkwardness. Nevertheless, I did ask a member of staff if my presence would be an issue or inconvenience for them. Thus, the advice for researchers is to be prepared psychologically.

9.6.3 Interaction with migrant participants.

I have had experience interviewing migrant care workers and administering questionnaires. It may be assumed that migrant care workers may find a foreign researcher more familiar and easier to relate to. However, I found that individual differences and characteristics may be more relevant to whether participants find me comfortable and easy to relate to. Given that all the interviews and researcher-administered questionnaires were conducted by me, it is difficult to tell whether participants would respond to me differently if there was British researcher collecting data for this research project. It is worth noting that in some cases, I found that the cultural differences between me and the participants influenced my interpretation of participants' facial expression. It seemed that acknowledging and understanding culture differences might aid the interaction with participants during the interviews.

9.7 Conclusion

This thesis contributes to furthering our understanding of care workers' perceptions, barriers, and work motivation and identifying self-determination theory as a comprehensive and valuable framework to understand care workers' motivation at work, care practice, and job satisfaction. It provides evidence to understand care workers' work experience and work identities in relation to their care practices and motivations of continuing their role as a care worker.

The first important finding is that this thesis enhances our understanding of care workers' work experience and work identities and how they influenced care workers' perceptions of the barriers at work and the facilitators for continuing to work as a care worker. As a career that is dominated by people and interactions with people, care workers established their work identities through the explicit training and implicit learning on the job, including peer support, learning from colleagues' shared experiences and interaction with residents. Second, the findings reveal that social interaction has a significant role in conveying the role expectations and the meanings of care work to care workers. Social interaction enables care workers to experience the satisfaction of need for autonomy, competence, and relatedness. This satisfaction then facilitates care workers to internalise role expectations and the meanings of care work into their self-concept and experience intrinsic motivation at work. Care workers' internalisation subsequently leads care workers to implement role expectations and the meanings of care work in their care practices and experience a higher commitment and job satisfaction. Third, managers' management style and management

practices reflected their perceptions, views, and values of care work that then shaped, directed, fostered, and maintained the care home culture and established a fundamental framework to guide care workers' care practice. In order to facilitate care workers to cope with the barriers and difficulties at work and develop work identities and organisational commitment, managers need to create a work environment which provides care workers with nutriment. The nutriment in a care home context includes encouraging care workers' independency in care practice, provides consistent, positive and immediate feedback for the care practice, and fosters the development of relationships between care workers, their colleagues and residents. The findings of this thesis emphasise the importance of having the consistency in management practices which enables care workers to receive consistent feedback for their care practice, eliminates incongruences care workers may otherwise experience between their work identities and the real job of caring, and facilitates the development and maintenance of a stable and positive care home culture. The key to consistency in management practice is conducting management practices in accordance with the meanings and values of care work conveyed to care workers, providing feedback in accordance with the meanings and values of care work, managing the issues in a consistent, fair, and justice manner, and establishing a unified and cohesive management team.

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APPENDICES

Appendix 1: Ethical approval for study 1

Kingston University London

Faculty of Arts and Social Sciences

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Penrhyn Road
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UK

20 May 2015

I-Ling Yeh
PhD student
Department of Psychology
School of Psychology, Criminology and Sociology
Faculty of Arts and Social Sciences
Kingston University

Dear I-Ling Yeh

Application for ethical approval for a study entitled: Formal carers' experience in caring for older people at the end of life in adult domiciliary care (homecare services and care home) settings.

To confirm that your revised ethics application for the above named project has been approved by the Faculty Research Ethics Committee.

Yours sincerely

Emma Finch
(Secretary to the Faculty Research Ethics Committee)
Faculty Research Manager
Faculty of Arts and Social Sciences
Kingston University

Appendix 2: Invitation letter to care home manager for study 1

TO

[Name of manager]

[Address of care home]

Researcher: I-Ling Yeh,
Email: k1456072@kingstom.ac.uk

Dear [MANAGER OF CARE HOME]

An invitation to take part in a research project on providing end of life care

I am writing to you regarding a project which aims to enhance our understanding of carers' experiences of providing end of life care to older people in different social care settings. There is considerable research investigating end of life care provided in social care settings from the perspectives of older people and their families. Given that a large number of older people receive end of life care in a care home, we are interested in investigating the care home staff's view on providing care at the end of life.

We are hoping to interview 10 care home staff from 2-3 residential care homes. We are keen to work with you and invite your staff to participate in the study. We anticipate that the interviews will last approximately one hour and can take place in the care home or at Kingston University, where the researchers are based. Taking part in this study, your staff will be asked about their experience of providing end of life care for older people. The findings of this study have the potential to improve the quality of life of the professionals in those social care settings. For further information can be found in the enclosed information sheet. This study has been reviewed and given favourable opinion by the Faculty Research Ethics Committee (FREC) from the Faculty of Arts and Social Sciences at Kingston University.

I would be grateful to be given the opportunity to visit you and provide you with further details of the study. I look forward to hearing from you. **If we do not hear from you, the researcher I-Ling Yeh will give you call on [date] between 9am and 12 noon to discuss whether you are interested in participating in this study.** Please feel free to contact me on (k1456072@kingston.ac.uk) if you have any further questions regarding the study.

Yours sincerely
Researcher: I-Ling Yeh (k1456072@kingston.ac.uk)

Supervisor:
Dr. Tushna Vandrevala,
Address: Faculty of Arts and Social Sciences
Kingston University
Penrhyn Road
Kingston upon Thames, Surrey KT1 2EE
Tel: 020-84176317
Email: T.Vandrevala@kingston.ac.uk

Prof. Evanthia Lyons,
Address: Faculty of Arts and Social Sciences
Kingston University
Penrhyn Road
Kingston upon Thames, Surrey KT1 2EE
Tel: 020-8417-2442
Email: E.Lyons@kingston.ac.uk

Appendix 3: Invitation letter to care workers for study 1

Kingston University London

Dear

An invitation to take part in a research project on providing end of life care

I am writing to you regarding a project which aims to enhance our understanding of carers' experiences of providing end of life care to older people in different social care settings. Carers play an important role in providing care for older people at the end of life. Learning from your experiences can supplement our understanding of end of life care in care home settings. We would like to invite you to take part in an individual interview. Your manager has given the support for you to take part in this project. Please understand that the interview is not an assessment, your responses will be kept confidentially, and your participation will not be detrimental to your current employment. We anticipate that the interview will last approximately one hour and can take place at the care home or at Kingston University, where the researcher is based.

For further information on this study, please find enclosed an information sheet. If you have any concerns about this study, please do not hesitate to contact the researcher, I-Ling Yeh who will be pleased to answer any questions you may have. This study has been reviewed and given favourable opinion by the Faculty Research Ethics Committee (FREC) from the Faculty of Arts and Social Sciences at Kingston University.

Yours sincerely

Researcher: I-Ling Yeh (k1456072@kingston.ac.uk)

Supervisor:

Dr. Tushna Vandrevala,
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18/05/2015

Appendix 4: Information sheet for study 1

Kingston University London

Information Sheet

Formal carers' experience in caring for older people at the end of life in care home settings.

Researcher: I-Ling Yeh
Supervisors: Dr. Tushna Vandrevala and Prof. Evanthia Lyons

For my PhD thesis in Psychology at Kingston University, I would like to invite you to take part in an interview about your experiences of providing end of life care for older individuals. Before you decide whether you would like to take part, it is important for you to understand why this research is being conducted and what it is going to involve. Please take some time to read the following information and discuss it with others if you wish. Please ask if there is anything that is not clear or if you need further information.

What is the purpose of this study?

The aim of this study is to explore formal carers' perspectives and experiences of providing end of life care for older individuals in care home settings. Carers will be asked questions on their views and experiences of looking after older adults, from their transitions into care settings to the end of life. Learning from the experience of formal carers will provide more information to supplement our current understanding of end of life care in home settings and care home settings.

Why have I been invited to take part?

You have been invited to take part because you are currently working as a formal carer in the UK and have experience of providing care for older individuals.

Do I have to take part?

No, if you do not want to take part then you do not have to. If you would like to withdraw from the interview at any time, you can. Your responses will then be removed from the data. Please contact the researcher by 31st September if you would like your data withdrawn from the study. If you require any further information before you take part, please contact the researcher via the details given below.

What do I have to do?

If you agree to take part, a researcher (I-Ling Yeh) from the Kingston University will interview you for approximately one hour, at a time and place convenient to you. You will be asked to answer some broad questions regarding your experiences of providing care for older people. With your consent, the interview will be audio-recorded.

What are the possible disadvantages or risks of taking part?

We do not foresee any disadvantages or risks associated with taking part in this study. The interview is not an assessment and your participation will not be detrimental to your current employment. We are aware that inviting you to discuss end of life care may cause you to recall unpleasant or distressing memories. If you become upset, the interview can be stopped. You will not be forced to continue with the interview. If the interview causes you any distress, we encourage you to contact the manager of your care home, your GP. You can also access further information from MIND (www.mind.org) or contact them on 0300 123 3393 (weekdays 9am - 6pm).

What are the possible benefits of taking part?
We do not foresee any direct benefit to the participants involved. However, the findings of the current study may have the potential to improve the quality of life of the professionals in those social care settings by exploring what their needs are in providing end of life care for older people. Furthermore, improving professionals' quality of life and well-being may have a positive impact on the older people they look after and subsequently enhance the quality of care older people receive at the end of life.

What if there is a problem?
If you have any concerns about this study you can contact the researcher I-Ling Yeh, who will be conducting interviews and will be pleased to answer any questions you may have. You can also contact the supervisors Dr. Tushna Vandrevala and Prof. Evanthia Lyons. Please find the contact details below.

Will my taking part in this study be kept confidential?
Yes. All the information which you give in this interview will be kept strictly confidential in accordance with the Data Protection Act 1998. Any information recorded about you will have your name removed and you will be given an alias. You will not be identified in any report or publication that arises from this study. Only the researchers named on this information sheet will have access to the consent forms (where your real name will be stored) and to secure computer records.

Who has reviewed the project?
The study has been reviewed and received a favourable opinion from the Faculty Research Ethics Committee (FREC) in the Faculty of Art and Social Sciences at Kingston University.

Contact Details
If you require more information, please contact the researcher below:

I-Ling Yeh, PhD Psychology student, Kingston University,
Email: k1456072@kingston.ac.uk

Dr. Tushna Vandrevala,
Address: Faculty of Arts and Social Sciences
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Penrhyn Road
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Prof. Evanthia Lyons,
Address: Faculty of Arts and Social Sciences
Kingston University
Penrhyn Road
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Tel: 020-8417-2442
Email: E.Lyons@kingston.ac.uk

Thank you for taking the time to read this Information Sheet.

Appendix 5: Consent form for study 1

Formal carers' experience in caring for older people at the end of life in care home settings.

Participant Identification Number:

Researcher: I-Ling Yeh.
Supervisors: Dr. Tushna Vandrevala and Prof. Evanthia Lyons

Please carefully read through the following sentences and tick the box next to the sentence if you agree with it.

- I the undersigned voluntarily agree to take part in interview on the experiences of providing end of life care for residents. [ ]
- I have read and understood the Information Sheet provided. I have been given a full explanation by the investigators of the nature, purpose, location and likely duration of the study, and of what I will be expected to do. [ ]
- I have been given the opportunity to ask questions on all aspects of the study and have understood the advice and information given as a result. [ ]
- I consent to my personal data, as outlined in the accompanying information sheet, being used for this study and other research. I understand that all personal data relating to volunteers is held and processed in the strictest confidence, and in accordance with the Data Protection Act (1998). [ ]
- I understand that I am free to withdraw from the study at any time without needing to justify my decision and without prejudice. If I wish to withdraw from the study, I can contact the researcher prior to 31st September 2015 [ ]
- I confirm that I have read and understood the above and freely consent to participating in the interview with audio recording. I have been given adequate time to consider my participation and agree to comply with the instructions and restrictions of the study. [ ]

PARTICIPANT

Signed:……

Date:……

Name (CAPITALS) ……

RESEARCHER TAKING CONSENT

I have explained the study to the above participant and he/she has indicated his/her willingness to take part.
Signed:……

Date:……

Name of researcher taking consent (CAPITALS) ……

Appendix 6: Demographic questionnaire for study 1

Kingston University London

DEMOGRAPHIC QUESTIONNAIRE

Identification number: ___

There are two pages in this demographic questionnaire. Please read through the questions and answer them by ticking the box next to the response which is the most appropriate or by writing down your own response in the 'other' category.

1. **What is your gender?**

Male ☐	Female ☐	Other☐ (Please specify: _____).

2. **How old are you?**

_____ years.

3. **Are you currently employed full-time or part-time?**

Full-time ☐	Part-time ☐

4. **How many hours do you work as a carer per week?**

_____ hours.

5. **How many years have you been working as a carer in Britain?**

_____ years.

6. **Had you been working as a care working in other countries?**

Yes ☐ (Please specify: _____)	No ☐ (please skip question 7).

7. **How many years had you been working as a carer in other country?**

_____ years.

8. **What is your religion?**

No religion ☐	Buddhist ☐	Muslim ☐
Sikh ☐	Hindu ☐	Jewish ☐
Christian ☐	Other religion ☐ (Please specify: _____).	

9. **What is the best description of your ethnic background?**

White ☐	Mixed/multiple ethnic groups☐
Black/ African/Caribbean/Black British ☐	Asian or Asian British ☐
Other ethnic group(Please specify: _____).	

10. **What is your nationality?**

_____.

11. **Where were you born?**

_____.

12. How many years have you been staying in the UK?

_____ years.

13. What is your first language?

_____.

14. What training course for care workers have you had?

_____.

15. Do you have any vocational qualifications?

_____.

16. What is the highest level of qualification that you have attained?

☐No qualifications	☐Less than secondary school
☐GCSE or earlier	☐Secondary school//A-levels
☐Undergraduate degree	☐Postgraduate degree
☐Doctorate degree	☐Other (Please specify: _____)
☐Prefer not to say	

Appendix 7: Interview guide for study 1

Kingston University London

Interview Guide

Formal carers' experience in caring for older people at the end of life in adult domiciliary care (homecare services and care home) settings.

Researcher: I-Ling Yeh
Supervisors: Dr. Tushna Vandrevala, and Prof. Evanthia Lyons

The aim of this study is to explore care home staff's experiences of providing end of life care for residents. With your permission the interview will be recorded. All the information which you give in this interview will be kept confidential and any information recorded about you will have your name removed. This is PhD thesis project, and the interview is not an assessment, but it will allow me to learn from your experience. There is no right or wrong answer and you will not be judged. Please share you experience and opinions with me.

1. **Please can you tell me about a typical day for you working as a carer?**
   - Which part of your work do you like the most?
   - Which part of your work do you find difficult?
   - How do you cope with the difficulties of your job?
   - What do you think makes a carer a good carer?
   - In a typical day, what do you think is the most important for the residents?
   - What do you think the residents need the most?
   - What do you find challenging when providing care for residents? Can you please give me an example?

2. **Please can you tell me about how residents feel when they first move to a care home?**
   - What do older people find most difficult when they move to a care home?
   - What do you think can help residents with the difficulties they have?
   - What is important to older people who live in the care home?
   - What do they complain about?
   - What do they enjoy the most?

3. **Please can you tell me how you help residents when they move to a care home?**
   - What do you do to get to know them?
   - How much time do you spend with the residents?
   - As time goes by, do you find you spend more time or less time talking to them?
   - Do you find residents want to talk or they prefer to stay quiet?
   - What do you talk to residents about? (e.g. diet, health, families, friends, their past, future, dying or death)
   - How can you know if a resident is happy or unhappy?
   - What do you do if a resident is unhappy?
   - How do you build relationships with residents?
   - How do you find out what residents may like or dislike?
   - Do residents tell you about their needs directly? If not, how do you know about their needs?
   - Are their needs always met? If not, what are the difficulties to meet their needs?

4. **I'd like to ask you about your experience of providing end of life care for residents. Can you please tell me what does end of life care mean to you?**
    - How do you care for a person at the end of life?
    - What is most important to residents at the end of life?
    - What do you think is "good" end of life care?
    - Has anyone died in your care home recently?
    - What did you do in this case? How was it dealt with in your care home?
    - Can you please tell me your experience about discussing end of life with residents or their families?
    - Do you discuss dying with residents?
    - Do you discuss dying with their families?
    - Do you discuss dying with other colleagues (staff, managers, other professionals)?
    - What do you think is important to talk about planning for end of life?
    - How do you bring up the discussion of planning for end of life with residents or their families?
    - When do you think is appropriate to talk about future care plan?
    - How confident do you feel when talking about end of life care with residents or their families?
    - What do you think can make you feel more confident when talking about end of life care with them?
    - What is the difficulty for residents or their families to talk about end of life care?
    - What do you think can help with the difficulties you just mentioned when talking about planning for end of life care with residents or their families?
    - What difficulties have you experienced when providing end of life care for residents?
    - What support do you have to deal with the difficulties you have experienced?

5. **Can you please tell me how do you work with other professionals in a care home?**
    - How much contact do you have with health professionals (e.g. GP or district nurses)?
    - Do you think it is important to interact with the health professionals?
    - Do you discuss residents' problems with your colleagues, managers, or other health professionals?
    - Do you discuss the difficulties of your job with other health professionals, managers, or your colleagues?
    - What are the difficulties of working with other people in these settings?

6. **Can you please tell me how you work with residents' families or friends?**
    - How often do resident's families or friends come to visit the resident?
    - Do you have any reason to interact with them? Do you see them when they come?
    - How often do you chat with resident's families or friends when they come to visit the resident?
    - Do you discuss older people's experience or problems with their friends or family members?
    - How do you get along with them? How do you find the interaction between them and older people?

Finally, is there anything else you would like to share with me?
Thank you for your help with this study.

Appendix 8: Transcription of N04 in Study 1

I: Please can you tell me about a typical day for you working as a carer?
N04: I'm a dementia carer, so we have training by un dementia matters, which is based over in Brighten, so when I first joined the company, all our residents live together the old home in the general… because when they joined us, they didn't have dementia, they all stayed mixed, when we joined here in Aug 13th, we then we got dementia unit, we got 18 residents at the moment, they wear uniform here, upstairs we don't wear uniform, because the, the uniform makes the barriers,
I: With the people with dementia?
N04: Huh, so like if you go to somebody, and you are dressed, they quite often they say 'I know you, you are one of me, I'm one of you', because there is no uniform, so you look the same, and you get lot of kisses, you get lots of cuddles, you get lots of hand holding
I: It's more like friends, rather than the carers
N04: Yeah, we um… we eat with the residents as well, yeah, we are different, completely different to here, you must try to come up to us, coz we have our own kitchen,
I: So, you cook as well?
N04: No the trolley comes from the chef, but we will lay the table, we will serve, we will wash up, um then when they eat, we have a tea play, and then because sometimes they don't want to eat, you say 'look at my toast, do you like my toast?' they have their toast, and they can be eating their toast, and then going to om, you got om, you share your breakfast with them, and then a couple… few of them… we got a few people would come and… you would say 'excuse me, would you come and help me to lay the table' so they help to lay the table for the lunch, and then lunch time again, we eat with them. Evening time some people will help wash up, we bake cake with them, we do um… we don't call it massage, coz we are not trained massagers, you may get a bit of cream and say put it on your hands, and then you rub your hands, and then they will do the same, and we got one gentlemen, if he saw you, he will take you hair out completely, you have to put your head on his chest, and about 10 minutes, he will do it with you (stroke the hair), so um dementia is all about touching, feeling, emotions, it's lovely, it's a lovely… it's a lovely job, so… I'm really um I really enjoy it, you know.
I: It's really different from what I can imagine, I mean to look after the people with dementia,
N04: It's um… it's um DCN… it's about DCN (Dementia Champions Network), so it's just different because we have got caught up training and DCN coming and give us fresh up, it's about wording , like you wouldn't say to somebody 'I'm going to feed her', no, you will say to your friend 'I'm going to assist with.. say her name is Jackie, I'm going to assist Jackie with her meal' so yes you are, but you are not feeding, you are assisting, and then I'm helping XX go to the loo, you won't say I'm taking XX to the toilet, it will be 'I'm assisting XX to the bathroom.' Like I don't believe in pads or nappies, no, it's their rooms, and I will say come with me, we will pop into the bathroom, and then I said 'you can pull you underclothes, so I don't say pad, I don't say nappy, it's under cloth, we call under cloth, they call under cloth, you know,
I: Is it about dignity or respect?
N04: In fact the whole home is about dignity anyway, and you might add things like um say you pass somebody, I wouldn't say you got wee on you, I'm going to change you, I would say I think you splash some water on your skirt, come with me, we get changed, they can do it by themselves, make them feel 'I'm not a baby', it's confusing, so I just say 'I think you got some water on your skirt, come with me. We get you changed, you still get them changed, you still get them washed, and I think ,coz I have been doing this since 2003, I always use the CDN, and I was doing home care as well, so I started caring about 20 years, so I think afterwards, you get to know it, we have got on the dementia we call um the bridge, so you got your bridge, and it's three stages, so if you are just join the dementia and you start your journey, like a journey in dementia, you are going to sunflower, that's stage one, if you

are further on the journey, on the bridge, you go to number two, and that's middle, that's green, if you are the stage where you are quite later stage, we have another area which is um purple, we call it lavender, so the people with their own individual needs are with their individual family, so we don't call it dining room, it's just called a lounge, some people call the bedroom a flat, if they call it a flat, it's a flat, yes, if they call it a penthouse, it's a penthouse, in the dementia side, it's different coz you going with what they are saying, one day they said to me 'where is my mother?', you know for sure they are in their nighties, so their mother is not here, you won't say 'your mother is dead', I will just say 'sorry I didn't hear from here today' , technically I haven't heard from her today, so I'm not lying, but I'm also not saying she is dead, so you really got to… for example, when you want to take them back to their bedroom, some of them would go, some of them you need to take them, 'come, come with me, I take you back to the bedroom' you go to the room and then 'can you come with me to my room?' so you go again, she came back, coz they once in, some of them cannot remember, so they come again, and it's depending on where you are in your journey.

I: So is that your daily routine for the.

N04: Yeah, and some people are happy doing painting, we bake cakes, we paint nails, some of them love going down to the garden, I will say 'can you help me to get flowers for the lunch, they help you there laying the table, and even there is dish washer, but it won't dry up, so they dry up, we have some space, and then can go there to get themselves some space, we got big fridge, we have some sweet and chocolate, so if they are hungry, they can go to the fridge, it sets up not clinical, it sets up as your home. We don't use the word corridor, that's called hallway, yeah, in the hallway, you will see all the things, there are doll upstairs, some people with dementia thinking it's their children, so they will like… one of the ladies, got a doll upstairs, that's her baby. we got everything there, it's really, really nice.

I: Very nice in deed.

N04: To listen and to see, you have to see to believe.

I: So, like you look after people with dementia, but when they first came, what kind of difficulties they may face?

N04: It depends, um before they came, my manager or my leader with the carer, and we did the initial assessment, so after the assessment, and then we will involve the family and authorities, and before they come here, we got to decide where the resident will be live within the family, because if somebody comes in recently, and then you put them into stage one, they may not be able to cope with that, it might be too busy for them, so when they are in stage two, they will be less… um say people are reading newspaper, most of they watch telly, and have conversation with their friends, when they come to stage two, they haven't got there, they just be there and have lots of time. Quite a lot of them need to be assisted with the meals, so it changes as it goes along, But in the first group, they may have the sign of dementia, you got the sign, you've been diagnosed, but it hasn't completely surface yet, but they will be with us, because they got dementia, at that moment they said they haven't got it. And I said, okay, I'm sorry, coz there is no point to say you have got it coz they are not going feel… they think they haven't got it …

I: Is that sort of denial?

N04: Some of them might be. But they said it's aged as well, you know, 70s, 80s, 90s, my elderly one is 99.

I: In dementia unit?

N04: Yeah, he is 100 at December, by Charismas, we lost one, in new year's Eva, the elderly is 118.

I: Ow.

N04: That's a man, and we lost a lady in boxing day, when she passed away, I was there, and she was 103. And people say that even the families we used to have, I have got three people upstairs, I used to work in another place, and the families said how different is here? We love it, they love it, the atmosphere, they love we give them more time and it's not all that tasks, if I has been told 'could you please clean that sink now?' if I'm with somebody,

the sink they need to cleaned, sink can wait, tasks wait, you are there and you do things by we call by the moment, so always say would you do the breakfast just wait, then they don't remember and I will say today it's a lunch choice, does it look nice, so you live in the present, this is for lunch, and they will say what you are going to have? Or you will say I will have that, so you try to bring in what they would do and then um we have menu cards, and we just say what would you like shown in the card? They can read it and give the choices, and they set up the table with some settings, so before you serve, that comes to the table first, salt and pepper, with a glass of wine, glass of juice, so they are doing the table, it's lad already.

I: It's like a restaurant.

N04: Yeah, yeah, and then I become to know that you like white wine, but I won't give you white wine, I would say 'would you like a glass of red or a glass of white?' I know she likes white, but I will still say to you red or white? Would you like cranberry? Would you like orange? If you like cranberry, I still give you both choices, so they can make their own choices.

I: Okay although they have dementia, they still got the right to make choice.

N04: Sometimes in the morning, when you get some people up, some of them, I get them up, they will answer you, but because further long to the edge, they answering but they don't really take what they are saying, so at least you can say would you like this pair of trousers or this pair of trousers? But they cannot answer you, so then you think it's a such hot day today, I don't want to put a lady into a pair of jeans, she's got thin trousers, so I will say 'I tell you what today, why don't we wear these thin trousers? It's hot outside', you know, this brown goes well with these trousers, we don't need jumpers today, it's hot, so you are choosing for them, because maybe that time they cannot choose themselves, but you are choosing for the weather, whereas some people will either… we got few people are dressing themselves, and some of them would say to you 'I want to wear that', but I'm only… I'm giving two choices, you cannot give them too many choices, so I will say right, I got lady upstairs, she loves blue, it's all about blue, so in her top choices, I will hold a blue top, and I will hold another different colour, and I will say to her 'what colour of top would you like to wear it today?' blue? So, I put the top up to here so she can visualise the top, and then I got a pair of trousers, I put the trousers here, and when she is looking down, she sees the top and trousers.

I: Okay.

N04: 'Would you like these trousers?' and she might go 'bit thick', then I will go to find some thin trousers, 'they are better', but then the next day, when I see this lady, she may not know who I am, yesterday, she knew me by name, yesterday, my friend another carer was getting her ready, and this carer comes from India, and she was like 'oh, I have been to India before', and then she said 'what's your name?'. and she (carer) said my name is Sunny,' 'oh, how do you spell it?' so the carer had to spell her name, and then she said to Sunny said 'I'm gonna call someone to give you a hand', because you know some parts of care you need two people, and then she said 'I'm gonna get N04, I like N04, N04 is my friend. So, I said good morning Ms. X, and then she said, 'good morning N04', just like that, she knows who I was, and when I first met Ms. X, maybe five years ago, I remember one day she said to me 'I like that', and she likes my ring, 'what's your husband's name?' 'I said his name is Kevin, but he likes to be called Kev' 'has he go any hair?' I said 'no, he is bald'. And about a month later, she said, 'how is Kevin?' and then she went he doesn't like to be called Kevin, he likes to be called Kev' she still knew he didn't like to be called Kevin, 'did his mom used to call him Kevin when he was naughty? And I said 'yeah', but even then, she speaks that until now, she still calls him Kev saying he doesn't like to be called Kevin, and only once she asked me his name.

I: That's interesting.

N04: But if you see that lady today, she has been up for breakfast, now she in on the bed, she needs to sleep, so she has really good day, all day she will be bright, and she will say to

you ‘where are you coming from, what do you do?’ she will ask you all the questions, but then the next day, flat, then tomorrow, she will be a bit more bright.
I: So, you can actually see the changes over time and.
N04: Yes.
I: How long does it take for you to know each resident?
N04: It varies. Yes of course, you got information but I will go to families, if you live at home with your mother for three years, before you join me, you are gonna know your mother better than any paper work, so you try to get some tips, how they like things done, how do they communicate, and after a while, I will formally know all the info and their needs, so I can see things important, what’s happening what’s going to happen? And what’s the outcome, so you just need to learn and pick up, um we got a new gentleman at the moment, and he cannot speak, I know what he can say is ‘no, no, no, no, no’. so he has been here for a week, I tried to get to know him, and when he says ‘no, no, no’. I got to think ‘is this no, no, no, because he is no, no, no, or sometime no is yes’.
I: It makes it more complicated.
N04: It does, but you can tell by his facial expression, and because he married a German lady, they call grandfather a word puppy… oppy, so sometimes you can see him sitting there on his own, he’s got a vodka, and I walked by and said ‘good morning oppy’ then he goes smile, I asked how does it taste? And he says ‘no, no, no’, (laugh), but ‘no, no, no’ is no, but means yes, yes, yes.
I: Right, so you can see the differences from his facial expression.
N04: Yeah, he has his own food, but sometimes, some of them like to eat the food, they got the spoon, but fingers, okay, no problems, they do it, after dinner, they got washed, it doesn’t matter, what they can do if they want it to is to use the pictures, but sometimes, if they hasn’t been done since something started, it’s hard to introduce later on, so say somebody has got stroke now, I will try those picture cards to begin with, not wait two years, do it straight away, coz even they cannot speak, with picture card, all they have to do is to point, or you can say ‘are you thirsty?’ if they can hear me, ‘are you thirsty?’ pop up your thumb if you are, and if he is not thirsty, (with gesture) so they still can do thumb, so that will be yes or no answer.
I: Is that the training course or it’s the way you work out with them?
N04: Yeah, the way you are, because the different training course is different, with dementia training, our main focus is… we call person centred care, so we don’t care if the bath is dirty, we don’t care if there is washing up in the sink, that tasks can be done when you are free, and our main purpose is residents, everything can wait, yeah, like… if I’m leaving today to go home and I haven’t finished my tasks, I will say to my colleagues, sorry, didn’t get time to do that, and they will take it over, and I spent my day out in the garden to look after somebody, pick up the flowers, or just sitting in the garden to have a cup of tea, you know.
I: They need people to be with them.
N04: Yeah, when they come down to the activities, they got activity programme, they go out, people come in, um… not many of them would come down, they don’t like to be in the new environment, but we do things upstairs, you might up hat on, you might put a little like the money bell on, or you just walk with somebody, and you just shake the bell, and the bell does a rattail to get their attention, or if they are… put the music on, if the person with the music on and there, you just say ‘would you like a dance? Get up the people and dance, so it’s just the things like straight off.
I: Okay, so what do you think what makes a carer a good carer?
N04: Amazing, you got to have love, it’s got to come from the heart, you know because you just come to be a carer if you just come in for a job, say you got to be loving on the inside, to be loving, and then many things the way I was brought up is the respect elders, so if you respect the elders, be kind, be loving, you cannot get far from, but then it’s also um try to get to know the person a little bit, if they are sitting in the back side, they are not asleep,

but just sitting there go… people going 'are you okay?' and then they will… they don't want to come out, because they are just thinking 'what she is doing there?' but while you um… like we got a man upstairs, he likes to do math, so I said to him 'Mr. Y, can you help me? I don't know the answer' so I put some math counts down, he doesn't speak much, but also yes, he would sit there and do the math on there, one moment he was sitting there and doing nothing, and I know he likes math, we do the math, another lady, she likes doing the baking, if they bake the thing can't eat, it doesn't matter, it's just the point of doing the baking, so I said 'oh I got to bake this cake for afternoon tea, but cannot do it, coz I don't know how to do it? Can you help me?' they're thinking they're helping me, we sit together and we bake cakes, and then we put in the cake stand, and down here, upstairs also, coz they can smell the cake, or they have the cake stand, they come round the hallway, and I said to somebody 'would you like one?' we made this, so you give them this, so you giving them the purpose of taking the cake stand with me, and hold my arm, you cannot too well, hold the cake stand, but then offer you as a friend, so it's purpose, give them the purpose, coz there is no point you just get a person up at 9 o'clock and leave them all day, that's why we have activities, like I said we go to the garden, and you always try to do the things with them, but we also have the things saying like say for instant, last night, if you went to bed at 9 o'clock, today I won't say to you 8 o'clock you are going to bed, you go to bed whenever you want, you get up when you want, we don't have a set time, some people do like to go to bed set time by choice, but if I go round, let's say half pass 8, and there is gentleman still up, and I will say like 'are you ready for bed?' 'What time is it?' 'Half pass 8,' 'well, it's still light outside', 'okay'. And then I will just go to say to the nurse that this person doesn't want to go to bed, and she can pass to night staff saying 'yes, we asked, but he declined', and then you just think, no time is setting stone, but they are in the time frame, so if I'm serving lunch today at one o'clock, main course, and you are not hunger, I won't say to you 'come on, lunch', we have two hours window, so the food is served at one, if it is not eaten by three, it has to be thrown, because it's all fully health and hygiene, like when you keep… if you keep you food in the two hours cooked, and then just ate it then, it's got to be food hygiene, in this tow hours it's up to them, and anywhere else in the care home, you will think well, what I am gonna do now, they got their food, but upstairs, we are lucky, we have toaster, and then they like different things, so you buy jam, marmalade, peanut butter, and Nutella, do you can have toast with jam, or you want the brown toast, you got the toast, then we got the fridge where we keep cold the sweet and things, so you can have it, we got candy store, and then the shelve, like we got the sandwich.

I: Okay, so although they don't really follow the routine, so you still got the flexibility for them.

N04: Ice cream, we got ice cream in the freezer, and then you think well by 6 o'clock, we have the supper, so yeah, and then sometimes, we get um like a piece of pastry from shop, and then it comes in with a piece of chocolate of pastry, and then we will turn it into pizza, we go downstairs, and said 'oh is possible we can have some ham and some cheese and something like mushroom' then I will say 'can you do me a favour? Can you go to help me wash the mushroom?' and then you give them a blunt knife and then go 'can you do me a favour, show me how to cut the mushroom?' before they start, like I'm doing like I'm washing my hand, can you wash yours?' so wash the hand in the sink, then they get the paper tower, and the they go bake pizza with you.

I: So, they don't feel like they are useless.

N04: No, and we got a cabinet, and you can see rising, and then the smell, and then we try and catch the moment, and the pizza is in the oven, they will hold your hands, I will take a photo, coz upstairs, there is a wall, we got photographs. And it shows you what we're going, and if I write care plan today, yes, I will write the personal care side, coz you have to, and then you do quite a lot of social, so I will say myself and Ms A and we made a pizza for everybody, or I gave her a hand massage, coz if you read the care plan, it just says I assist this person with the care, she had a shower, she did have her mouth open, eating and drinking,

that's standard, but you'd like to pit a little bit life into it, so you know, myself and Mr B went to high stress and had a cup of tea, or her daughter came in and down to the concert, you know, like this morning, I took, I was upstairs, and I only got one and I catch the moment upstairs, one of my residents, he was upstairs just stands up, he wasn't doing anything, he was just sitting there and watching… it was a lovely um photo, what I do, because we got camera upstairs, but I didn't add the camera, so I would then I give this photo to me boss, who will then print it off me, for this is lavender, and he was just sitting there, so in front of him, he's got the window, we also got this machine, inside it's a big tube of water, and you put in imitation fish, and coz it makes bobbles, and the fish goes up and down, up and down, so open it up, and you got two glass stores, and you got this big bit of plastic, but it's got light's shining through, so if you are there, I will bring the light, and I will put it on you, so you got all this light watching, and then you can just sit there and then stroke the light, and then the fish and the water changes colour, so you will be watching this fish up and down, see yourself in the mirror and it's got mp3 player on it, it's got the projector, and the slides go to the wall, and it's got an answer port, that you can put inside a bit if a… you know, if you got a spread in your kitchen, then hot spread, what makes kitchen smells like coffee whatever, it's got that in the back, so you can change your oil for like smell like coffee and smell like baking, all in one machine, so even they may never say 'I wanna do that' take them in there, four five people with you, you sit there with them, help them in there if they'd like a drink, well just sit and relax, it's nice and clam in there, so even though they might be living in middle, it doesn't mean they got to be there in whole in that area, so if I'm not in middle, and I have to leave to somewhere else, I won't tell them I will leave them in their own, I would say I will go round to see my friend, would you like to come with me? And then those people will go and take your hand, it's like also not to be stir, sometimes you just like this at home, you know, you wouldn't come in to your home, and say to you 'good afternoon Mr. C', no, so that you for instance, I would say 'good morning (residents' nickname), how are you?' he will say to me, I'm fine darling how are you? And then because he can walk, his feet go bit like this, he wants a kiss on the cheek, so I give him a kiss on the cheek, 'oh, thank you my darling' and the next one is waiting for his kiss, so it's about six in the role to get their kiss for the morning, it's only the one in their first stage, and then they will say to me 'oh what time are you working during the day?' so they know you are here for the job, 'oh, yeah, I'm finishing at the half pass two, anything nice for the dinner tonight? You know, they ask you for your dinner, are you going out? You know, it must like their grandchildren with them, they ask what you are doing, you come in the next morning, did you sleep well last night, was hot last night, they really do joining with us, because they can, in others the you will have to join with them, and that's the way you got change for being how we are and you speak about the weather, today's weather, but then the people they are bit further along the line, you then going to their thinking, so you got to change and change, so say a resident, he didn't know where is his mother, then you got going to what his mind and thinking, so sometimes we got to, we speak to him, 'do you think your mother is at work still? what time is it now?' we got a clock, it's 3 o'clock', do you think mom is still at work yet?' 'oh, she won't come back until 5pm' 'oh, okay then, try again later'. So, you won't say you won't do something, but just… you just try to get um not away from it, so they don't get beyond… they just not… they just say 'where is my mom?' and then get stress, then it's not good. So, we try to do things by time, we have got gentle man who got… came in yesterday, when she left, she said to me 'where is Ms E?' and I said 'oh, I saw her a minutes ago'. You don't want to say they've gone home, coz it may upset him, it all depends on what the resident is, some people you can say they've gone home, they will be here tomorrow, some people if you said that, it upsets them, so you really got to think of who he is and what the answer is gonna be, and I might say 'yeah, yeah, a moment ago, I did see her, but I didn't see her for a while, I'm not saying she's gone home, but I said I haven't seen her for a while.

I: So, it's all kind of truth, but in different way in order to comfort them, so how could you do such things at the end of life? When you provide end of life care for them?

N04: End-of-life care, we spend a lot of time with them, so if we've been told this person is at end of life care, me myself, is on the shift, I will make sure that person is not one his own, I could just say to him, make sure he stays with them, if they are asleep, I don't care, make sure when they open their eyes, you are there, and the minutes they wake up, they are not being… you know, they may not be too far along, just give them comfort, all you need to do, you know their like, so I stroke your face, and you put my hand away, I won't stroke your face again, coz I know you don't like it, but I would stroke their face, their palm, specially recently, I lost my father in august, my father had cancer and he was only 66, my dad, yeah, and my dad's comforting, you get your fingers and said 'dad, don't worry, I'm here', and my dad used to love this, and the nurse would say to me 'your dad is really agitating today, I was giving him an injection, no, not, he was agitated, he needs injection'. I said 'no, you're not doing right', coz they have to contact me, I said 'can you wait for me, and I will be up', within the night, I got to the hospital with pyjama, 'Dad, dad, don't worry, dad, it's me', five minutes stroke his hair. That's why it happened here, so it's stroking their arm, stroking their hair, if they can take fluid, give them a little bit of drink and add some atmosphere for them, so I like to have a bit like um… like it here, it's like 'mm,' if you are up in here, in front of me, I would put some flowers, you know if you like flours, put some flours, if you like some music, put the radio on, slightly, coz the last thing goes is your hearing, yeah, so hearing music, you open mind to see families, if you are there, open the eyes, he sees me, so it's just, just so.
(changed the location)
I: So, what do you think is good end-of-life care?
N04: It's being there, being there and also showing your compassion to not only the person at end of life and to their families, their families can come in with upset, so yes, they know their father, their mother is passing, but you still got to have compassion to them, coz if there are upset, if it's gonna go through that person, yes, it's not.. it's not… as… so you try to take it all into consideration, you know, and the possible where we are, we have people walking like, say they can walk, they go into the rooms, and then you saw like someone is going to the room themselves, so you say 'oh, a lady is in the bed, can you come with me for a bit?' (laugh) you know, coz they think obviously they go into the room all the time, so you got to be.
I: Do you join the discussion with doctor to see if this resident is in end of life care?
N04: Yes, we can do, we are… everyday, we have a meeting each shift, and then you have something in each unit, you will have a list which tells you all the residents, and then the nurse will just tell something about the residents, so you write it like I do, you write down the chart, so it might be that someone is gonna go out for a trip, so you write it down, and it gives you, we put them all in the DNR.
I: So, it's all in place.
N04: Yeah, and then it tells you that some people have to be checked every half hours, coz we do a lot of wondering around, and then the next we will complete the form, so the observation, every 30 minutes you say like, this gentleman doesn't want it, okay 'he was in the lounge, just on his own', and it's the same like we do try to stay in them, and you know, the lady who went, I knew a couple weeks ago, she just seems like she's giving up, um like you say 'would you like a drink?' 'no' you know, and then it's their choice, not to eat not to drink, you will try, you will try, you will try, but I think if you're 60, if you are in her age, nothing you can do to make it better, coz she loves chocolate, this lady, I go out to buy the chocolate, put it on the side, put it a plate in pieces, 'you want some chocolate?' 'no', she used like um sort of nice orange squash, I got one and said, 'for you', 'no.', and that's what happens, and that's what happens whole years, you know, and you cannot force anyone to eat or drink, so until they open their mouth to do it, you cannot.
I: I suppose if they don't eat or drink, it probably means they are in the very late stage.
N04: It can be, what happened is if they don't, when they, when their eating goes down from normal and we carers can notice their eating is going down, every day we think about

it and say like this person is not eating, so then we will decide to put her chart in place, so then it documents what you have for the breakfast, how much have they eaten, so we can get a judge, if you are in the place where you don't go to toilet independently, and you use the urine bag, we also document in that how much out in the bag, what colour was it? So if you have been drinking well, your urine should be clear, if you're not drinking, your urine will be concentrated, and will be dark, so all those information for our next colleague to find, we start that to begin with, if then if they are not drinking in properly, then the doctor will come, and out of say Saturday afternoon, if I got upstairs and found out that somebody is poorly, I will tell my nurse and she will find the doctor, they will come to visit, they come 24hours a day for us, and then up for them to decide what they can put here, we cannot give IV, it's just the way care work, so if you want to have some IV, then you will have to go to the hospital, yeah, just something most care home don't do, because you haven't got… you haven't got the4 trained staff deal with the IV, you know it's like to put IV in somebody is so difficult.

I: But how about the nurse, can nurse do that?

N04: No, we don't have IVs, a various reason why we don't, but we have never done it, the work I have done before, we have done it, it's just basically like a rolling about it, maybe, you know, but if you get the stage where they have IV, yes, we do, we sent them to the hospital, they have a IV and then get back, and then they just come back.

I: So, it's not like they will stay in the hospital.

N04: Depends on what it is, if um like one of them went to the hospital on Friday, they said he got the urine infection, but because he wasn't eating or drinking, he wasn't taking any antibiotic, so that didn't go, and the on the top of that, he got the tablet, and because he couldn't swallow, he was holding food, so he went to the hospital to have IV fluid and then to try to get the infection away, and then they say he will come back on Monday, coz it will need at least a weekend, so he comes back on Monday, and he came back yesterday, they say he is taking fluid and he is alright, but today he is in bed, we keep him in bed at the moment, only because we'd like the fidgeting to come out, if he is in the hospital, they may have changed his care plan, physician is coming to assess him again.

I: Right, so he wasn't really like totally fine.

N04: He's fine, but he is tired today, and what's the point to get him out and sitting on the chair and fall asleep again, and comes in form the hospital, he only lay in the back, so no doubt, I would say they only got the bottom and back, and what we do, we will keep him in bed today, but then 10am you will be lying in your back, 12pm, you will be you left side, 2pm you will be in you right side, so take your pressure off, instead of sitting in the chair all day, and that's what you will find in the hospital, they all got sore in their bottom.

I: Yeah, I don't think…

N04: They don't have enough staff, and that what we do, we make sure every round is we will turn every two hours, you still have fluid to drink, if you don't want it, you will, at 12pm, offer the water, declined, so we can still say yes, it's not well, but we still offer it, if you don't want to take the stroke, I cannot do that, you know, and it's the same if residents, families they tell me they want to go to hospital, or they got to have nursing care, when they get to end of life care, some residents will say it before they are poorly, make sure we speak to them and then we speak to the next of kin, their power of attorney to decide what's the best.

I: So, will you get involved in the discussion?

N04: I do, because, well some people think it's not my job, I'm a carer. It is my job, because I look after them, you give tablets, you do the injection, but I look after them, so it's my job, and I, I will speak up in the meeting, what's that? What we do, (laugh) can we try this? (laugh) you know, I, coz I'm older than some of us as well, and I have some experience, can we have a try on this? Oh, well, they don't want to go to hospital, okay, if it's in the final decision, you cannot change it, because they don't want to go to hospital which is their wishes, that's why they ask us here, meaningful, so that machine is hold you out, even if it's kept in that room, it's a will, so I can put that in our room with you, when you open your

eyes, you will see over here, you know, it's different, or like um if you line cuddling toys, I will go round and oh yes, you are there, so by the side of your bed, you have a stuffed toy animal, just things they like, you know, so it's finding what they like, and how to approach.
I: So, when you mentioned about meaningful life here, can you give me some examples?
N04: Every resident upstairs, has their life history in their bedrooms, so there is photographs, and it will give you bit of information about what they like, so say if say this person likes hose ridding, and they got photo with horse riding, so if I'm facing here, I will put a bed side table with their view, put their photos in the table, so they can see it's them and their horses, memories, put the flowers on there, so even though they thinking they live here, they can still see their own things, so they won't see oxygen mask, if they use it, it's alright, but in their view, they see their personal things, you know so if they are in bed, the wheelchair will be in the bathroom, you don't see it straight away, you know, you put things in the table, they can just… just see, some of them used to have bowels, twist it to make sounds, I love it, you know, so if I keep going in, coz even their eyes are shut, they are still flickering coz they can hear what you are doing, also like families come in quite often, they will response to their families, and if they are here for a bit, they responses to us, you know, they hear your voice and know it's you, coz they know you, so it's also important for new people to go in as well, coz I may not be there every day, somebody must be going in as well, so even we got 18 people, I don't do the same people every day, if I got 8 people today in my area, and I have staff, I won't get all the same people to wake, I would say 'yesterday, I assist this man, today I'm going to assist that man' so they can see different faces and getting on, and they see different approach of care, for them it will be a routine, I don't want to make routine for them, you know, if, if I… if they say to me today 'I don't want a bath', 'okay, maybe tomorrow', you know, if they don't want to have a breakfast, 'okay, maybe have some later', you know, and I said you know, at the end of life is difficult, coz when I first started, my people passed, it was the stage where I used to wash him, so even though they passed, you still like coming to my friend and hello, how are you? even though he wasn't there, you will still say hi, and then we have to wash the person, and change their clothes, ready for undertaker to come, for one that I stopped, so you know, once the person go, you just come out, close the door, if people wondering, I only stay around, in case somebody walk in the room and found somebody in the bed, but that's what happened, you know, sometimes tell me, when it happened here, it was doctor coming to certificate, and once doctor certificated then we phone the undertaker, and then they come straight away, everything will be within two hours together, so you only got to be carefully with that person still in the bed, and then if I… coz I don't think it's because I'm old school, but whenever we have the um sheet over them, if it's a lady, next to the pillow, I will put a few flowers, just few flowers on the pillow, if it's a man, and then I will put a few flowers in their chest, it's just nice, like I said, whatever you do, make sure the window is open, just keep the window open, and then when the undertaker's come, you don't have to, but I'd like to go in with them, even though they will lift from the bed to a chair, I'd like to be there, just make sure it's done nicely, and not… if they cannot do it their own, I will say do you need a hand, it doesn't… it doesn't bother me, if I'm coming over and help to move the post, it doesn't bother, and then we have a rule, when people go out, over the coffin, we put on the union jack flag, from the reception, and then old school b, if you are in the corridor, and you are not coming downstairs, you stay outside the room, and the back against the wall, and you just stand while this to watch, after that, you can go to do whatever you want, me, I'm different, I will follow the coffin to the lift, hands in my back, and just see them out their final journey, I won't take the lift, coz the phobic, so I run down the stairs, when they come out of the lift, I then follow them out the door, the only point is to say completely out, and I will use this and then I will go outside and I will wave to the person to the ambulance and when they go off, then I will come in, so if they die, I will follow them completely into the end, some people don't, but that what I have been told when I was 20s, you know, when I first started, and I think it's nice, coz it's sort of a big family, we all go to um… we all go to

the funeral if you want to, you don't have to, but if you want to go to the funeral, you go to the funeral, so you go in for yourself, you go in for the person you look after, and you respect it, I haven't been to this year, but I used to go, I'm not out for that stage, I have been to funeral since my dad's and in that moment, I don't want to go to funeral, you know, but we usually take turns, and I if I come in to work with jeans for instance, in the bag, I will put trousers, so you go to funeral looking respectful, you respect the home and you respect yourself, and you will hear they say 'thanks this care home looks after my aunt' you know. It's not following all the way through.

I: So, what make you work as a carer for so long time?

N04: Always first answer comes to mind is that I love my job, I don't do for the wage, I don't do for the price, I do it because I love my job, which is only half answer,

I: Half?

N04: Yes, the other half is personal but it doesn't bother me, when I was 16, in 1996, 86, I got told that I will never have children, when I was 16, because I was always a such a loving person, this is my dream job, because I haven't got the children to care for, of course I got nieces and nephews, but they are not mine, so that's why I love my job, I love caring people and I love dementia, every day is different, you know, today somebody might go to you, they don't know, they don't know they are doing it, you know, they like to go to (kisses hug, touch?) they don't know, so next day, they don't know who you are, that's dementia, so in dementia, every day is different, good days, bad days, that's, that's how they feel, and we might say 'oh that woman today scratch me', 'she scratch me' finished, how will they feel? How much they feel in their day? If she scratches you, they must have a bad thought, or something must be going on, a lot of them won't tell you that, so you got to try to think what have happened today? That's when you said 'oh, come and give me a hand, can you help me? Or should we have a cup of tea?' I know a cup of tea doesn't always work, (laugh) that's just a cup of tea, and maybe put um, we don't watch TV or TV programme, we watch more calm down thing, they like, they like all the food, like the cooking programme, dancing programme, or films, you know we don't have reality or talk shows, you know, we just try to put TV on, just try to get um focus on something else, it might be, it's just might be different that day, but we all wake up and grumpy some days, that's the answer, it might not be, if I come in at 8am say 'come one, let me get you wash now', say got 'I don't want it, I don't want it', if I come to you at 8am, and you are sleeping, I will leave you, if I come at 8am, and you are awake, it would be 'would you like to get up now?', those who can, will say yes or no, those who cannot, we leave them asleep until they are awake, that's what I do, I wouldn't leave them until mid-day, but if it's like 9.30am, and they are still not wake, then I will think well, I still try to get them up now for the breakfast, I cannot give them breakfast at 12pm and give them lunch at 1pm, so then you have to think they have been in bed for 12 hours now, but I wouldn't shake, I will go in and say 'good morning, I just come to make the light on', and a lot of them may have the odd face, I will go straight and call their name, and all sudden you open your eyes and then I would say 'do you want to get up now?' you won't just go to then and start to wash them, just try waking them up and then… if they know the time, and you just say oh it's light up now, time to get up, you know, and those will tell you they don't get up, but those they cannot, we have to try to get them up, otherwise, they will sleep all day, which they will miss out the activities, they miss out a lot of staff, their socialising, eating and drinking, so you have to get them up, for their own sake as well, and families come in and you know,

I: Yeah, that's what I want to know about the balance.

N04: Well they do say when these people were outranged, you don't have a bath to wake.

I: Really?

N04: Yeah? Even my mother said she was young, it was only once a week bath, and my mom is in her 60s, and that's what used to happened when 1940s, so some of these people were brought up with a bath once a week, so what we will do is at least one bath a week, at least, and then we document that, so the next person sees it, some of them have shower or

bath every day, they ask you, and also use your common sense, if you go in to a person in Monday, this lady's hair is normally white, nice white hair, I went in and I thought her hair is grey, and I say 'oh, when is the last time this lady had a shower?' don't know, coz you work differently, you don't know, so I just said to my partner 'I'm not being funny, I have a face off but I said she needs to shower today, so she said okay and ask 'would you like a shower?' she said 'no', but with this lady if you ask her every day, she says 'no', so soon later, you have to, so I said 'oh you know, what is sticky last night? And you feel quite hot, maybe a nice cool shower will cool you down, what do you think? If you quick' so she then let us, so then a new… I know she doesn't like it, so it was okay with the water on, hair washed, soap on, and soap off, done, (laugh) you know, coz we got new staff, she said to me 'why can you bother?' I said you cannot, coz I you siting here, this is… when we first came here, I got told to go get a lady to bath, he was in the bath, but the face was so close to the water, we never knew that, but the observation was the water and her face was too close, so now in her care plan, please do not bath just to wash, so then she doesn't get bathed, but they all got en-suit bathroom, so they have got their shower, they got no a shower, they got a hold in the floor, you put the chair, they got the sink and then they got um a lavatory in each bedroom, yeah so that's why, that's we got to tell the new… coz we got the new staff only comes here working so you got to guide them, say to them we don't need to bath this lady or that man has his bath every couple of days, you can tell if they don't want it (laugh), it's a such fine line, and then you can use other trick, if your mother comes in to visit, so your father, and you say I haven't given him a shower for a few days, they can say you smell and have a shower which one of them does that, and they will do it, because families can say that, you cannot, I have got a lady comes in for her father, and he doesn't like to change his clothes, and I tries to say to him, we have been trying every day, it's not only me, when his daughter comes in, she will say 'dad, you stink, you will have a shower, we haven't got, but we got a bathroom, he can use the bathroom with her, coz they don't mind, and he was really taking his clothes off, that's what I have been trying every day with him, you know, but it's always to do with his daughter, and he does it.

I: Yeah, families.

N04: He would do it, he would complain, but he would still do it, coz I said to her 'why you say that to your dad?' she said 'coz I'm family', I said we cannot, she said 'no, but there will be a problem' you cannot but you need it to be done, as you got the daughter in.

I: How could you deal with such thing?

N04: You just keep trying, like um if I ask and I was told no, I don't ask the second time, coz they will be angry, so what I might be is when I when they ask the noon shift comes on, before then, I would say to my nurse, and I would say that morning, I offered the bath, he had declined, she would passed onto new staff and then the handover, so then the one of the noon staff would have a go, if he says no again, that will be passed to a night staff and if this person is not going to bed by 11pm, night staff might be able to do it, so just keep to give the information.

I: So, the night staff will do it during the midnight?

N04: It depends, coz some people sleep during the day, and wake up at night, specially this whether, coz it's light by 4am, they waking up early, so you got really to try thing like today I'm not with this guy today, and he sees me, 'hi, I know you', 'oh, yeah, how are you?' 'oh, yeah, I'm fine', yeah, I said finished, but then tomorrow, if I'm working there, I would say to him 'do you want to have a bath?' 'no', but then I will put 'offered and declined', and I will say come and change your clothes, you know, if he says no, then it is a no, but you must keep trying, everything, eating and drinking and independence for toilet, you cannot just put them in the toilet, it's independence, if I'm taking them into the loo, and I know you can pull your clothes down, I'm not gonna do it for you, you pull it down yourself, alright, a lot of them cannot manage the paperwork himself, so when that's done, could you pull your clothes please, let's go to the sink, and then go to the sink to wash their hands, because they can wash their hands, they can pull the clothes on, everything they cannot do is clean the button,

but they can still do the front, so it's keeping… as soon as you stop, they can lose it, like a lot of people when they came, they can eat themselves, that will be slow, but they will do it, I have got a staff feed 'here is your lunch' and of course they can start eating it, now they lose the ability to do it, and I said please don't, they can do it themselves, if I'm there, the person can do it themselves, I will leave them, if they get dirty, and the napkin gets dirty, put a new napkin, if their top is dirty, offer then to change it, no problem, if you do that for them, they will lose their ability, and here we promote more independence as the top of the talking, but it's easier for some people to assist your meal within 5 minutes, than an hour, it's easier for me to do it, but if it's cold it doesn't matter, if they get their finger dirty, it doesn't matter, wash it, (laugh) if it's getting into your hair, they would go oh, so what, when it's dry, you brush it out, the home and everything, you wash it, that's it, quite I got home, they leave a fielded and on the bus, I will only wear two colour to work, and if you need to travel on bus for two hours, you wanna be… and what I do, I said to them I've got three different ones for work, I wear blue top and black trousers, or blue trousers and black top, and I wear trainers, and I wash them separately as well, I don't use… I don't use my machine coz here, you're dealing urine, you dealing with… how could you put that in your washing machine, so like my husband for a company with a uniform, so this is work wash, this is home wash, coz you don't know, what if somebody here has got anything, you don't know, well you will know, how do you know like there might be urine in your clothes, and you can put in your washing, no.

I: So, it's like a protection?

N04: Yeah, coz in the old place we work got uniform, apron and groves, here, I don't wear apron here, and only once I will use the groves when I work in middle, so if I wash your arms I don't wear groves, it's better of me hand is in your skin.

I: Does that… like contact?

N04: Yeah, human contact, it's nice for them, isn't it?

I: Yeah.

N04: You don't want to wash your face with groves on, it's not nice isn't it? If I give you a tissue and say, 'come on, wash your face and wash yourself', so every time when I put my groves on is when I do personal care which by saying on the other side, if I know today, I have got…. Say say you have got a rash and thinking 'don't know what the rash is', it might be some sort of skin infection, then I will wear me groves, coz I don't know what you have got, but then you tell me tomorrow and say 'yeah, doctor came in and it's fine, it's okay'. But I think it's so much better to get them washed and staff with naked hands, coz those are if they wash themselves, they won't use the groves.

I: Do you think it's like make a distance between you and the residents?

N04: That's the reason why we came here, we don't have uniform, as the uniform has a bit of distance for them, and we don't wear uniform, which is lovely. They do here, in this floor, they do wear uniform, this is the general nursing floor, my floor, dementia floor, we don't wear uniform, the top floor, that's the general, they wear uniform, it's… it's… it's just general care, most people here you get them up in the morning, and you won't see them again for the day.

I: What?

N04: Because they are independent, they might just say to you 'nurse, can you take me to the toilet?' you know, that might be it, but when they are in the electric chair, they might come and go. And then some of them in the manual chair, we have to then help them with everything, and their activities down here is only get done by the activities, well, as upstairs, we do activities, and we come down for this as well, and if there is no activities then they are on their own, they may come to coffee bar, and you may make them a cup of coffee, some of them in the wheelchair but haven't got the dementia, they are here because they are elderly, they are here because they need the support with the personal need but they still got the mental capacity.

I: So, how about your interaction or contact with residents' families?

N04: A lot, um it's an open-door policy, so they come up and they say 'hello, are you alright? How thing?' so you know the relatives very well, or they might come in to 'oh, how was mom doing in last couple of days?' I haven't been in and give me a moment I will go and find out, so I go to the computer and log on, 'oh, yesterday, mom went to the garden with a carer' 'oh, is she, that's brilliant', coz I don't know the answer, it doesn't mean I cannot find out, so I asked another carer, she may not know that either, so I log on to the computer, I can look at it, it will tell you how was it doing, 'where is my mom at the moment? I'd like to take my mom down stairs to the concert', 'oh, okay, I will leave it there, and I will see her after', and we have every three months we have relatives meeting, everybody can come and the meeting with me boss and couple of carers, and there is um they can ask questions, so we explain what carers run, what 's going on with the home at the moment, what are we doing, what's the coming up events. Any questions, coz they might not… the way they see their father, they see that 'they are not talking to me' it's not that, because they are here and they got dementia, they cannot remember 20 grandchildren's name, but give them a memory box, give them a memory book, take a picture, put the person's name, that's it, that's what they need, 'oh, yes, my daughter', don't tell them, you can show them, it's there, if you tell them, it will be gone.

I: So, how important do you think you need to interact with the families?

N04: A lot, we do it a lot, we spend time with families, they come in and if they are going out, they will come to us and say to us 'I'm taking mom out for an hour; coz they have to, just in case the fire alarm, we need to count for everybody in the building, 'oh yeah, okay go back soon', or they just come in to see how they are doing, and what's going on, 'my mom is not well today, do you know what happened today?' I would say 'no, sorry, I haven't looked after your mom today, hold on here, I will go and get the nurse' 'oh, excuse me nurse, whoever that is, I have got some relatives concern about her mom' they will say okay, they will come to say what's wrong, say something impact from the last week, things changed, so the nurse will tell them, you know, nothing wrong she just eat less coz she said she is not hungry, could be something thing simple, but if it's got to the stage everything is wrong, we will phone them, so if somebody is going to the hospital, we will phone the next of kin and say your father is not well, and he is going to the hospital, he is going to this hospital, we phone straightaway, if they haven't answered the phone, we leave a voice message, please get back to us, and then they know, when they coming home, we will get a call to say they have come home, we then phone them again, so we just keep them always informed. And say if they are not well today, or he is poorly, and they may call 6am and we will tell him… I won't tell them, I will get the nurse, coz it's not my job to tell them, the nurse just say it 'Oh, yeah, better at night'. They can phone whenever they want.

I: But like if you are the person who look after the residents, why you don't tell them directly?

N04: Coz it's the way we do it, I supposed why is because I can see how you are in your personal needs, I cannot say that you have got your medical needs, say I cannot tell you if you got your tablet today, coz I don't do that, or like if I say to nurse that you got temperature I think, I cannot say yeah your mom's temperature is 37, coz I don't know, so the nurse can give more information, just say it's my point of view, yes, I got your mom up today, she has got all the washing and dressing, and that's as far as I go, but I don't tell them any clinical, coz I'm not the nurse, if I say something and nurse says it's a different thing, then why I say that? But the nurse told me the different.

I: Okay, so it may confuse them.

N04: You can only say what you have seen and what you have done, if they ask me any medical, I don't do any medical… I don't do the tablets, some people say to me they have got some wound on them, coz I'm not a nurse, I don't know the in-depth of what… I don't know as what it is, you know, I could just say she wasn't well but let the nurse speak to you, say if your mom has got a CLPD for instance, going in to the CLPD symptoms and sign and

tablets, yes, you know a little bit about CLPD and what it is, but I cannot tell the tablet they are on, I cannot say something which is not me, it's the nurses can.
I: So, you provide the care for them, but you don't do the medication.
N04: No, it's nurse.
I: So, for instance, the nurse may have less time with the residents, and say if residents refused the medication, will you help?
N04: No, we will go with them, but only in a good way, but then what you will say is something like 'this is your tablets' some people will say what they thought, and then the nurse will say what is this and what is this, and I would say something like I had my tablets this morning already, which I have, would you like to have yours? 'no' and you look, they have got the water there, do you want to take with a bit of juice? So then I might go to get a glass of juice, so they will have it with juice, some of them… cannot… don't… before we give somebody their tablets, you've got to ask them 'would you like to take your tablets now?' but they said no is no, some of them hasn't got their mental capacity to say that, so what happened, go through doctor, go through the government, and note in the care plan, and we got a care plan in place saying here 'they don't know that they have the tablet that they got to take', so it's all legally in the paperwork, and some people don't like to take the tablets, they like to take it with a little bit of food, so different people but before you give the tablets you got to ask them 'here is your tablet, are you ready for your tablets?' if you say no, I will leave you, and then come back in half hour and 'here is your tablets' coz once the tablets has been signed off the chart, you cannot put it back, so it's like it's like… you just say 'it's your tablets, do you want them?', and if they don't, in there… where… you sign you name and you put an R, coz we don't use the word 'declined', oh no, we now use the D for declined, used to be R, so you put a D for declined, it's the terminology like um.
I: Is there any different?
N04: In dementia care, so I wouldn't say to you 'you walk out the corridor', coz at home, you don't have a corrido in your house, so I will say to you 'you walk in the hallway'.
I: Okay so make them feel like they are still at home.
N04: It's not, it's not your… it's not your room, it's your bedroom, I don't know yeah, but that's dementia care.
I: But it makes sense.
N04: Otherwise thinking I got corrido at home, you tell me know and I now go hallway, so you have to, yeah.
I: Okay, thank you for your time.

Appendix 9: Ethical approval for study 2

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8 November 2016

I-Ling Yeh
PhD Student
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School of Psychology, Criminology and Sociology
Faculty of Arts and Social Sciences
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Dear I-Ling

Ethics 151711 'Care workers' professional identity and motivations in the provision of end of life care for older people in care home settings: A questionnaire study'

To confirm that the Faculty Research Ethics Committee of 12 October 2017 conferred a favourable opinion on your revised application 151711 entitled ''Care workers' professional identity and motivations in the provision of end of life care for older people in care home settings: A questionnaire study'

Yours sincerely

Emma Finch
Research Operations Manager (FASS)
Clerk of the Faculty Research Ethics Committee
Faculty of Arts and Social Sciences
Kingston University

Appendix 10: Invitation letter to care home manager for study 2

TO

[Name of manager]

[Address of care home]

Dear [MANAGER OF CARE HOME]

An invitation to take part in a research project on work experience in care home settings

I am writing to you regarding a project which aims to enhance our understanding of care workers' views and experiences of working in care home settings. There is considerable research investigating the important role care staff assume in terms of providing care for residents in care home settings. Given that a large number of older people receive end of life care in a care home, we are interested in investigating the care home staff's views and experiences on working with residents as a professional care provider.

We are hoping to recruit 200 care workers from 20-30 care homes participating in a survey study. We are keen to work with you and invite your staff to participate in the study. Taking part in this study, your staff will be asked to complete a questionnaire which can be complete within approximately 20-30 minutes. They can complete the questionnaire independently or with the help of a researcher (I-Ling Yeh) using web-based or hardcopy questionnaire. The findings of this study have the potential to improve the job satisfaction of the professionals in care home settings. Further information can be found in the enclosed information sheet. This study has been reviewed and given favourable opinion by the Faculty Research Ethics Committee (FREC) from the Faculty of Arts and Social Sciences at Kingston University.

I would be grateful to be given the opportunity to visit you and provide you with further details of the study. I look forward to hearing from you. **If we do not hear from you, the researcher I-Ling Yeh will give you call on [date] between 9am and 12 noon to discuss whether you are interested in participating in this study.** Please feel free to contact me on (i-ling.yeh@kingston.ac.uk) if you have any further questions regarding the study.

Yours sincerely
Researcher: I-Ling Yeh (i-ling.yeh@kingston.ac.uk)

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Appendix 11: Invitation letter to care workers for study 2

Kingston University London

Dear

An invitation to take part in a research project on work experience in care home settings

I am writing to you regarding a project which aims to enhance our understanding of care workers' views and experiences of working in care home settings. Care workers assume an important role in providing care for residents in care home settings. Learning from your views and work experiences will supplement our current understanding about improving the job satisfaction of the professionals in care home settings. We would like to invite you to take part in a survey study. Please understand that the questionnaire is a tool allowing me to learn about your work experience. Your responses will be kept confidentially, and your participation will not be detrimental to your current employment. We anticipate that the questionnaire will take you approximately 20-30 minutes and can take place at the care home or at Kingston University, where the researcher is based.

For further information on this study, please find enclosed an information sheet. If you have any concerns about this study, please do not hesitate to contact the researchers who will be pleased to answer any questions you may have. This study has been reviewed and given a favourable opinion by the Faculty Research Ethics Committee (FREC) from the Faculty of Arts and Social Sciences at Kingston University.

Yours sincerely

Researcher: I-Ling Yeh (i-ling.yeh@kingston.ac.uk)

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Appendix 12: Information sheet for study 2

Kingston University London

Information Sheet

Care staff's work experiences in care home settings: A questionnaire study

Researcher: I-Ling Yeh, Becky Penney, Kine M. Hillestad
Supervisors: Dr. Tushna Vandrevala and Prof. Evanthia Lyons

For our degree (PhD and BSc) in Psychology at Kingston University, we would like to invite you to take part in a survey study about your working experience in care home settings. Before you decide whether you would like to take part, it is important for you to understand why this research is being conducted and what you would be required to do. Please take some time to read the information below and discuss it with others if you wish. Please ask questions if there is anything unclear or if you need further information.

What is the purpose of this study?
The aim of this study is to explore care workers' views and experiences on working with residents. Care home workers will be asked to complete a questionnaire.

Why have I been invited to take part?
You have been invited to take part because you are currently working as a care home worker in the UK and have experience of looking after older people.

Do I have to take part?
No, if you do not want to take part then you do not have to. If you would like to withdraw from the interview at any time, you can. Your responses will then be removed from the data. Please contact the researcher by **31st March** if you would like your data removed from the study. If you require any further information before you take part, please contact the researcher via the details given below.

What do I have to do?
If you agree to take part, you will be answering a short questionnaire. The questions which you will have are relating to your work experience (e.g. How much you enjoy working with residents? The chances you have to talk about your concerns. In general, I think that I can obtain outcomes that are important to me.) You can choose to complete the questionnaire on your own or with the help of a researcher. The questionnaire takes between 20-30 minutes to complete. A researcher from the Kingston University will help you while you are answering the questionnaire at a time and place convenient for you.

What are the possible disadvantages or risks of taking part?
We do not consider there to be any disadvantages or risks associated with taking part in this study and your participation will not affect your current employment. However, if answering the questionnaire causes you any distress, we encourage you to discuss the feelings with your care home manager or contact your GP. You can also access further information from MIND (www.mind.org) or contact them on 0300 123 3393 (weekdays 9am - 6pm).

What are the possible benefits of taking part?
We do not consider there to be any direct benefits to you. However, the findings of the current study may help us better understand how we may help improve job satisfaction in care home workers.

What if there is a problem?
If you have any concerns about this study you can contact the researchers, who will be pleased to answer any questions you may have. You can also contact the supervisors Dr. Tushna Vandrevala and Prof. Evanthia Lyons. Please find the contact details below.

Will my taking part in this study be kept confidential?
Yes. All the information which you give will be kept strictly confidential in accordance with the Data Protection Act 1998. You will not be identified in any report or publication that arises from this study. Only the researchers named on this information sheet will have access to the consent forms (where your real name will be stored) and to secure computer records.

Who has reviewed the project?
The study has been reviewed and received a favourable opinion from the Faculty Research Ethics Committee (FREC) in the Faculty of Art and Social Sciences at Kingston University.

Contact Details
If you require more information, please contact the researcher below:

I-Ling Yeh, PhD Psychology student, Kingston University,
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Becky Penney, Undergraduate Psychology student, Kingston University,
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Thank you for taking the time to read this Information Sheet.

Appendix 13: Consent form for study 2

Care staff's work experiences in care home settings: A questionnaire study

Kingston University London

Participant Identification Number: _____

Researcher: I-Ling Yeh.
Supervisors: Dr. Tushna Vandrevala and Prof. Evanthia Lyons

Please carefully read through the following sentences and tick the box next to the sentence if you agree with it.

- I the undersigned voluntarily agree to take part in interview on the experiences of providing end of life care for residents. [ ]
- I have read and understood the Information Sheet provided. I have been given a full explanation by the investigators of the nature, purpose, location and likely duration of the study, and of what I will be expected to do. [ ]
- I have been given the opportunity to ask questions on all aspects of the study and have understood the advice and information given as a result. [ ]
- I consent to my personal data, as outlined in the accompanying information sheet, being used for this study and other research. I understand that all personal data relating to volunteers is held and processed in the strictest confidence, and in accordance with the Data Protection Act (1998). [ ]
- I understand that I am free to withdraw from the study at any time without needing to justify my decision and without prejudice. If I wish to withdraw from the study, I can contact the researcher prior to 31st March 2017 [ ]
- I confirm that I have read and understood the above and freely consent to participating in the interview with audio recording. I have been given adequate time to consider my participation and agree to comply with the instructions and restrictions of the study. [ ]

PARTICIPANT

Signed:.....
Date:.....
Name (CAPITALS) .....

RESEARCHER TAKING CONSENT

I have explained the study to the above participant and he/she has indicated his/her willingness to take part.

Signed:.....
Date:.....
Name of researcher taking consent (CAPITALS) .....

Appendix 14: Questionnaire for study 2

Questionnaire: Understanding about work experience in care home settings

Identification number: ___

Thank you for agreeing to help us learn about your work experiences in care home settings. All the information which you give will be kept strictly confidential and your participation will not be detrimental to your current employment. The duration of completing the questionnaire will be approximately 20-30 minutes.
Please answer the following questions by clicking the most appropriate response or by writing down your own response in the 'other' category.

1. **What is your gender?**

Male ☐	Female ☐	Other ☐ (Please specify: _____).

2. **How old were you on your last birthday?**

_____ years.

3. **What is your nationality?**

_____.

4. **Where were you born?**

_____.

5. **How long have you been staying in the UK?**

_____ years _____ months.

6. **What is your first language?**

_____.

7. **What is your religion?**

No religion ☐	Christian (including Church of England, Catholic, Protestant and all other Christian denominations.) ☐	Buddhist ☐
Hindu ☐	Jewish ☐	Muslim ☐
Sikh ☐	Any other religion ☐ (Please specify: _____).	

8. **What is the best description of your ethnic background?**

White ☐	Mixed/multiple ethnic groups☐
Black/ African/Caribbean/Black British ☐	Asian or Asian British ☐
Other ethnic group ☐ (Please specify: _____).	

9. **Please tick any of the following qualifications you have.**

NVQ1 ☐	NVQ2 ☐	NVQ3 ☐	NVQ4 ☐	NVQ5 ☐	☐ Other (Please specify: _____)

10. **What is the highest level you have attained?**

☐ No qualifications	☐ Less than secondary school
☐ GCSE or earlier	☐ Secondary school//A-levels
☐ Undergraduate degree	☐ Postgraduate degree
☐ Doctorate degree	☐ Other (Please specify: _____)

11. **Are you currently employed full-time or part-time?**

Full-time ☐	Part-time ☐

12. How many hours do you work as a care worker per week?

_____ hours.

13. How long have you been working as a care worker in Britain?

_____ years _____ months.

14. What care settings have you been working in as a care worker?

Residential care home ☐	Nursing home ☐	Homecare agency ☐
Hospital ☐	Hospice ☐	Others ☐ (Please specify: _____)

15. What is your current position?

Care assistant ☐	Senior carer ☐	Care manager ☐
Healthcare assistant ☐	Care home manager ☐	Others ☐ (Please specify: _____)

16. What is your current average hourly pay?

£_____

17. Do you think your current salary is sufficient to fulfil your everyday needs?

Not at all sufficient ☐	Slightly sufficient ☐	Moderately sufficient ☐
Very sufficient ☐	Completely sufficient ☐	

18. Where do you think your salary rates in relation to other care workers?

Very Poor ☐	Poor ☐	Fair ☐
Good ☐	Very good ☐	

19. How good do you think your salary is comparing to other jobs requiring similar skills?

Very Poor ☐	Poor ☐	Fair ☐
Good ☐	Very good ☐	

20. Does your current income influence your quality of life?

Very negatively influences ☐	Negatively influences ☐	Neutral ☐
Positively influences ☐	Very positively influences ☐	

Please rate your level of agreement with the following statements on a 5-point scale (1= Strongly disagree, 2= Disagree, 3= Neither agree or disagree, 4= Agree, 5= Strongly agree) by clicking the appropriate box. Your responses are confidential.

	(1) Strongly disagree	(2) Disagree	(3) Neither agree or disagree	(4) Agree	(5) Strongly agree
01. When someone criticizes the care home where I work, it feels like a personal insult.					
02. I am very interested in what others think about the care home where I work.					
03. When I talk about this care home, I usually say ''we'' rather than ''they.''					
04. This care home's successes are my successes.					
05. When someone praises this care home, it feels like a personal compliment.					
06. If a story in the media criticized this care home, I would feel embarrassed.					

Please rate your level of agreement with the following statements on a 5-point scale (1= Strongly disagree, 2= Disagree, 3= Neither agree or disagree, 4= Agree, 5= Strongly agree) by clicking the appropriate box. Your responses are confidential.

	(1) Strongly disagree	(2) Disagree	(3) Neither agree or disagree	(4) Agree	(5) Strongly agree
01. I feel that I am a person of worth, or at least on an equal plane with others.					
02. I feel that I have a number of good qualities.					
03. All in all, I'm inclined to feel that I am a failure.					
04. I am able to do things as well as most other people.					
05. I feel I do not have much to be proud of.					
06. I take a positive attitude toward myself.					
07. On the whole, I am satisfied with myself.					
08. I certainly feel useless at times.					
09. I wish I could have more respect for myself.					
10. At times, I think I am no good at all.					

Please rate your level of agreement with the following statements on a 5-point scale (1= Strongly disagree, 2= Disagree, 3= Neither agree or disagree, 4= Agree, 5= Strongly agree) by clicking the appropriate box. Your responses are confidential.

	(1) Strongly disagree	(2) Disagree	(3) Neither agree or disagree	(4) Agree	(5) Strongly agree
01. I will be able to achieve most of the goals that I have set for myself.					
02. When facing different tasks, I am certain that I will accomplish them.					
03. In general, I think that I can obtain outcomes that are important to me.					
04. I believe I can succeed at most any endeavour to which I set my mind.					
05. I will be able to successfully overcome many challenges.					
06. I am confident that I can perform effectively on many different tasks.					
07. Compared to other people, I can do most tasks very well.					
08. Even when things are tough, I can perform quite well.					

There is a list of values. Please rate each value in terms of its importance within your care home by placing a check in one of the 7 columns (1: of lesser importance to 7: of greater importance). Think about each one in relation to its importance as a guiding principle for your care home as it exists today.

	1	2	3	4	5	6	7
	Of lesser importance						Of greater importance
The reputation of the care home							
Employee welfare							
Tolerance for diversity							
Value to the community							
Stability							
Organisational growth							
Profit maximisation							
Innovation							
Honesty							
Integrity							
Achievement							
Respect for others							
Expressing the individuality							
Security							
A comfortable life							
Success							
Creativity							
Quality of care provided							
Equality							
Friendship							
Happiness							
Salvation							
Obedience							
Love							
Capacity							
Self-Control							
Independence							

There is a list of values. Please repeat the procedure for rating the values within your care home. However, this time, rate the values in terms of the importance that you, as an individual, place on each value as a guiding principle in your own life.

	1	2	3	4	5	6	7
	Of lesser importance						Of greater importance
The reputation of the care home							
Employee welfare							
Tolerance for diversity							
Value to the community							
Stability							
Organisational growth							
Profit maximisation							
Innovation							
Honesty							
Integrity							
Achievement							
Respect for others							
Expressing the individuality							
Security							
A comfortable life							
Success							
Creativity							
Quality of care provided							
Equality							
Friendship							
Happiness							
Salvation							
Obedience							
Love							
Capacity							
Self-Control							
Independence							

The following questions concern your feelings about your job during the last year. (If you have been on this job for less than a year, this concerns the entire time you have been at this job.) Please indicate how true each of the following statement is for you given your experiences on this job. Remember that your boss will never know how you responded to the questions. Please use the following scale in responding to the items.

	(1) Almost never true	(2) Usually not true	(3) Rarely true	(4) Occasionally true	(5) Often true	(6) Usually true	(7) Almost always true
01. I feel like I can make a lot of inputs to deciding how my job gets done.							
02. I really like the people I work with.							
03. I do not feel very competent when I am at work.							
04. People at work tell me I am good at what I do.							
05. I feel pressured at work.							
06. I get along with people at work.							
07. I pretty much keep to myself when I am at work.							
08. I am free to express my ideas and opinions on the job.							
09. I consider the people I work with to be my friends							
10. I have been able to learn interesting new skills on my job.							
11. When I am at work, I have to do what I am told.							
12. Most days I feel a sense of accomplishment from working.							
13. My feelings are taken into consideration at work.							
14. On my job I do not get much of a chance to show how capable I am.							
15. People at work care about me.							
16. There are not many people at work that I am close to.							
17. I feel like I can pretty much be myself at work.							
18. The people I work with do not seem to like me much							
19. When I am working I often do not feel very capable.							
20. There is not much opportunity for me to decide for myself how to go about my work.							

For each of the following statements, please indicate how true it is for you on a 7 point scale (1= Not at all true, 2= Usually not true, 3= Rarely true, 4= Neutral, 5= Often true, 6= Usually true, 7= Very true)

	(1) Not at all true	(2) Usually not true	(3) Rarely true	(4) Neutral	(5) Often true	(6) Usually true	(7) Very true
01. When I working as a care worker, I think about how much I enjoy my job.							
02. I do not feel at all nervous about doing care work.							
03. I feel that it was my choice to do care work.							
04. I think I am pretty good at care work.							
05. I find care work very interesting.							
06. I feel tense while doing care work.							
07. I think I do well at care work, compared to other care workers.							
08. Doing care work is fun.							
09. I feel relaxed while doing care work.							
10. I enjoy doing care work very much.							
11. I don't really have a choice about doing care work.							
12. I am satisfied with my performance at care work.							
13. I am anxious while doing care work.							
14. I think care work is very boring.							
15. I feel like I am doing what I want to do when I work on care work.							
16. I feel skilled at care work.							
17. I think care work is very interesting.							
18. I feel pressured while doing care work.							
19. I feel like I have to do care work.							
20. I describe care work as very enjoyable.							
21. Circumstances forced me into care work.							
22. After working at care work for a while, I now feel competent.							

Please rate your level of agreement with the following statements on a 7-point Likert-type scale ranging from 1 (Almost never true) to 7 (Almost always true) by clicking the appropriate box. Your responses are confidential.

	(1) Almost never true	(2) Usually not true	(3) Rarely true	(4) Occasionally true	(5) Often true	(6) Usually true	(7) Almost always true
01. I am willing to work beyond that normally expected in order to help this care home be successful.							
02. I describe this organisation to my friends as a great care home to work for.							
03. I feel very little loyalty to this organisation.							
04. I would accept almost any type of job assignment in order to keep working for this company.							
05. I found that my values and the care home's values are very similar.							
06. I am proud to tell others that I am part of this care home.							
07. I would just as well be working for a different company as long as the type of work was similar.							
08. This care home really inspires the very best in me in the way of job performance.							
09. It would take very little change in my present circumstances to cause me to leave this care home.							
10. I am extremely glad that I chose this care home to work for over others I considered at the time I joined.							
11. There is not much to be gained by sticking with this organisation indefinitely.							
12. Often, I find it difficult to agree with this care home's policies on important matters relating to its employees.							
13. I really care about the fate of this care home.							
14. For me, this is the best of all possible care homes for which to work.							
15. Deciding to work for this organisation was a mistake on my part.							

Please rate the following statement regarding your working experiences on a 10-point scale ranging from 1 (very poor) to 10 (excellent) by clicking the appropriate box. Your responses are confidential.

	Very poor									Excellent
	1	2	3	4	5	6	7	8	9	10
01. How much you enjoy working with residents.										
02. How your role influences the lives of residents.										
03. Your closeness to residents and families.										
04. The care given to residents.										
05. The effect you have on residents' lives.										
06. Whether your skills are adequate for the job.										
07. The training you have had to perform your job.										
08. The chances you have for more training.										
09. The people you work with.										
10. Whether you feel part of a team effort.										
11. Cooperation among staff.										
12. The support you get when doing your job.										
13. The chances you have to talk about your concerns.										
14. The demands residents and family place on you.										
15. Your workload.										
16. Your work schedule.										
17. The amount of time you have to do your job.										
18. How fairly you are paid.										
19. Your chances for further advancement.										
20. Your overall satisfaction with your job.										
21. Would you recommend working at this facility to a friend?										

Appendix 15: The detailed descriptive statistics for the indicators within each latent construct

Construct[1]	Items	Valid (N)	Missing (%)	Mean	SD	Skewness[2]	Kurtosis[3]
OI	01	199	3.9	3.85	1.07	-1.012	0.605
	02	198	4.3	4.05	0.91	-1.362	2.409
	03	198	4.3	4.17	0.84	-1.202	2.075
	04	199	3.9	4.07	0.87	-0.836	0.682
	05	199	3.9	4.13	0.85	-1.084	1.643
	06	198	4.3	4.08	0.99	-1.225	1.336
SEs	01	199	3.9	4.14	0.80	-1.26	2.769
	02	198	4.3	4.35	0.65	-1.177	3.624
	03 (R)	198	4.3	2.03	1.11	1.065	0.509
	04	196	5.3	4.16	0.81	-1.611	4.486
	05 (R)	197	4.8	2.05	1.11	1.143	0.601
	06	197	4.8	4.16	0.89	-1.471	2.836
	07	197	4.8	4.05	0.86	-1.501	3.384
	08 (R)	197	4.8	2.24	1.11	0.666	-0.335
	09 (R)	199	3.9	2.61	1.32	0.299	-1.18
	10 (R)	199	3.9	1.98	1.08	0.97	0.137
SEf	01	205	1.0	4.11	0.71	-0.999	2.912
	02	205	1.0	4.11	0.70	-1.105	3.413
	03	205	1.0	4.13	0.63	-1.176	5.412
	04	205	1.0	4.12	0.69	-0.881	2.235
	05	205	1.0	4.07	0.69	-0.739	1.889
	06	205	1.0	4.22	0.64	-1.143	4.955
	07	205	1.0	3.82	0.88	-0.506	0.042
	08	205	1.0	4.11	0.68	-1.065	3.593
OrgV	01	199	3.9	6.39	0.99	-2.111	5.561
	02	200	3.4	5.94	1.30	-1.53	2.531
	03	199	3.9	6.18	1.17	-1.838	3.973
	04	200	3.4	6.13	1.10	-1.699	3.489
	05	199	3.9	6.09	1.18	-1.826	3.843
	06	200	3.4	5.82	1.39	-1.323	1.405
	07	200	3.4	5.38	1.71	-0.999	0.112
	08	195	5.8	5.70	1.30	-1.218	1.64
	09	199	3.9	6.21	1.22	-1.852	3.509
	10	199	3.9	6.10	1.22	-1.612	2.52
	11	200	3.4	6.20	1.10	-1.921	3.966
	12	200	3.4	6.32	1.08	-2.091	4.989
	13	199	3.9	6.09	1.20	-1.58	2.485
	14	199	3.9	6.34	1.18	-2.433	6.374
	15	197	4.8	6.17	1.30	-2.089	4.585
	16	199	3.9	6.03	1.32	-1.778	3.077
	17	198	4.3	5.89	1.26	-1.428	2.097
	18	198	4.3	6.53	0.89	-2.361	6.031
	19	197	4.8	6.23	1.22	-1.868	3.217
	20	199	3.9	5.89	1.43	-1.506	1.907
	21	199	3.9	6.04	1.39	-1.817	3.121
	22	197	4.8	5.83	1.40	-1.447	1.924
	23	196	5.3	5.64	1.52	-1.34	1.347

	24	196	5.3	5.84	1.59	-1.688	2.223
	25	198	4.3	5.99	1.35	-1.74	2.857
	26	199	3.9	6.04	1.27	-1.729	3.018
	27	200	3.4	6.18	1.23	-2.079	4.821
PrsV	01	192	7.2	6.27	1.13	-2.085	5.066
	02	194	6.3	6.24	1.11	-1.672	2.509
	03	193	6.8	6.18	1.17	-1.646	2.818
	04	192	7.2	6.03	1.23	-2.026	5.098
	05	192	7.2	6.22	1.08	-1.679	2.802
	06	190	8.2	5.75	1.44	-1.375	1.551
	07	188	9.2	5.16	1.78	-0.832	-0.237
	08	189	8.7	5.93	1.24	-1.313	1.547
	09	192	7.2	6.43	1.14	-2.698	8.056
	10	192	7.2	6.32	1.25	-2.572	7.28
	11	192	7.2	6.27	1.16	-2.238	6.095
	12	192	7.2	6.49	1.02	-2.708	8.494
	13	191	7.7	6.17	1.28	-2.227	5.557
	14	192	7.2	6.36	1.01	-2.172	5.719
	15	192	7.2	6.24	1.17	-1.915	3.876
	16	192	7.2	6.15	1.28	-2.047	4.701
	17	190	8.2	6.08	1.19	-1.66	3.417
	18	192	7.2	6.49	1.05	-2.836	9.163
	19	190	8.2	6.39	1.11	-2.443	6.874
	20	192	7.2	6.15	1.30	-2.065	4.641
	21	191	7.7	6.39	1.14	-2.803	8.96
	22	189	8.7	6.12	1.18	-1.448	1.7
	23	189	8.7	5.85	1.51	-1.639	2.283
	24	190	8.2	6.15	1.38	-2.014	3.894
	25	190	8.2	6.09	1.15	-1.493	2.203
	26	191	7.7	6.27	1.08	-1.977	4.79
	27	192	7.2	6.41	0.97	-2.322	7.284
VC		162	21.7	30.83	46.26	3.848	15.141
SPN	01	203	1.9	5.30	1.39	-0.811	0.568
	02	203	1.9	5.80	1.25	-1.078	1.189
	03(R)	201	2.9	2.75	2.04	0.876	-0.603
	04	204	1.4	5.54	1.45	-1.12	1.011
	05 (R)	202	2.4	3.79	1.76	0.039	-0.735
	06	203	1.9	5.92	1.21	-1.348	2.099
	07 (R)	203	1.9	3.68	1.97	0.169	-1.152
	08	204	1.4	5.43	1.50	-0.964	0.598
	09	203	1.9	5.28	1.61	-0.877	0.196
	10	202	2.4	5.86	1.32	-1.302	1.671
	11 (R)	203	1.9	5.34	1.59	-0.969	0.384
	12	203	1.9	5.72	1.33	-0.952	0.397
	13	202	2.4	4.98	1.67	-0.65	-0.217
	14 (R)	201	2.9	3.14	1.73	0.518	-0.657
	15	204	1.4	5.20	1.51	-0.659	-0.088
	16 (R)	201	2.9	3.55	1.89	0.354	-0.996
	17	203	1.9	5.14	1.71	-0.893	0.027
	18 (R)	203	1.9	2.29	1.50	1.299	1.097
	19 (R)	204	1.4	2.23	1.56	1.481	1.641

	20 (R)	204	1.4	2.91	1.72	0.675	-0.387
IM	01	202	2.4	5.63	1.33	-0.909	0.826
	02	202	2.4	5.63	1.81	-1.321	0.702
	03	202	2.4	6.19	1.42	-2.072	3.951
	04	202	2.4	6.27	1.01	-1.475	1.78
	05	200	3.4	6.02	1.30	-1.593	2.634
	06 (R)	202	2.4	3.02	1.93	0.635	-0.797
	07	201	2.9	5.14	1.63	-0.615	-0.268
	08	201	2.9	4.87	1.78	-0.673	-0.29
	09	200	3.4	4.97	1.64	-0.5	-0.463
	10	199	3.9	5.67	1.59	-1.344	1.352
	11 (R)	201	2.9	2.42	1.82	1.163	0.296
	12	200	3.4	5.75	1.48	-1.524	2.126
	13 (R)	198	4.3	2.36	1.72	1.106	0.232
	14 (R)	199	3.9	1.82	1.43	2.101	4.074
	15	199	3.9	4.88	1.95	-0.692	-0.614
	16	200	3.4	5.90	1.29	-1.408	2.223
	17	199	3.9	5.80	1.38	-1.271	1.541
	18 (R)	199	3.9	3.16	1.93	0.428	-1.039
	19 (R)	197	4.8	3.32	2.28	0.439	-1.317
	20	199	3.9	5.32	1.68	-0.989	0.342
	21 (R)	199	3.9	2.60	2.09	1.032	-0.331
	22	200	3.4	5.98	1.38	-1.543	2.266
C	01	203	1.9	5.86	1.37	-1.399	1.987
	02	203	1.9	5.75	1.34	-1.118	0.941
	03 (R)	202	2.4	2.94	2.07	0.706	-0.898
	04	202	2.4	5.06	2.07	-0.296	-0.959
	05	202	2.4	4.41	1.89	-0.95	0.414
	06	202	2.4	5.30	1.58	-1.301	1.5
	07 (R)	200	3.4	5.92	1.30	0.018	-1.211
	08	203	1.9	3.96	2.02	-0.881	0.475
	09 (R)	202	2.4	5.59	1.36	0.197	-1.209
	10	203	1.9	3.61	2.04	-1.156	0.951
	11 (R)	203	1.9	5.69	1.44	0.593	-0.815
	12 (R)	203	1.9	3.02	1.94	0.672	-0.726
	13	202	2.4	3.00	1.92	-1.395	1.866
	14	203	1.9	5.85	1.37	-0.89	0.158
	15 (R)	203	1.9	5.50	1.49	2.099	4.132
JS	01	200	3.4	9.12	1.51	-2.668	9.27
	02	200	3.4	8.81	1.57	-2.128	6.017
	03	200	3.4	8.55	1.61	-1.612	3.615
	04	199	3.9	9.23	1.29	-2.484	7.431
	05	199	3.9	8.84	1.45	-1.956	5.34
	06	199	3.9	8.93	1.33	-1.88	4.449
	07	200	3.4	8.85	1.51	-2.097	6.097
	08	197	4.8	8.73	1.61	-1.862	4.362
	09	199	3.9	8.50	1.61	-1.275	1.557
	10	199	3.9	8.56	1.72	-1.69	3.236
	11	199	3.9	8.26	1.89	-1.606	2.919
	12	198	4.3	8.31	1.89	-1.578	2.581
	13	200	3.4	8.16	2.05	-1.566	2.252

	14	197	4.8	7.53	2.10	-1.163	1.279
	15	200	3.4	7.33	2.35	-0.984	0.306
	16	200	3.4	7.85	2.03	-1.407	2.128
	17	198	4.3	7.47	2.25	-0.811	-0.177
	18	198	5.3	5.76	2.93	-0.184	-1.224
	19	200	3.4	7.05	2.47	-0.776	-0.206
	20	200	3.4	8.21	2.04	-1.738	3.163
	21	200	3.4	8.19	2.40	-1.638	1.908

[1] OI = organisational identification, SEs = Self-esteem, SEf = Self-efficacy, OrgV = Organisational values, PersV = Personal values, VC = Value Congruency, SPN = the Satisfaction of Psychological Needs, IM= Intrinsic Motivation, C= Organisational Commitment, JS= Job Satisfaction.

[2] The normality thresholds for skewness is 2.0

[3] The normality thresholds for kurtosis is 7.0

(R) = reversed item

Appendix 16: Parameter Estimates of the modified measurement model

Construct	Item	Estimate	Factor loading	R-square
PI	PI03	.585	.712	.508
	PI04	.789	.933	.87
	PI05	.569	.682	.466
SEs	SEs01	.545	.695	.482
	SEs02	.562	.877	.769
	SEs06	.525	.606	.367
SEf	SEf01	.473	.672	.452
	SEf02	.587	.843	.711
	SEf03	.494	.791	.626
	SEf04	.55	.8	.639
	SEf05	.545	.8	.64
	SEf06	.541	.851	.724
	SEf07	.576	.656	.43
	SEf08	.538	.791	.626
SPN	SPN01	.949	.692	.479
	SPN02	.767	.62	.384
	SPN08	1.062	.717	.514
	SPN10	.825	.632	.399
	SPN15	1.053	.705	.496
IM	IM01	.883	.674	.455
	IM04	.677	.682	.466
	IM05	.969	.763	.582
	IM10	1.115	.718	.516
	IM16	.712	.561	.314
	IM17	1.056	.783	.613
	IM20	1.188	.722	.521
C	C02	1.144	.867	.752
	C05	1.127	.723	.523
	C06	1.016	.794	.631
	C08	1.038	.773	.597
	C10	1.11	.778	.605
	C13	.869	.640	.409
	C14	1.078	.734	.539
JS	JSP	1.202	.769	.591
	JSR	.906	.692	.479
	JSWC	1.179	.763	.582
JSP	JS01	.811	.857	.735
	JS02	.818	.832	.692
	JS03	.826	.818	.669
	JS04	.616	.762	.581
	JS05	.715	.788	.621
	JS06	.635	.761	.58
	JS07	.737	.777	.603
JSR	JS09	.806	.711	.506
	JS10	.997	.822	.676
	JS11	1.243	.93	.864
	JS12	1.197	.899	.808
	JS13	1.136	.782	.611
JSWC	JS14	.878	.664	.441

JS15	1.164	.782	.611
JS16	1.018	.792	.627
JS17	1.18	.829	.687
JS18	1.153	.621	.386
JS19	1.153	.737	.543
JS20	.85	.658	.433
JS21	1.118	.734	.538

Appendix 17: Ethical approval for study 3

Kingston University London

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13 July 2017

I-Ling Yeh
PhD Student
Department of Psychology
School of Social and Behavioural Sciences
Faculty of Arts and Social Sciences
Kingston University

Dear I-Ling

Ethics application 161739: 'Care home managers' perspective on organisational and professional values'.

To confirm that the Faculty Research Ethics Committee of 28 June 2017 conferred a favourable opinion on your revised application 151739 entitled 'Care home managers' perspective on organisational and professional'

Yours sincerely

Emma Finch
Research Operations Manager (FASS)
Clerk of the Faculty Research Ethics Committee
Faculty of Arts and Social Sciences
Kingston University

Appendix 18: Invitation letter to care home manager for study 3

TO
[Name of manager]

[Address of care home]

Researcher: I-Ling Yeh,
Email: I-Ling.Yeh@kingstom.ac.uk

Dear [MANAGER OF CARE HOME]

An invitation to take part in a research project on working with care workers

I am writing to you regarding a project which aims to enhance our understanding of care workers and their care practice in care home settings. There is considerable research suggesting the important role care home managers play in determining the organization values of the care home and supporting care workers in providing care for residents. Given that a large number of older people receive care in a care home, we are interested in exploring care home managers' view about the expectations and the support for care workers to provide care for residents.

We are hoping to interview 10-12 care home managers form residential care homes or nursing homes. We are keen to work with you and invite you to participate in the study. We anticipate that the interviews will last approximately one hour and can take place in the care home or at Kingston University, where the researchers are based. Taking part in this study, you will be asked about the experience of working with care workers in the care home. The findings of this study have the potential to improve the quality of life of the professionals in the care home settings. For further information can be found in the enclosed information sheet. This study has been reviewed and given favourable opinion by the Faculty Research Ethics Committee (FREC) from the Faculty of Arts and Social Sciences at Kingston University.

I would be grateful to be given the opportunity to visit you and provide you with further details of the study. I look forward to hearing from you. **If we do not hear from you, the researcher I-Ling Yeh will give you call on [date] between 1pm and 4pm to discuss whether you are interested in participating in this study.** Please feel free to contact me on (I-Ling.Yeh@kingston.ac.uk) if you have any further questions regarding the study.

Yours sincerely
Researcher: **I-Ling Yeh** (I-Ling.Yeh@kingston.ac.uk)

Supervisor:
Dr. Tushna Vandrevala,
Address: Faculty of Arts and Social Sciences
Kingston University, Penrhyn Road
Kingston upon Thames, Surrey KT1 2EE
Tel: 020-84176317; Email: T.Vandrevala@kingston.ac.uk
Prof. Evanthia Lyons,
Address: Faculty of Arts and Social Sciences
Kingston University, Penrhyn Road
Kingston upon Thames, Surrey KT1 2EE
Tel: 020-8417-2442; Email: E.Lyons@kingston.ac.uk

Appendix 19: Information sheet for study 3

Kingston University London

Information Sheet

Care home managers' perspective on organisational and professional values.

Researcher: I-Ling Yeh
Supervisors: Dr. Tushna Vandrevala and Prof. Evanthia Lyons

For my PhD thesis in Psychology at Kingston University, I would like to invite you to take part in an interview about your experiences of helping care staff with the provision of care for residents in the care home settings. Before you decide whether you would like to take part, it is important for you to understand why this research is being conducted and what it is going to involve. Please take some time to read the following information and discuss it with others if you wish. Please ask if there is anything that is not clear or if you need further information.

What is the purpose of this study?
The aim of this study is to explore care home managers' experiences of helping care staff with the provision of care for residents in the care home settings. Care home managers will be asked the questions about their expectations towards care workers and how they help care workers to meet the expectations in the provision of care for residents. Learning from the experience of care home managers will provide more information to supplement our current understanding of care workers and their care practice in care home settings.

Why have I been invited to take part?
You have been invited to take part because you are currently working as a care home manager and have experiences of working with care workers in the provision of care in a care home setting.

Do I have to take part?
No, if you do not want to take part then you do not have to. If you would like to withdraw from the interview at any time, you can. Your responses will then be removed from the data. Please contact the researcher by **31st December 2017** if you would like your data withdrawn from the study. If you require any further information before you take part, please contact the researcher via the details given below.

What do I have to do?
If you agree to take part, a researcher (I-Ling Yeh) from the Kingston University will interview you for approximately one hour, at a time and place convenient to you. You will be asked to answer some broad questions regarding your experiences of working with care workers. With your consent, the interview will be audio-recorded.

What are the possible disadvantages or risks of taking part?
We do not foresee any disadvantages or risks associated with taking part in this study. The interview is not an assessment and your participation will not be detrimental to your current employment. We are aware that inviting you to discuss end of life care may cause you to recall unpleasant or distressing memories. If you become upset, the interview can be stopped. You will not be forced to continue with the interview. If the interview causes you any distress, we encourage you to contact your GP. You can also access further information from MIND (www.mind.org) or contact them on 0300 123 3393 (weekdays 9am - 6pm).

What are the possible benefits of taking part?
We do not foresee any direct benefit to the participants involved. However, the findings of the current study may have the potential to improve the quality of life of the professionals in the care home settings by exploring what facilitating care workers in the provision of care in the care homes. Furthermore, improving professionals' quality of life and well-being may have a positive impact on the older people they look after and subsequently enhance the quality of care older people receive in the care homes.

What if there is a problem?
If you have any concerns about this study you can contact the researcher I-Ling Yeh, who will be conducting interviews and will be pleased to answer any questions you may have. You can also contact the supervisors Dr. Tushna Vandrevala and Prof. Evanthia Lyons. Please find the contact details below.

Will my taking part in this study be kept confidential?
Yes. All the information which you give in this interview will be kept strictly confidential in accordance with the Data Protection Act 1998. Any information recorded about you will have your name removed and you will be given an alias. You will not be identified in any report or publication that arises from this study. Only the researchers named on this information sheet will have access to the consent forms (where your real name will be stored) and to secure computer records.

Who has reviewed the project?
The study has been reviewed and received a favourable opinion from the Faculty Research Ethics Committee (FREC) in the Faculty of Art and Social Sciences at Kingston University. This means that independent reviewers who protect the dignity, rights, safety and wellbeing of participants and researchers have deemed the study favourable.

Contact Details
If you require more information, please contact the researcher below:

I-Ling Yeh, PhD Psychology student, Kingston University,
Email: I-Ling.Yeh@kingston.ac.uk

Dr. Tushna Vandrevala,
Address: Faculty of Arts and Social Sciences, Kingston University
Penrhyn Road
Kingston upon Thames, Surrey KT1 2EE
Tel: 020-84176317
Email: T.Vandrevala@kingston.ac.uk

Prof. Evanthia Lyons,
Address: Faculty of Arts and Social Sciences, Kingston University
Penrhyn Road
Kingston upon Thames, Surrey KT1 2EE
Tel: 020-8417-2442
Email: E.Lyons@kingston.ac.uk

Thank you for taking the time to read this Information Sheet.

Appendix 20: Consent form for study 3

Care home managers' perspective on organisational and professional values

Participant Identification Number:

Researcher: I-Ling Yeh.
Supervisors: Dr. Tushna Vandrevala and Prof. Evanthia Lyons

Please carefully read through the following sentences and tick the box next to the sentence if you agree with it.

- I, the undersigned voluntarily agree to take part in interview on care home managers' perspectives on organisational values and motivations among care workers. [ ]
- I have read and understood the Information Sheet provided. I have been given a full explanation by the investigators of the nature, purpose, location and likely duration of the study, and of what I will be expected to do. [ ]
- I have been given the opportunity to ask questions on all aspects of the study and have understood the advice and information given as a result. [ ]
- I understand and agree that my interview will be audio-recording and transcribed verbatim. [ ]
- I consent to my personal data, as outlined in the accompanying information sheet, being used for this study and other research. I understand that all personal data relating to volunteers is held and processed in the strictest confidence, and in accordance with the Data Protection Act (1998). [ ]
- I understand that I am free to withdraw from the study at any time without needing to justify my decision and without prejudice. If I wish to withdraw from the study, I can contact the researcher prior to 31st September 2015 [ ]
- I confirm that I have read and understood the above and freely consent to participating in the interview with audio recording. I have been given adequate time to consider my participation and agree to comply with the instructions and restrictions of the study. [ ]

PARTICIPANT

Signed:……

Date:……

Name (CAPITALS) ……

RESEARCHER TAKING CONSENT

I have explained the study to the above participant and he/she has indicated his/her willingness to take part.

Signed:……

Date:……

Name of researcher taking consent (CAPITALS) ……

Appendix 21: Demographic questionnaire for study 3

DEMOGRAPHIC QUESTIONNAIRE
Identification number: ___

Please read through the questions and answer them by ticking the box next to the response which is the most appropriate or by writing down your own response in the 'other' category.

1. **What is your gender?**

Male ☐	Female ☐	Other ☐ (Please specify: _____).

2. **How old were you on your last birthday?**

_____ years.

3. **What is your nationality?**

_____.

4. **Where were you born?**

_____.

5. **What is your first language?**

_____.

6. **How long have you been working in current position?**

_____ years _____ months.

7. **What is your religion?**

No religion ☐	Christian (including Church of England, Catholic, Protestant and all other Christian denominations.) ☐	Buddhist ☐
Hindu ☐	Jewish ☐	Muslim ☐
Sikh ☐	Any other religion ☐ (Please specify: _____).	

8. **What is the best description of your ethnic background?**

White ☐	Mixed/multiple ethnic groups ☐
Black/ African/Caribbean/Black British ☐	Asian or Asian British ☐
Other ethnic group ☐ (Please specify: _____).	

9. **What is the highest level of qualification that you have attained?**

☐ No qualifications	☐ Less than secondary school
☐ GCSE or earlier	☐ Secondary school//A-levels
☐ Undergraduate degree	☐ Postgraduate degree
☐ Doctorate degree	☐ Other (Please specify: _____)
☐ Prefer not to say	

Appendix 22: Interview guide for study 3

Kingston University London

Interview Guide

Care home managers' perspective on organisational and professional values.

Researcher: I-Ling Yeh
Supervisors: Dr. Tushna Vandrevala, and Prof. Evanthia Lyons

The aim of this study is to explore care home managers' experiences of helping care staff with the provision of care for residents in the care home settings. With your permission the interview will be recorded. All the information which you give in this interview will be kept confidential and any information recorded about you will have your name removed. This is PhD thesis project, and the interview is not an assessment, but it will allow me to learn from your experience. There is no right or wrong answer and you will not be judged. Please share you experience and opinions with me.

1. **Please can you tell me about your role as a care home manager?**
   - Please can you tell me what you do as a manager?
   - What did you do before taking the current position?
   - How did you start working as a care home manager?
   - What do you like best about working as a manager here?
   - What do you find challenging about working?
   - If you could change one thing about your role/job, what would it be?
2. **Please can you tell me about your expectations towards care workers?**
   - How do you expect care workers to provide care for residents?
     - Can you give me an example(s) of good practice in the care home?
     - Can you give me an example(s) of bad practice in the care home?
     - What do you think care workers feel about the expectations?
     - How do you think the care workers feel about their role in this care home? / Can you give me an example?
     - Do you think the staff working in the care home see themselves as professionals?
     - Do you find care workers often follow their belief and understanding or do they follow the guidance from you or the care home? / Can you give me an example?
   - How do you expect care workers to interact with residents?
   - How do you expect care workers to interact with residents' family?
   - How do you expect care workers to work with other health professionals?

- How do you expect care workers to work with other care workers?
- What do you expect a new care staff to do when they first start?
- What professional values do you think are important in this care home?
- What do you think care workers like best about being a care worker?

  Can you give me an example?
- What do you think care workers find challenging about being a care worker?

  Can you give me an example?

3. **Please can you tell me about how you motivate staff to provide care in the care home?**

- What do you do to motivate care workers to work independently?
- What do you do to encourage care workers to interact with residents?
- What do you do to encourage care workers to interact with residents' family?
- What do you do to help care workers to work with other care workers?
- What do you do to motivate care workers to work with other health professionals?
- What do you think are the main motivations for the staff to work as a care worker?
- How do you inform the care workers of the care home expectations/ values?
- How do you ensure that care staff are aware of the expectations/ values?
- What do you think about how care workers feel about the expectations/ values?
- Do you think there are different motivations for staff to work as a care worker? / Can you give me an example?
- What difficulties do you think care workers would experience at work? / Can you give me an example?
- What do you think about the influence of these difficulties on care workers?
- What do you do to help care workers to deal with the difficulties you mentioned?
- What do you do to encourage the staff to provide care for residents?
- What do you do to encourage the staff to commit to the work?
- What do you think may make the staff feel more satisfied with care work?
- What do you think may make the staff feel less satisfied with care work?
- How do you encourage care workers' behaviour when it is in line with the expectation/ values?

- How do you deal with care workers' behaviour when it is not in line with the expectation/ values?

4. **Please can you tell me about your thoughts regarding professional boundaries?**
    - What do professional boundaries mean to you?
    - What do you think care workers' responsibilities are in the care home?
    - What do you think about care workers forming a close relationship with residents? / Can you give me an example?
    - What do you think about care workers keeping a distance from residents? / Can you give me an example?
    - Will you encourage care workers to form a meaningful bond with residents?
    - How do you ensure that the care staff are aware of the professional boundaries?
    - What do you do to support the staff to maintain the professional boundaries?

Finally, is there anything else you would like to share with me?
Thank you for your help with this study.

Appendix 23: Transcription of M09 in study 3

I: Please can you tell me about your role in the care home?
M09: I'm a deputy manager, we have to ensure that our home complies with all legislations, rule and regulations as stated by the government, and also the care quality commission and this covers everything to ensure that our residents receive the best care possible and they are not abused or mistreated in anyway.
I: Okay, so what did you do before taking the current position?
M09: What I did before this, I have done a lot of things, my main career in life was in the military, I was in South Africa navy for 26 years, until I was medically discharged through a major surgery, and yeah.
I: That's very different from working in a care home, so why you--
M09: Okay, when I left the navy, I wasn't allowed to work, because my medical health, but I did part-time jobs, I worked in everything from selling handbags, working in a warehouse, and garden service, and when we move over to England, my wife is a carer in a care home, I used to drop her off to the work every day, I have done a lot of things with my wife in respect of her clients, coz she used to do live-in care previously before coming to this care home, I used to get to know the family, take them out, you know, the person she was looking after, so whenever she did the course, I did the course with her, so she did the first aid, I did the first aid. She did the dementia and I did the dementia, that type of things, and those courses building up, when she started to work here, I drop her off, and if something is wrong in the house, and the manager would say 'can 09 fix it?' so I fix it. and I used to come in, 'Can 09 help to do this? Can 09 help to do that?' you know, coz I had the qualification, and then um one day the cleaner never turned up, so I drop her off, and they said 'oh the cleaner didn't come, can you come to clean the bath room and that', and I said fine, and the next minutes, I was speaking to the owner, and her gets to know me, and we discuss things, and then he offered me the position of deputy manager from my previous experience of management and things like that, and my previous experience of caring, and I started working and yeah, I think if I'm going to do the job, I must do it properly, so I did the NVQ5, instead of doing NVQ2,3 and 4, I went straight to 5 and I passed it in 12 months, and I have been doing that for a couple of years, when I first started here, we were required improvement by CQC, and now we are good, so it has come up, we're actually doing quite a good job here, I think, this is what you call life experience, you know, I have always like people and this management style, I don't do anything, I'm not autocratic or bombastic, I'm always very diplomatic in my management style, I believe in democracy, and things got to be done, they got to be done properly, and I want to get everyone's views on how they should be done, because if I get their views on something should be done, then I know if I put that in place, they are going to do it, coz they actually give their input of how it should be done, but with the guideline that ensure they follow the legislation and CQC requirement, as long as all these things sort of fall together, then we make up our duties, responsibilities, and our policy and procedure are in accord with that.
I: So, is that difficult to get everyone's view?
M09: Yeah, when I first started, I stayed in the office and I went through all the files, one of the first thing I went through is all the policies and procedures, because this is picked up by previous CQC inspection, I reckoned about 75% of procedure were non-existent, so I started doing research on the company like and administration sort of company for care home, you know, normally you pay them and they will do all the work for you. The owner of the home just feel why pay someone else to do the work when you can do it yourself, you know, so I did a lot of research, also through CQC, through google, policy and procedure, for example of sickness and absentee, you know, what is the great way to deal with sickness and absentee in the care home, and then I do research, draw up the policy as I thought would fit. And in the meeting and say what, this is what legislation says we have to do, this is what I think we got to do, and discuss it. and if anyone got any input to make it better or make it flow smoothly, and then I will incorporate that in there and then we put it up, and then it took

me just over a year just to update all the policies and procedures, what's down there, you can ask me anything about it, coz I knew it all, (laugh) coz you know all the policies and procedures of a care home, and the duties and responsibilities of those people that have to carry out information, oh, carry out those requirement, then I think you know how the care works, but you, the methodologies I don't think it's so good, um they are very.. if, this is that's the way must be done, there is no breaking the rules, that's why it needs to be done. But when you find something like, um when you write a care plan, a care plan is in accord with the resident, I would say you draw that care plan according to the resident's requirement or the needs of that residents. You cannot stick to a hard and fixed rule, you got to be able to bend, either way, you know, so it's like a tree, if a wind blows and the tree doesn't bend, it's gonna break, and so you know, we got picked up by CQC, because um, we had one resident who had bipolar disorder, bipolar disorder is they have changing mood, that's what bipolar is, they have changing mood, one day they can be lovely and the next day they can be miserable and crying whatever, and next day they can be angry, you know, um as long as you know what it's about, and if you know what is the key that is going to set this person off, what's set them off, then you can actually put that in the care plan, okay, let's check, he has been with us 3 years, he has never displayed any changing, he has been diagnosed with bipolar for many years, um he was really bad, but since come into the home, good care ,stable environment, good food, you know, tell you when to have shower, things like this, it's interesting he has never displayed any changes in anything, and so we write in the care plan, you know, he has bipolar disorder which is a changing mood. But we also have a policy in the side, the policy and procedure, so if there is any changes to any residents occurs, they have to report to the senior carers or management immediately, so for example, you go to Martin's room and say 'good morning Martin, would you like to get up?' all that, and generally, he is in the good mood and all that, and today is not, then it's not normal, it's different, so you got to report 'oh, I went in to get Martin up, today he is very grouch, never being like that'. That indicates immediately something wrong, so we know that and put in the care plan, we just said he had changing mood. CQC said require improvement, because we have to list what is bipolar, which we said it's changing mood, but also exactly what and which can go on to, I can show you volume and books of bipolar, what information do they want in there. It's not hard and fast rules, they want what is this, what is the key to set him off. We don't know, we have never… no one can tell us, how I'm supposed to put the key in there. Anyway, so we create some orders. You know immediately they said that, and I said fine, by tomorrow morning I will be able to update it, and straightaway call the person does this say 'what I want you to do is to find out what bipolar is'. Went on the internet and printed out bipolar and stapled in his care plan exactly what it is, just sort of the general over view and write the um… due to the fact that he had never had any changes in mood swing or anything like that since he has been, so we don't know what the key to set him off, so that's what they wanted was in there, but we set for 9 months with require improvement. When you see require improvement on your rating, it goes on to the website, and then people, we still have 4 empty rooms here, they come in, and they like the environment, but because our rating said, 'require improvement', they don't want to put their family member in. Plus, we had a fight with them, after… if something is picked up, generally, you know, this is not hard and fast rule through the CQC, they said generally or usually they reinspect within 3 months to see if it has been updated or not, and the they can re-change the thing. So after, we did it immediately, informed them immediately, so within a week, we have informed them this has been redefied. And they never carried out another inspection and they come 9 months later to do a focused inspection in the headquarter on the care plan, because this was it. they went through the care plan, said we have updated that care plan and computerised our system, we did the research into it, we did a lot of work into it, and the system we got now is extremely good to see which she (the inspector) said it's an excellent system, and then upgrade our things form require improvement to good, but overall rating remained require improvement, so nothing change really, I know, because they said 'if we don't inspect you within 6 months

after the initial inspection, then we have to do another fully inspection before they can change require improvement'. How did that work?
I: That sounds a little bit weird.
M09: Exactly, so anyway, we contacted the lawyers, contacted CQC directly, say that we want the money for the lost 9 months, well we didn't say 9, we give you 3 months, 6 months and we have 4 rooms empty, £650 per week, we want this money now, because you have affected our business, we are business, all of sudden, CQC knocking the door and carry out the fully inspection.
I: That's a very weird system.
M09: Yeah, tell me about it, but now it's changing now, since we have done that, now they have changed it, if they do carry out inspection at any time after something has been picked up, they have to change the overall opinion as well.
I: I'm sure you are not the only care home.
M09: No, no, no, everybody has problems with CQC, people tied to the home because of CQC, the one article in the caring times, we get this magazine called caring times once a month, and one of the woman closed her home, she got picked up for one thing which she felt was not great, um it was factorial needs accuracy, she complained and all that, they sent the inspector, everything else was good, when the inspector was around, while they sent the whole team of inspectors arrived. And all the sudden, she un not only require improvement, they want to do closing home down, they found all these things wrong all the sudden, I don't know how true it was, but it was an article in the magazine, and I remember showing it to the home, they were like 'oh, we are not the only one'.
I: That's weird.
M09: You should speak to initial care associate for your project, speak to them about fuss and of the CQC. Listen, CQC does the excellent job, really does, but I think they hold is not correct, because any judgement they make is one-person judgement, any one-person judgement is very subject, you know it's not objective, it's subjective judgement, because I took the same care plan and I gave it to a social worker, and I didn't tell them what's wrong, I just say 'go through that care plan and point any fault out to me' and he went through and said to me you actually have a really good care plan, coz you got a lot of information here than the most of the home they got. I said, 'didn't you find anything wrong with it?' and he said no. well we got 'require improvement' because of that detail. No, couldn't believe it. anyway, as I said, it's a subjective opinion of this, and that's the way they carry out the, Listen, overall, they do a very good job, because they stop abusing home etc. etc, we have reach the stage now, so we don't have another inspection in 12 months, because it's a very strange situation, it's not only for us, but also for the staff as well, coz they work on you know, in case they got asked questions that they cannot answer, they are very confident in their work, I have got excellent carers and they should not be, I tried to tell them 'don't be frightened by these people, they are just persons like you and me, they just ask you the questions, just answer them honestly, if you don't know, just say sorry I don't know, but I will find out, I will have the manager to tell me about it'.
I: What was the reaction when the staff knew that you have require improvement?
M09: They were disappointed, very disappointed, because they work very hard, you know, if you read, I would advise you to go on the internet and read about requite improvement inspection, and read someone have got outstanding, they read exactly the same, they rate exactly the same.
I: I think I checked before, the descriptions are very vague.
M09: This is what make us so angry, one of our previous inspections, we got this thing here, this is a lack in the window that you cannot push the window further than this, what I have for the old one is different kind. So, they marked us down and said that's not acceptable, that the residents can get out of the window and fall out, because we have to have special one with the key, the same day they told me that, I said which window you are talking about? He told me the windows, I went to the shop bought the 15 of them and I put them on every

window, before they left from the inspection, they still marked us down, (laugh) honestly, two other people, we went around and put this on every window with keys, and I got all the keys here, and they still marked us down, they said 'we found it, so we cannot go back.' I said, 'you are not here to help us?' they said 'no, we are here to inspect you, not help you'. (laugh) that's what they told the owner. 'we are here to inspect you, not to help you'. I have got the new… that was quite a few years ago, things have changed since, and things are getting better, they are still very subjective in the judgement, we feel um and I think the they rule the two regime in some respect need to change that, but they are changing, things are improving, we got a very good inspector now, he came in, the first day he did was to monitor everybody, he spoke to residents, he spoke to all the residents, every single resident, 25 residents at that time, he spoke to all the visitors and he spoke to all my staff, he spoke to me and manager, he just watched and walked around and look, and the second day, he started to go through all the paper work, my paper could be better, I didn't say it's the best, because I couldn't evident quite a few things, I can show you what I have done, I've got all the information, but I haven't taken that information and make like a summary of 17 faults, this and this and this, and what can we do to make sure this doesn't happen anymore, I just got a record for all the faults so I have the evidence what action I have taken, although I have taken individual action for every single one of them, which we've updated the care plan, done the risk assessment, accorded the specialist, occupation therapist to assess to see maybe they need different… so it's individual basis, I have done the right things, but I didn't put them all together to say 24 residents just lost balance unusual and so we got.. four of them we got the occupation therapist, so that's what we are doing now is putting that in, like activities, our full times activity coordinator, but she left due to the transport problem, she is catching two buses and train to come to work, so she got a job which is closer to her, which is fine, we were using non-trained people, this has been working, I have hired fully qualified activity coordinator, she started today, and she got some really good ideas, and she is taking on board what I have said, you know, respect and evidencing, and she know exactly what I'm talking about which is nice, coz she knows what we mean, coz you know, I don't know how to evident coz I have never done that before, I have been doing research and what I found, I sort of understood and then I explained to her and she was 'yeah, yeah, I know,' and she explained other things to me. 'I will just leave it to you' (laugh).

I: You were mentioning your staff's reaction to the rating; how did they feel after they upgraded the rating?

M09: You know I gave the good news, coz we got the pre-assessment of that, the um coz they sent it to us say this is the assessment you had, everything is good, and really good comment made for our everything, and then we have the opportunity to challenge for the accuracies, which we don't need to coz I agree with everything they said, so I called the staff and had a meeting and I told them. And they sat back to their sit and 'oh', you can actually see the difference, they got something to be proud of you know. It was very depressing when you're doing everything you ought to do and you do them very well and you got picked up something in the care plan and everything goes down accordingly, that you get sort of deflation, you know, why I'm doing this? But once I said this, you know, it's actually been recognised now, um there was a big difference in the staff, you know, I can actually see them being proud of what they do.

I: When the staff first started working here, did you show them all the regulations?

M09: Okay, what we do is um we normally advertise if we can n indeed and employment agency, what we try to do is see if we do it through indeed on the internet and all other employment agency on the internet, then we get people that they need to catch two trains from London, you know, they got to catch the train or bus, it becomes very difficult, and we have a lot of lateness, tardiness, we have people cancelling shifts because the train delayed, although you find out that these trains tire them up, they got jaded because they got to catch two trains before they started working, so by the time they get here, they are tired, you know, so what we try to do is to put locally in the shops and post office and you know anywhere

people put up job advert maybe put down there. Generally quite a few applied, and also um friends and families and things like that current carers living areas, I think at the moment, we only got two actually commute, all the rest live locally, and, yeah, when they come in, we carry out interview, and we speak to them to find out how they hear about us first of all, why do they want to be a carer? Is that just filling time? In fact people are honest you know, I'm just looking for a job, and I cannot find a job anywhere, you know, I have never trued this, and I'd like to try, you can actually see this, sometimes you can actually see the way wasting the time, we get a lot of people come in, had a proper interview and turn out it's wasting time, because they have to get some many interviews for the benefits, and so they come, I don't know what they tell them the people assessing them, but they don't come back, but generally they come in for an interview and they then will do two morning shifts, they are not allowed to work in the home, they are not allowed to work in the home, unless they have followed all the criteria and the legislation by the CQC, they have to have DBS check, they have to have moving and handling course, they have to have some reference and something like that, those paper work has to be gathered, what I want them to do is to come to shadow someone, so they come in for the morning shift 7:45 to 2pm, they come in, and they will follow the carers around, all they have to do is to observing, they will follow the same procedure as in respective of infection control and all that, they will.. if the carer is providing care and she has to wear gloves, they will wear gloves, if they have to wear apron, they will wear apron, so they will follow around. And this gives me three things. First thing is to tell them can they do that thing that they can do the job, and we do specifically in the morning, and we get them to um, put them in the area where we know the residents are incontinent, they have faeces on them, they have urine on them, it's really the bad, it's not the glorious side of caring, you know, and we can see how they handle it. first of all, they see for themselves, do you think you will be able to do the job? We have some people, after the first person, they come to say 'thanks, but this is not really for me, it's just gonna waste your time' and then leave, others said they will come back and never come back. Secondly, it gives me, I can see what they like, like myself or the senior actually watch their reaction, you know, when they, you know, can you just pick it up and put them in the red bag, you know, it's like the bag for faeces and urine and they got to put them in the bag, if they (feeling disgusting), then we know they are not going to stay in the care. So, it gives us some ideas who they are and we think they can do the job. That's two. And the third, we have to pay for the DBS check, that's the security check, and that's £68, so if I do apply for the DBS check for everyone applies for the job, the owner will go bankrupt, so I don't want to spend money on that, unless the person feels they can do it, and I feel they can do it, and then I got two days top of work, maybe help wash dishes and clean, you know, lay the table. They have done that personal care with the residents, so I actually got some work out of them and then I feel, you know, the owner feels, you know, he is paying for something, because we cannot do anything until DBS come through, and then what I do is I give them the application form, and DBS check form, and list all the requirement, like passport, identification, bank statements all the things are required by DBS, give it to them and then the second time they come in to do the second shift give me all the paperwork. I then immediately apply for DBS and send away the reference for this person. So by the time DBS comes in, and I got the reference, then they can start immediately, and then I will… if you know, in many occasions we had like moving and handling course for other staff, and if they're waiting for the DBS, I will put them on that course, or the course for first aide or something, I will put them on that course, because I know they want to work, so I pre-empt this DBS coming through care you know. So, once it comes through, they can start working immediately, so I call them in, give them all the documentation. Like I gave two today, our home staff documents, induction check list, all these, then they start shadowing with really working now, and they will start getting hands on, but not by themselves, they will have to work with a key carer until they are assessed by the senior carer, 'the carer can work on their own now'. and then we just carry on, and then we got the um like care certificate, once they've done the induction, done

the moving and handling, infection control, done the all basic courses, they have worked about two months and I know they are settling, I know they are not just leaving, then I will put them in new care certificate, which you teach them all of that, caring and care world.

I: It sounds like a very long process**.**

M09: It is, it is, you cannot, someone cannot just walk in and say, 'I want to be a carer' and then they start working, that's a long process, so if we are short of staff, you know sometimes it can take up to a month. some people apply for DBS today and tomorrow it comes through clear, an activity coordinator applied at 4pm, and I came in next morning, I had a clearance, clear. Other people, 6 months, 3 months, 4 months, some people like 4 months, they are still working here. I don't just a person for what they did when they were young, as long as they are not in the debarring list, they can, you know, I have, had, I'm not saying I've got now, staff that have been up for theft, you know, you suspect someone of something like that, you know they have done their time, they serve their thing, I'm not going to punish them, coz I will monitor carefully and camera everything like that, you know, they do do the proper training, so we give them a chance, sometimes it works out, sometimes it doesn't.

I: So, do you prefer someone with previous experience?

M09: I prefer someone with no experience, because they tend to bring bad habits for the home they came from. I'm not saying they are bad habits, but they are not what we want, we have very restricting in respect of enduring to the rules and regulations, and the legislation in respect of providing care for the residents, and if someone we know the person trained the staff for moving and handling for example, we've never been picked up moving and handling problems by social workers by therapist, by doctor or anything, so we know it works, now we don't know who train the person before in moving and handling, and how they were allowed to move and handle residents in their care for example, so you know, um things change in the daily bases, if something happened in the care home, they have a new investigation, they have a review and policy changed, and procedure changed, and CQC puts it up, and everyone must endure to it. this is what we do, so I get notifications form CQC and QCS stating what is changed in policy and procedures, and I update us and I will let my staff know accordingly. If they get taught in other care homes, you got a manager or senior carers that don't care, then you tend to find that flowed into the carers, because then they start doing… it's not illegal but it's bad habit. Okay, if they come to work for me, then sometimes they bring it with them, sometimes it's very difficult to get it out of them, and say 'you know, let's…'. 'but that's how I did in other care home'. I don't care how you do in other care, I want you to do how we do in our care home, coz I don't want the police knocking on our door one day, because one of the residents' arm is broken because you lift him by the arm or something, you know, so you got to be very carefully, and I think we are over careful but our staff know our requirements, and they are very good at it, we do catch one or two staff members just not thinking, doing something that they shouldn't, they're immediately pulled out, they're immediately put in other course, I had one staff member done and put on another course, and told them, you know, this is not the way to do it, you look like you need another course, I have my staff done 4 courses in a year, but she wouldn't learn, but she is doing better now, because everybody knows and they say 'you got to do that', you know, it's very important that, you know, you follow these things, for example, we've got two residents now that are on end of life care, palliative care, get them both up in the morning is the hoist work, when we change them clean them, you know, toilet them things like that, it's all taking them up on their bed things like that, and it's two carers, and if you don't work with them properly, you're gonna hurt them. If you don't tell them what you're doing, you're gonna make them frighten, so you got to make sure this gets done all the time, you know, so this is why it is important that my staff, we have a set of rules, and everyone does it that way. Do they have opportunity, every supervision I have, one of the questions I can show you, 'any concern or worries, any strong views around the delivery of the service'. When we talk, I always say to them all our policy and procedures that we put in place that tells you how to do your morning care, how to do you afternoon care, to do evening care, how to work with

someone when they are in bed, how to toilet the person. Do you think they work? And do you think anything needs to be changed that will make it better? Because if they do, then they will tell me. And it's not once but everyone, because all those policies and procedures have been discussed with them when we put them up. So carers actually had the input, 'I don't think we should do in that way, I think we should do that way'. And we learn, and we find out what they think should be done is followed in accordance with what CQC required and legislations require? Yes, then we can put it in, and we tried and after two three weeks, we call another meeting say 'well, how was it working?'. 'this is working, but that is not working' or 'it's a good idea, just it's not working in practice'. You know, then we change it, until we've got. And now we have a set of rules and regulations that I think work. And if you look up CQC report form the last one, even the previous one, it stated out our residents and the care we provide, it's always been good, and yet they're still asked every single supervision and I do supervision every two three months with all my staff, and they're asked, 'Do you think it's still working? Do you think that anything needs to change?' specifically people that come from other care homes, and we will ask them 'how do we do it like that and why do you do it like that?' does it work? Well sometimes it works yeah? But we never had close mind to any changes and how we do things. We are very open, management here, open to suggestions.

I: If staff's suggestion was not totally complied with the legislation, what would you do?

M09: Then we explain to them, yeah, it has to be, you know, we will say 'yeah, that's a very good idea, but it's not in accord with the legislation, it's not the procedures required by CQC and all these others'. And I won't just say that, but I will go and investigate it. and then, generally there is a review and this says this was tried, and the reason why it wasn't used is because someone has got pulled out and hurt or something like that, you know, it's like moving and handling, this changes in daily basis, um something happened and when someone is moved in according to the procedure that they have laid down, and one person get injured, then they do the investigation, why did this person get injured? And they will say but they followed the procedure, this is exactly how I did it. okay how do you think we should do this, so it is not gonna happen? They will find the means of doing the same thing and but just slightly differently that it's not gonna pull out the socket or whatever the case maybe, and I will change the system, say we are putting in… if someone gets hurt, and we will ask them how it happened? 'well, I'm doing exactly what you said' 'but what exactly what you did'. And then generally 'oh, I do the…' you know. 'are you supposed to do that?' 'no, not really'. 'Oh, you firstly have to be… this first and then…'. 'oh, yes.' Hey we are not perfect, you know, things happened, even if you follow the rules and regulations, things happened, you know, the guy in the hospital now, he got a broken hip, we know the full risks, everything is in place, and he just fall, just like that, just nothing you can do, that's the things, carers did nothing wrong, I've got the video on CCTV, she did everything that should be done. Hindsight, maybe she could have said a little bit more to lift something like that, but you don't know. Generally that's where you stand, you know, um you know, there is no perfect world that you do everything, there is a lot of trail error, as long as you follow basic rules, you're gonna be fine.

I: How do your staff response to the changes which you mentioned as 'change in daily basis'?

M09: Listen, it's all discussed, like a said, if I'm going to make a change in the routine of how to change someone's bed for example, if they even make a routine like that, it will be discussed with them, and then they will say 'you know, that won't work', this will be discussed with all the carers that actually do the work, and then we will then that will be policy, so if someone is not doing that way, then they are not doing the policy, are they? And they will be happy because they have a decision in making that policy or procedure.

I: So, for those who did not follow the agreement, what will you.

M09: Okay, they get training, they get corrective training, you know, um training is continuous, I can show you what training follows up, everyone is on the course, soon as they finished a course, they will go into another course. Corrective training, um for example, they are not following the routine for morning routine, um and we noticed it, coz we assess all the time, seniors are walking around and just notice a little thing and then I will call them in, 'listen, you know, your procedure is not very good, this is what we have noted, why is it like that?' 'I don't really know, whatever the case may be, I always do it that way'. Well, but then it's wrong, and then the next time they do... care for someone, I will let them do with someone else, and then that person will carry on the assessment, you know, and then they will show them the right way to do it, one of my senior carers will say 'right, we will do this person now.' for example toileting, you have some problems when you take someone to the toilet, you must do something wrong, this is the way to do it. they will take her, and they will do it. the next time, they will do the second time, and the third time they will do it. and it is all working now, they will continue like that, until the such time they get it perfect. So, it's always continuation training and we believe in continuation training all the time, and reinforcing you know, if we see someone, you know, I always say, moving and handling, you never use a closed hand, so you know, you don't need to hold on to someone. It's always the flat of the hand, You can move someone without using the flat of the hand, you are not going to grab someone to move them, even if they lay in bed, you are going to put the sling under them, so you stand on the side, put one hand on the shoulder here, one hand on the hip, and you tell the person 'I'm just going to move you'. And you slide them over like that, then you can put them in… so there is no need to grab, you know, no need for them to pull, the same as um standing up on a chair, now they need to tell the resident to stand up, the resident's gonna stand up and gonna move off, they got the walker and they must put their hand on it, and then they push themselves up, so standing, they transfer to the walker, the carer, hand on the flat back at the button, not on their butt, just above the butt, and just give them um helping push, it's not much straight required to do that, and if you stand up and push up, that's quite hard, but if you got someone to give you a push. This is just basically a normal thing, and you actually see sometimes underarm, they grab underarm to help them to lift up. 'what are you doing that for? are you.'. 'oh, sorry'. Put on the back. We watch this all the time, everybody is watching, everybody is watching, it's just a habit, you know, um the carers are always… one of the questions I will ask is um safe guarding, okay, safe guarding is in my interview, I said to them 'do you know any one, any of the carers here, that you feel is not providing proper care, is being rude to the residents, abusive, all that you know, you must let me know, because it's very important that I know, that this person doesn't get abused, and it's important in my supervision, every time when I have supervision, every time when I have a meeting. And part of abuse, what is abuse? It's by grabbing someone and not using correct moving and handling techniques. So if I grab your arm there and pull you out, you can end up big bruises, so if my carer told me 'Linda got 5 little bruises' then I know someone grab and pull, they grab their arm to help them stand up. Because their skin is so thin, and they are so brutal, and bruises are so easily, or you get skin tear, or something like that, so you got to be so careful, and that's why you have to use proper moving techniques. So we always know if someone not using correct moving and handling coz they got bruises, not saying that, you know, residents don't knock themselves, they bang on the chair, something like that or reach something and knock their hand, the skin will tear, so what happened there, nobody knows, but these things happened, but no one's actually done that purposely or wrong techniques. You got to sort of know when to say 'okay, you got to investigate this'.

I: So, you mentioned about CCTV, what do you think your staff's view about CCTV?

M09: They never checked, any time I check CCTV is if something happened, and I will look at that timeframe, as well, we don't look the CCTV, down there, it's open, they will see me go there, to stand on the chair and do it up in the thing.

I: So, the camera is there, and you know you are being watching.

M09: You know, you don't even notice it anymore. At beginning, I think maybe people will self-aware. But I say to them, as long as you do things right, you got nothing to worry about, yeah, I did pick up, I heard the rumour that my one carer, my male carer was picking up the resident, and moving them, he didn't use the hoist, what's what he used to do it when he was a young carer. So I went to the CCTV, there it is, so I did check when he was on duty, I saw a couple of things, he did wrong in moving and handling, so he re-do the moving and handling course, he is very good, he is an excellent carer, but he feels if.. I had a chat with him, I think he felt that we start to use hoist and things like that are very invasive on the residents, because you got to move them a lot, put the things around them, hoist them up, you know, it's not the most comfortable thing, quite frighten for them, and it takes time, it can take 10 minutes just to move from the chair to the wheelchair, and back to the room you know, whereas (holding)… that was he said… and I said 'it's all very well, but it has been banned, why? You could drop it, you could injure your back' and then just two things, I'm not taking anything else, you could hook their legs, you can trip over it and fall on the top of them, and break their neck, there are so many things could go wrong, you know, because your feeling sorry for them as you say, or you just want to get it done quick. And he agreed, he said that he felt that you know, it will be so much kinder for her, and quicker for her, and she prefers it, you know. I said 'you don't know that, she is not talking, is she?' she is on palliative care, she is not saying anything. How do you know? Maybe she doesn't like it, so we got to follow the rules and do things properly. Otherwise, we don't do them at all.

I: So, what do you expect them to interact with residents?

M09: Listen, we believe in the mom treatment, you know.

I: Mom treatment?

M09: Mom, mother, would you do anything to your mother that you would do to the residents, would you put the arm? Would you talk to her in the bed, you know, whatever you want for your mother, I want you to have for your residents, so if you love your mother, the resident is just as much… just like your mother, it's someone's mother, or someone's father, you know, that's important, you know, if you haven't got that compassion, and I think you shouldn't be, you know, if it's just a job to you, then what you are doing this for? we do get carers started off like that, and then they turn out to be excellent carers, and you can actually see the changes from the routine just going through it, because I have to do it, I have to get that person up, I have to change their pad, I have to dress them, I have to wash them, I have to put them in the lounge, you know, I have to bring lunch, because it's my job to someone who cares. You can actually see on the staff's face and the way they react to them, just put their hand on their shoulder when they're talking to them, hold their hand, the way they talk to them, you can actually see the change of some carers to become more compassionate, and start thinking 'this could be my mother' you know, they're (residents) all nice people, even though they got dementia, sometimes they do horrible things and say horrible things, you know, try to pinch you (laugh). It's not them, it's the disease, you know, yeah, so I think my carers are… you know at the moment, I think I've got a very good bunch of carers, we had occasions where carers that I wish they just leave, I don't know, I seem to wish they just leave you know (laugh). No, I'm just joking, but you know, some people, it's just not their vocation in life.

I: Can you describe or whether there is sort of turning point for carers to change?

M09: I don't know, I don't exactly know when the turning point is, a lot of carers that come here, you can see that's what they want to do, they always want to do, always want to do caring, always want to do nursing, and they just got their compassion helping people, we have had, like I said, people come in just a job, and you can actually see the change in them, as they get to know the person, and they joke with them and laugh with them, they had a little bit cry with them, they become more attached with each residents, you know, I think that's where the changes you know, it's not just a job, that's a nice person, I don't mind doing that for that person, yeah I think that's, that's a big thing as well, when.. to be a carer, you have to, you have to communicate with residents, it's not just like, you know, when you

change a baby, you're always kissing them, tickling them, you know when you change. You don't just change them throw them back to the bed. It's the same to the old people. When you do their care in the morning, and you are the first person they are talking to them, you find out sometimes the most fantastic things about them, what did they do in their previous life, he was a CEO of a company or something like that you know, the story they come up with, you know, we have a gentleman here, he is a very intelligent man, he used to write for newspapers everything you know, he would say to me 'you are the manager? Come and sit down' and he would tell me his stories, yeah, that is quite interesting, yeah, we get some very interesting people here, you will be supervised, you will be supervised. And I'm telling you something, it's all eye opener, you know, my god, that could be me, tomorrow, you know, dementia comes in, you're gonna need somebody to look after you. You think your family are fine, until you reach the stage where they become um challenging, where they become incontinent, and you have to sort of deal with it yourself, do you think, you know, you got to start cleaning your mother or your father, and showing them and feeding them, and you know, changing them, and they are not appreciated for what you are doing, you start to hate them. You know. I've spoken to family members that come in, and I said, you know, 'what's wrong?' you know, it's nothing wrong, it pretty normal, I think I would have hated my parents, if that was me and at the beginning, you owe them, you know, and that owing them then become aide (laugh) 'I don't want to do this' you know, put them in the home, and then you feel guilty, because you put them in the home, uhh, this is just no ending cycle, you got to be a little bit of psychiatrist and speak to people and say 'listen, it's normal feeling you know, everybody feel guilty put their parent in the home, but think about this, how is your life changed since they have been in the home'. they have a life now, you have a life. They still come in to visit, you know, we have some residents' family come in everyday, others are once a week, others are once a month, some never, you know, we have some that got no family, you know, so it's very difficult, we are their family, you know, so we got to make them that they are part of our family. and this is what we try to do, all of our residents, and we include the family as well, part of our family, so whatever we do here, we always invite the family to come here as well.

I: How do you expect your staff to interact with the family?

M09: Oh yes, of course, definitely, listen you can interact, um, see this is where rule and regulation come in again, confidentiality. Okay, carers can talk about general behaviour things like that, how their mother is, 'we had a laugher today' 'I was doing care for her, she tried to tickle me' or something like that you know, that's the type of the communication, 'oh she is in the lovely mood today', or 'she woke up a bit miserable today, and I did inform the management, the senior'. And say 'if you find out more, go speak to them, you don't talk about the incontinent, you don't talk the bad things, you know, that's left for the management, the management and senior carers who are trained to liaise with family members, um they (carers) don't talk to doctors and nurses, that's senior carers. So, if doctor want sort of, they come in and want to ask something, please speak to, speak to senior carers, I'm sure they will be able to help you. Coz that's their opinion, we cannot have their opinion, we got to have an overall opinion, you know, I mean you got to be… um 'in my opinion, she was in the bad mood this morning'. You know, but everyone else 'it's what she normally like when I do her care'. So now she says 'she was in a bad mood', then they come to us and say 'why is my mom in a bad mood this morning? What happened?' you know, so rather than us, they have full access to the care plan and care notes, family members, even the residents have the full access to their care plan, because um we got to know how they want to be cared for, for their needs. They got care needs, they got to tell us what their care needs are, if they can, and how they would like us to do it? you know, ' how would you like to get up at 6 o'clock every morning?'. 'no, I want to sleep until 7am'. 'okay, you can sleep until 7am'. You know, not you will get up at 6am, no, that's not her need, she wants to get up at 7am, 8am, or 9am. You know, sometimes it's not always possible to do exactly what they want, in the time they want, because you got.. in the morning shift, 4 carers are on, and a senior, and

we got 25 residents, so not everyone can be done at the same time, so they sort of divided up into 4 sessions and everyone's got the…, and then they carry out the care form experience of who they should do first, and who they should do second, so they tend to concentrate on someone who is wet or got faeces or something. Can you imagine lying in bed and they are doing someone that's not the problem because you like doing them, they don't get, they go to the toilet and all that, and there is this person lying and wet and faeces and waiting for carers to come, so you got to have priorities, you know, and staff learn this and it's all learning curves, you know, learning experience.

I: When a new staff comes in, how can they learn this?

M09: Okay, when the staff come on the duty, the shift runs from quarter to 8 in the morning until 2 o'clock in the afternoon, 2 o'clock in the afternoon until 8 o'clock at night, quarter to 8 at night to 8 o'clock in the morning, and the 15 minutes, quarter to 8 you got normally all the night shift and morning shift, so we are going to talk about morning shift, because it's the most important shift, you got night staff coming off, they got one or two people up, majority of residents are still in bed, and they have a hand over meeting, from quarter to 8 to 8 o'clock they have a handover, where the night staff will tell the day staff, the 4 carers plus senior, what happened at night, who is that? What they have done, everything, plus what have been written in the handover book anything that happened through the night, so the senior will look this, and listen to that, and say 'right, now I've got the story and picture of what's been happening over the last 12 hours, who is up, who is in bed, who is awake, who is not awake'. But they know who is going to be generally, because that person is normally awake, whatever the case every morning, then you got your 4 carers, then you say we try not to give the same carers the same people all the time, we rotate them. so today we divided home into 4 areas, so we got 4 carers, 4 areas, so you are in area 1, you are in area 2, you are area 3, you are area 4, okay. In the area 4, this night staff got two of your residents up so therefore, you will help area 1 to get the resident with palliative care and help area 2 a resident who is also on palliative care. Well you need 2 carers. Then you go, you go around to all of the residents that they got to do, say 'good morning, how are you?' check if they are awake, if they are awake, 'would you like something to drink?' give them something to drink, either coffee, tea or water, whatever they want, then check the staff, their residents that are going to get up, they are prioritised now. I'm going to do her first, then her, then her, whatever the case maybe, and then they will start, and they will go, and of course, this one will buzz, one of the senior will go and say she is just busy there, she will come to you next. And she will go to the carer 'xx is buzzing now, she wants to get up now'. okay, then she will go in next. Or she will say 'next door is yy and she is very wet, I think I need to do her first'. 'okay I'll tell her 'you're gonna be there in about 15 minutes'. You know, so it's just a matter of compromise and talking to each other. Communication is extremely important in this job that we communicate with each other. If something happened, you got to communicate, if you are doing something and you working with each other as a team, you got to communicate, when you work with palliative care people in the bed, you got to talk to each other, you got to talk to the residents that you are working with. Not talk to each other about other things, talk about what's going on and the residents, and tell them what you are going to do. So it's continuous framework.

I: When you mentioned about communication, will language barrier be the influential factors in communication in the home?

M09: Yes, um it's a slight factor. All of my staff are speaking English, okay, some of them are… they are English, even the polish girl, they English, you know, we have one, two that… we have cleaner, we have laundry lady, their English is very poor, and one carer that is improving in a daily basis. Um they know the basis, they know what to call if there is something wrong, oaky, so they do talk to them and they talk basic things. I don't go into conversation with them and you know, um after sometimes, I hope their English improved to the extent they can, you know, I think every care home has a problem, because you cannot get local staff, you know, local, local British people. Um I have a couple, most of mine are

polish, we got a large polish contingent, very good workers, extremely good workers, um we got some Indians, we got some Bangladesh, we got south African, we got Dutch lady, Netherlands, I have one from Slovakia, so we got really multination of people here, you know, so yeah, you know, there is always language barriers. My biggest problem is to ensure staff speaking English, because we tend to find Polish or Indian workers, when they are working, they will speak their language, I tried to propose them how would you like if I and my wife stand in front of you and speak Africans? You wouldn't understand what we are saying. 'No. I wouldn't like it, because I might be talking about you'. And it's like they got a hole there, come out this side, coz if I heard them talking and I go down, and I say 'English, English, ladies'. And they say 'English, English' and they start talking English, and then I come upstairs, they go back to their language, I think uhh… (laugh). But it's all good fun, you know, we had some bad experience about the staff, you know, a lot of, there is a lot of bad fighting and talking about other carers, and you know, say horrible things about other carers, you know, really, really hard time. And I think to fire everybody, (laugh) 'if you don't like everybody, just get out!' (laugh). Of course, I have to come back to that, coz I cannot tell everybody 'there is a door, just go'. But we were very lucky, most of them causing problem… in the navy, we use to call them 'lower deck lawyers'. In the navy, you always get some junior rating that knows all the rules and regulations coz they went to the law school for three years, and then fell out the college or fell out the university, and join the navy, so they know a little bit law, you know, and they will come inside 'they told me this' and they get roused all the other juniors up, you know, we use to call them 'lower deck lawyers'. Same here, you know, one or two know all, everything about benefits and rules and regulations. But they don't (laugh). They always say something. First thing I would do is come and check what the Act says or the CQC says or something, and I find the exact words you know, I will go back. Like one woman, she's been bullied by a senior carer, you know, so I get the definition of bully, I phoned the Act and explained the situation to them, and they said no, that's not bullying, it's just telling the person they are doing the crap job, and they got to pull the fingers out (laugh). Sorry excuse my language. You know, they don't like to be told that they are not doing the job properly, you know, so therefore, they were being bullied. And of course, they were telling everyone else that there is a lot of bullies going on. It wasn't a good time, a couple years ago, we managed to eventually sort it out.

I: So, did they leave?

M09: Generally, yes, no, they leave on their own, because we make it unpleasant for them. We don't… we just said it's not acceptable, you know, and I actually threat to them, I said 'you know that person that can actually see you for deformation of character. You're telling everybody this person's done this, and I've heard this, they told me this, so therefore, I'm the witness, I will stand up in the court and tell them that this is what you said, coz you said it loud and I heard you. If they come to me and say they are going to sue you for deformation of character. If they come to me, I'm going to refer them, I will say go to see a lawyer and sue them for deformation of character'. (laugh). Coz you cannot say like that, you know, it's not right, it's just being ugly and nasty, and it's women working together I think (laugh).

I: To be fair, you are the only male participant I have in the current study, I suppose there is different way that you need to deal with.

M09: Oh yeah, well, you know, manager and I, we discuss this a lot, I get her perspective on that as well, you know, said, I generally follow the women's perspective anyway, I don't know it's a feminine side of me or I'm just scared of you guys. (laugh) but I know I have to be careful about what I say and things like that, especially when today's atmosphere of sex harassment um you got to be careful what you say to someone and you know, I, you know, carer came in and she wants.. I said you want someone in there, you know, and then I push my chair back here and… I don't want anyone saying that I made any comments, you got to be very careful nowadays, you know. How do you say, what you say and when you say. Because we are in a very legitimate society now, you know, all these historical things you know, 6 years' time they come in the office, they fill me up. No, thank you. You know, no,

I'm very scared of that, you know. But I think my staff are brilliant, I don't think any of them are they type of person you know. I always say to the staff when we have a meeting. 'if I say anything that you feel I'm being sexist or it's wrong, or not nice, you got to tell me, because it's not meant as any slander or anything like that, just tell me and I will apologise immediately, alright, you know, and I know where my line is, you know, and I think that's important, I think that's important, you know. Especially in the care world like this you know, you got a male in all females, (laugh).

I: How you find it somehow weird or it's easy for you to stress what you want to say?

M09: Not at all, I'm very… you know, I'm not like that, my personality is not you know, motivated towards a beauty woman or making sexual innuendo things like that, yeah, um I just say what I mean.

I: no, no, no, I mean do you find that.. I'm not sure if it's gender related, but do you find that you need to communicate to them in sort of different way?

M09: No, no, I treat everyone exactly the same, males, females. We do have male carers, at the moment, we only got one male carer, but we used to have 4 or 5 male carers before, and I treat everybody exactly the same, you know, I always got the open-door policy, as the other manager does. And she normally sends them to me (laugh) 'go speak to 09', and yeah, I tell them exactly how I feel you know, and I don't do anything gender-wise, I don't expect a male to do more than a female, or a female to do more than a male. Any time when I worry about gender is on the resident side. Coz we have some residents said 'don't want male carers'. So therefore, we must ensure that everybody knows that male carer won't provide care for that resident, coz they want female carers only. We got a couple of residents like that. We have other residents said, female residents only want male residents (?) you know, because they... I don't know, they just feel comfortable with female carers. We have one male gentle resident who wants female carers, but he is a bit of problem, (laugh) so we had to, all care provided. his care is provided by two carers, no care provided by herself, there are always two carers together, just to self-guard themselves, you know, from his advances, things like that, these are all the things you need to take into account when you manage a care home, you know, we have 25 residents, with 25 different personality, with 25 different problems, some is dementia, some with vascular, some with Alzheimer's, others with bipolar disorder, others have mental health problem from illness or accident, and everyone is different, so you have each one of them, and you got 31 staff, everyone is different, they all have different nationalities, got different customs, things like that, you know, if we… I think we are working our home, if we all work on the same set of rules and regulations and out policy and procedure, they will all do the same thing, we don't step on each other's toe and respect the culture, and things like that you know, and everyone is treated equally.

I: So, by applying the same policy and procedure, help people from different background and culture work together.

M09: Yeah, definitely, definitely, you see, we try the system, we had, I have one muslin lady um employed at the moment, she is a night staff carer, and she doesn't do men, okay, so I have to her on duty with someone who doesn't mind doing men, and then I have a problem with one gentleman who requires two carers (laugh). So we try to help, you see in a caring world, you may be called upon to provide care we have some, we have some of the muslin ladies who refuse completely to do men and so, in the interview, we will say you know, unfortunately, we will try to assist in that by not giving you male to provide care for. there might be a situation where we will require your assistance. Not one on one but assisting someone else. And generally, they say yes. Okay, I haven't had anyone. We had one, I actually fired her, unfortunately, she was strictly no men, but she had worked here for 5 years, she was an excellent carer, excellent, excellent carer. But cancelling shift, and tardiness, coming late for shift, you cannot come late for the shift, you got to be here at quarter to 8 to have that handover. You cannot get here quarter pass 8, half pass 8, coz you don't know what's going on, everyone is in their area and you come in, you got to go straight to the area, you cannot do that. Cancelling shift, you know, she wants 4 shift a week, she

only turned up for two of them, you know, and she left because of this. You know, I say it's your choice you know, I'm gonna fire if you… and then she found a job somewhere else, and after a few shift, she phoned me 'can I come back?' so I got her to sign a document, I say 'you can come back, but first time you are late etc. etc. or cancel a shift, then you know, you're under probation'. The very first week, she cancelled a shift, and then I still let her get away with it, because she came with an excuse. And I said 'yeah, could have been, could have been' you know, anyway, we fired her. But she was strictly no men and she worked here for 5 years, never worked with a man.

I: That's very difficult.

M09: Extremely difficult, coz I liked her, I gave her so many chances, if it was for the owner or manager, she would have been gone long time ago. I'm the softy here, I always give them another chance, give them another chance (laugh), alright, one more chance, oh god, I think I have lost £400 so far in my years here that staff borrow money, they always say they are going to pay back, never pay it back (laugh). Just me you know, just the way I am. You know, I want happy staff, I want contented staff, I want good qualified staff. I don't want slack, I don't want tardiness, and they seem to realise that.

I: So, what do you do to motivate them?

M09: Listen you cannot motivate anyone, I'm sorry, you know, I have done leadership courses and that, how do you motivate someone? You got to make them proud of their work you know, you give positive feedback whenever is due, and when you… I feel it was allowed to make mistakes, so if you made a mistake, it's fine, but you know, be honest, and you will be shown the correct way to do it. you can make the same mistake for the second time, I won't have problem with that. Then I will say you have done that before, this is the final time, you've just done that again. Then I know you're just not interested. The third time, I will fire you now. that's not a mistake, it's just you are just not interested. So, I feel that… and also, I think this goes well with the staff, you know, because they are not afraid to say 'listen, I made a mistake' um, I'm talking about the same mistake. Listen, I can make mistake doing this and make another mistake doing that. It's different. So there will be a first time as well, but if they do this one the second time, they end up spoken to you, 'listen this is second time, we showed you how to do it, do you need me to show you the second time?' yeah, we showed you over again. For the third time, you are in trouble, and then you're gonna get a note put in your files. But if they go and make mistake somewhere else, because no one is perfect, they can make mistake, and I think that's the way you learn by making mistake. As long as mistake doesn't break someone's arm (laugh) you know, so you know, it's all within reasons, and I think if you give good feedback… you know, every day, when I leave here, I always thank everyone for the hard work, every single time I leave, I say 'goodbye, thank you very much for your hard work today'. Or 'xx, bye, don't make that mistake again' you know, coz she knows I know it, this is like reinforcing. I think that is motivation, and then the motivation also when we get the good CQC, you know, found that the good work we have achieved.

I: At beginning, you were saying you cannot motivate anyone, what makes you think in that way?

M09: How do you motivate someone?

I: I'm not so sure.

M09: Exactly, because everyone is different, your motivation for you will be financial, hers might be happiness, being paid attention to, his might be pet on the butt, coz you know, that's what some people are, that will be their motivation, so how can I motivate everyone? It's very difficult. Because there is no… I cannot remember any of my courses I have done 'how to motivate your staff'. they give you a lot of different things, but no specific things. How do I motivate my staff? tell them how good they are by saying 'you know, you can actually do that better by doing this course', and put them on the courses, by thanking them for any hard work they do do. By talking to them, when they come up to the door and knock and say, 'can I have a word'. I put whatever I'm doing down and say, 'of course you can'. And

I'm always like that, for everybody. They knock on the door and I'm busy with something, I won't say 'hang on a second let me finish this' unless I'm busy with someone, then I will say 'I will just wanna finish with this person and I will see you straightaway'. Then either they will sit here, or they will come back later. But, that's why I'm motivated. How do I motivate? You know, as I said, you tend to know your staff you know, some of them like to be joked with, um you know, some people you talk to them and you say 'how is your family?' and all that. 'what do you wanna know about my family?' you know, it got nothing to do with you. Whereas others, 'oh, how is the grandson doing? you know, how is the little one doing?' 'yeah, he is great.' 'how is the school? Have you sorted it out?'. You know, as long as you know your staff, you can talk to them that, and also you know who they are. Do they like talking about family? A guy in the kitchen doesn't likes to talk about the family. I said, 'how is the wife?' he said, 'why you wanna know?' you know, 'it's my wife, it's nothing to do with my job'. I never ask him again, you know. But if he does a good job, I will say 'xx, well done, it was hard work today, I will put extra... I will speak yy to put extra hours on your pay' which I also do as well with my staff. you know, £7.5 an hour, I put 2 hours on, that's £15, you know, so (laugh) it's not gonna break the bank, so you know. Specifically, they have gone out their way, they came in specifically coz someone's cancelled the shift, they come in and work really hard, they stayed extra next hour or two hours, I will definitely put some extra on, I will show my appreciation for that. But that's my management style, I have been corrected by the owner for that sometimes, you know, I said 'well, you want them to work here, then I got to motivate them'. (laugh) but to actually… as a group, it's very difficult. As an individual, you can motivate. I think as long as you know your staff, and if they got a problem, you can see it. you must be able to recognise if they are in a good mood or bad mood. If they don't look happy, call them aside and say, 'are you okay?' you need to show a bit of interest, 'are you okay? You got any problem? Do you wanna discuss it? you don't have to discuss it with me, I can always arrange someone'. You know, to show that a bit of empathy, empathy with them, and I think you get the respect, and I think you get a little bit of motivation. 'oh, he does care'. You know, and that's my work, and I try. And I always try to smile and laugh, you know, 'why you are laughing?' I said 'well, it's nervous laughing actually'. There is nothing to laugh at actually. It's ironic, you think about it, you know, this happens and this happens, and then that's quite funny actually in a sad way, you know, (laugh) I'm not everyone's cup of tea, some people don't like me, I'm sure, I heard rumours on and off, you know, (laugh) but you always get one or two, you know, don't like you because you tell them what to do, um I think it's very important that you know, you know your staff and what they are capable of doing. Because I don't want to give them jobs that they cannot do. But then again, I don't want to give them jobs that I know they can do and not extending themselves or challenging themselves, you know, it's a very fine line, and you know, I think we do this, you know, when I'm talking to you, I think it's all subconscious. Um I don't think 'oh, I'm gonna do this now'. it's just automatic responses to situations. And I think also, I think a good motivation tool, if you want to put in that way, show confidence, if something happens, it's not going to 'oh my god, what we are going to do here?' it's to be in the front line and saying, 'I know how to deal with this', you know, be confident and take charge. And I think that motivation as well that, okay everybody knows what they are doing, you know, coz if anything happened, the first thing they used to call me, someone would come '09, come quickly'. 'why are you calling me for, you are handling it.' they just want my approval sometimes you know, but it's all good fun. Of course, you know, I think that's one of the reasons, I shouldn't be working with my medical problems. I got quite serious medical problems. But I think this will keep me alive actually, you know, I would, I would, I sit home on the weekend, 'what I'm going to do' you know, because I got a lovely flat just 5 minutes' walk down to the road, you know. And I cannot afford it if I had to buy to the original price, because I got the special price to the person who was selling them, and I was there the right time and right place. I was extremely cautious about the price. I shouldn't have been able to live in that area you know, I think it's lovely vocation for anyone to come

in to this business, you know, I was speaking to a young girl on the training to be a senior carer this afternoon, she came in and she was a bit worry that I'm training her, I put her in that training to be a senior carer, and she is one of the two people that is taking the exception to do this and feels that she shouldn't be a senior and things like that. But it's my judgement, and the other manager's judgement, I said to her she mustn't worry about what they think, it's what I think, and the other manager think and what residents think, and your capability. And if they… she finds that they are sort of finding things wrong that she does now. 'oh, you didn't do this stuff and everything', you know, I said 'the way to treat that is to say "oh, I'm sorry, I'm supposed to do it like that, I will make sure I will do it like that next time."' It will take the wind right out of their sails. They are waiting for you because they've thrown that line in the water with a hook on and you have bitten on and you're now going to argue with them, and this is they really kneel in, and now they are making you look like a fool. I said, 'the best way of dealing with that type of people "oh, thank you, I know that, I will make sure I won't do that again".' You know, if they continue doing that, you come to see me, because now that's a harassment and it's bullying, you know, then I will investigate, and I will find out why they're doing that. If they got a legitimate reason, and I will say fine, you know, fine. 'Does she learn from what they told her?' 'yes'. Okay then you carry on from there. But I know the person she was talking about and she is a trouble maker. (laugh) and I know these jealousies there, and… (sigh). But this is politics.

I: Yeah, and I suppose this somehow influence the work atmosphere?

M09: Um just between the two of them, yes. Okay, I said to her, you know, don't you worry, just ignore it, so like I said to anyone talking beyond other people's back, just ignore. Listen, you hear a rumour, just don't hear it, coz if you don't know about, you're not going to worry about it. but if someone come to you and says 'hey, zz, you know yy said this about you'. Before she even said that, you should have said 'stop'. Yeah, they come here, and they now want to get someone else in trouble. It was two years ago, these people. '09, I need to tell you, so and so said.'. 'wait, I don't wanna know, I don't care, I don't care if they like me or don't like me. As long as they do their job, they respect me for what I'm doing here, they don't want to do the job, they can go. But don't tell me, I don't wanna know. If I don't know, I'm not going to worry.' And that's what I want you guys to do. Don't listen to someone gossipy, then you are only asking it for yourself. And anyone gossips, and anyone passes information about someone else to you, tell them off and come to tell me this person saying that. Coz I get to speak to them 'why you are telling them, coz it's not right. why are you casing problem between that person and that person?' you know, coz it's not right, is it? I don't know. Am I right? am I wrong?

I: I'm not the manager--

M09: Exactly, you got to deal with these things you know, and generally this… when you… at that time, I think I handled it correctly, and I think… the problem sorted themselves out, and now I've got extremely good staff, well, good team work, there is always a problem with one or two, it's not through the lack of team work or things like that, I think it's just um I've got… you know about sponge bob, you know, sponge bob.

I: Yeah.

M09: Okay, it's just a sponge, isn't it? I call them sponge brains. You know. You get people… I ran through my career in the navy, where ever I work, you got these people, they are lovely people, they come in here, you tell them everything, they go in and absorb all that information, and then they walk out here, and as they're walking out here, thought's seeping out like water from the sponge. You know. By the time they get downstairs, it's empty again. (laugh) but you get that type of people, and we have one or two of them, and the seniors go mad, like… I don't say to them sponge brain thing. I say to them 'this is the type of person, you cannot say 'that's your area, go and do it." you got to say "you are going to do A resident, work with B carer, do this, do that and do this and do that" and they will do it'. because the information's gone in there, they will do it. by the time they finished it, it's slipped out. But if you say 'go do area 5'. They arrive there with an empty brain and they cannot put together

their training, um you know, that list of things you have to do to provide the care, they cannot think of that, and they do silly things, you know. So if you say to them 'go to do A resident, make sure she is all dry, give her something to drink, ask her if she wants to get up. She wants to get up, get up, get her water, wash her, you know, go through the routine with her, fine, when she is finished, come back to me'. Bring her down for breakfast, and you see her there, okay now you go to do this person, no you go to do that person. And unfortunately, you do have to have, you do have someone like that in the work place. There is one girl, she does the online course and she gets 100% in the shortest time than anyone does. Now, you have learned, go to do with A resident. (laugh) By the time she gets to A residents, it's all seeped out (laugh) no, it's just the way of life, you know, you get people that… you know my wife always used to complain that we had a cleaner… and in the beginning with the clean starts, I'd like you to do this, this this and this. Whenever you come, you need to do this, this, this. And she came home and half of the thing hasn't done. I say 'what did you tell her to do?'. 'I told her to do…' no it doesn't work that way, she is that type of person, 'today I want you to…' even write it down, 'do the wash, do the ironing, wash the floor, change the bed..' whatever you want done, write it down and they can take it off, and then they know it got to be done. 'she knows what she needs to do….' (laugh) exactly, exactly.

I: What professional values are important in this home?

M09: Listen, um, god, this is quite difficult to answer, listen, everything is important in this home, whatever a carer does is important in this home, um if they, if they don't know what they are doing, they need to be trained, okay and they need the qualification. I believe, um every carer that I see, I believe when I look at them, they can be a manager one day, if they follow the career path that I lay up for them. Okay, when I first come here and their first supervision, I say this is my aim for you, I don't know what's your career prospects are, um but you will do induction into the home, you will work with staff, and start working by yourself, once you completed the induction, you've done that, you've done your moving and handling, you've done your infection control, and you're confident, and then I will discuss with you, and I will put you in NVQ2. In NVQ2, I will explain the consistency of it and now they should do it. and… but you must tell me what do you want, what you are aiming for? 'I just want to be a carer'. I say 'well, then NVQ2 is fine, if you worry about the residents'. So, for her, her thing is NVQ2, isn't it? so my thing for her would be NVQ2 at that moment. But for the home, I would like everyone to be NVQ3, but that's being… there is not enough room for promotion. If I was a care company that has 100 homes where I can transfer people around. You know. They reach the stage and all my carer… say all my carers here want to be progressing in caring for rest of their life, they will end up managers one day. We are one home, I cannot have that, you know, so I have to be realistic with them as well and say, you know, when you reach NVQ3 and you haven't reached senior, then maybe it's better for you to look another home where you can actually progress farther, you know, so professional values in my home, as long as they are happy, if they reach the top of their pyramid then I'm happy with what I can have achieved as long as we provide the care for our residents that's going to ensure our residents um.. are the centre of the world here. It is, because we are all… none of us will be here if it wasn't for the residents, you know, everyone is an individual, everyone's got their different needs, and how they want them carry that, and hopefully I put that across my staff as well. I take for example the young girl I'm training to be a leader, because I have the one senior that has been off one month and half, she keeps on threatening to retire, she is 65 or 66 now, she's been gone for too much and she is coming back on Monday, so it's gonna be very difficult to insert her back into the system, because her attitude is completely different from everybody else, so we want to try to see if we can have a back to work interview and decide what she wants, you know, if she is just gonna come and be a number here, then I'm afraid she would rather retire now. because we want outstanding, we don't want to just remain good. We felt we are good all along, but they have marked us down, but we're aiming for outstanding. Now I'm afraid, certain people aren't wanting the category to the outstanding. So, it's gonna be difficult. The other manager and I have discussed this.

But she has been working here for 20 years, but you know, it's all old-school, so she's got old values, you know, it's gonna be difficult (laugh). So, our professional values,what is it?
I: Yeah, professional values.
M09: I want everyone to--want to do NVQ5, and become a care manager in a care home etc, specially the one I'm working here, because I got some workers, I got a few staff training to be nurses, so it's like a part time job, so they are here not in a placement, or at the university or college, and I have other set… um I don't think I know what they want to do. But I do have, like the one I say to you, what does she want to do? She said 'I wanna do what you do'. You know, that's fine, because she is the only one of the junior said, I got one or two senior said, 'I'd love to take manager', but they might be able to do it, you never know, maybe, you never know.
I: I know recruitment is a big thing in the care home, do you have a concern that they may leave after you train them?
M09: Of course, of course, it's very difficult. I think it's different because you were an organisation with a lot of care homes, then you can move people etc. with one, one off care home, which is private, it's very difficult to maintain the people, unless I'm happy with… they reach their self-actualisation, they reach the stage where they are happy to do this for rest of their life, then I'm happy for them to fulfil that. But if they haven't reached that stage, they want to go higher. Like the one I'm training to be a deputy manager now. she was a deputy manager in another care home. um that's what her CV said, I don't know what she actually do in that care home, because her knowledge gap is quite-- I wouldn't say she was a manager, a deputy manager before. So I'm busy getting her in, twice a week she comes in and spends a morning here, and work with me here, and I make her make decision and things like that, you know, and what to do and how to deal with it, things like that you know, which is fine, because I don't intent to be next year this time, I want to stop working, hopefully the end of the year. And I want her to be up, and she can continue the good, and outstanding, you know. And then I got two others that would like to be, they both are in NVQ3 at the moment, but that takes a long time to go, so by the time… coz the one I'm training is in her 50s already, so I don't think her career is gonna be that long, so there is an opportunity for the other two to come up as well, you know, to become a senior carer, like my wife and the other girl used to do.
I: Is your wife working here?
M09: Yes, she works here, she used to be a carer, and then became a senior, and now she is a senior carer, she does look after everything as well, you know, also, she does training, does assessment, she works on the computer system, she does a lot of the you know, if we have best interest meeting, then she will sit on because she deals with people all the time, I sit on the best interest meeting, because I'm part of management, but I'd like to have someone like a carer who work with them all the time, because they can also answer some of the questions that I cannot. You know, a lot of them I can, but you know.
I: What do you think is good practice?
M09: What is good practice?
I: Yeah.
M09: Follow my rule and regulations, (laugh).
I: Simple, how can I ask you that question!
M09: What is good practice? Um what's the best interest of the residents and we're covering all their needs, how they want to be treated, how they want to be cared for, you know. That's the best practice. You know, The best practice is to ensure that residents get happy with everything happen to them within our home, and the things they want, so you know, I say to them 'what's your duty of care?' okay, the duty of care is to ensure that my residents are safe, but I say to them 'also, your duty of care is not to do anything with them that they don't want you to do with'. So if they don't want to wear a particular jumper, they don't have to wear that particular jumper, not forced on them, whatever, so whenever you provide care, you know, what is the best for that residents? Give them what they want. You

know, and that's part of our basic training, is never doing anything with a resident without asking them first. Start form the very basis, you want to turn their chair by the table or push the chair in, tell them what you are going to do. Coz a girl first came in, I used to watch her, she was just (push the chair without asking). The resident was (like in shock) (laugh). 'hi, A resident, I'm just going to move your chair, or we are going to do this, you are going to move from the table to there'. Telling them what you do and why you do it and how you are going to do it, 'I'm going to move the chair, we are not going to let you walk today, we are going to use a wheelchair.' That normally put a smile on their faces anyway. We have duty of care, and the question you asked. Now the duty of care in the respect of this lady for example, she had a stroke, so it's highly important, for all the residents, is to exercise, is to actually move. Now she has her way, transfer and everything the hoist and move in a wheelchair, and just stand up by herself, but, for her vest interest, is to make her stand up, but not make her. To explain to her the benefit of standing up, coz soon as stop using something, you lose it, especially when you are 90 years old and had a stroke, and your hand is not strong as it was. If she stops using them, stop pushing yourself up, you stop shuffling forward, even the 10 paces, you are going to lose the ability to do that all together, and then you become stationed in bed, everything is gonna be done for you, and I think she would prefer something like that, well, I know her sister would, but the doctor and the occupational therapist said she has o move, they have to move, they have to walk. They have to… because the blood circulates in their moving, and their body is moving and the muscle is moving, and the body is not starting to die, as soon as they stop moving the body starts to die, so.

I: How do your staff feel about the best practice or duty of care?

M09: No, yeah, they all for it, you know, some of them, you know, depend on the day, on the person, you know, they might have had a fight at home with the husband or boyfriend, they come here but they are still upset, they go do the thing, instead of 'what would you like to wear today? Would you like to use the toothbrush?' 'let me wash your face, let me wash…'. I just want to get finished you know, coz I want to have a cup of tea, I'm pissed off now, I need a cigarette. Okay, so yeah, generally, I hope, good practice is they carry out the duty and responsibility according to how we wanted by treating everyone as an individual that they are not paralysed and incompetent of doing thing for themselves. If they can still wash their face, their private parts and brush teeth and dry their face and things like that, not to do it for them, and I think they know that, but as I said, every day is a challenge and we don't know the person may be in a bad mood, refuse to wash themselves, they are not listening to any reason, or anything like that, then you actually have to wash them, even though it's not best practice for that type of thing you know, but to get over that situation. but then anything out of order, you need to report to the senior, then the senior speaks to the management, and because they know what's going on, because they know what's going on in the home, overall, it's carer only knows the residents they are caring for, they will find, it's likely to become a habit, and then they will come to me and talk to me. Then we will send maybe an email to the doctor say 'this is the situation with this your patient so and so, out of ordinary, maybe she's got a urine infection, maybe depress, maybe the medicine is not working' you know, there could be multiple reasons of why. We will follow the protocol in respect of that. And in respect of staff, as I say if I see the long face, sadness or anger, or whatever, I always 'are you okay? Do you want a chat?' you know, generally, they… what I like is they will come to knock my door, they will come to sit and talk to me, and, that means I must do something right, you know, they do respect my opinion of what they should do. And I will take action if they come to me and talk to me, then I will take action. And I think that answer your question as well, you know.

I: I'd like to ask about your thought regarding professional boundaries?

M09: Um there are professional boundaries, I believe, these are acquaintance, none of those people are my friends, this is a job, it's like any job, my friends are at home, I socialise with people at home and that, I don't socialise with people here, the only time I socialise with anyone here is wedding, if I'm invited, I will go to the wedding, and once alcohol

started flowing, then I will leave, and this is the experience form the navy. Or if we have a function here, like summer tea party or BBQ or something, then I will be here involved with everyone, and unfortunately, I cannot leave because I have to be here until everything is finished. (laugh) I don't get involved in any staff. if they have any personal problems, I will try to help them, I won't help personally by going and seeing people, I will advise them to see people, I even make arrangement to meet for one staff member's family problem, combination problem, etc. she is dealing with the doctor, I have the doctor's letter in respect of um the anti-depression she is taking. No, we have noticed a down turning this person, the standard of her work, the tardiness, things like that, called her in, wrote it done here, she told us all about it, and we write to the doctor, say 'we worry about it', it's not like she is going to do anything, you know, but we have notified them she needs help and she needs help now, not 6 months' time, you know, which seems to be the normal thing you know, you wait for your turn, and you know, so we have done whatever we can, I'm not personally going to her house, move them into a bigger house. This is my professional boundary is. Am I going to date anyone here? We try, you know, I try to tell other people, you know, these people are not your friends, they are acquaintances, if you want to hang out outside, they are gonna start talking about you, and you know, we have a couple of occasions where you know, two carers, two or three carers they go out for a night, of course one says something that one doesn't like, and all the sudden this atmosphere in the home, you know, so we try to tell them you know, leave your personal stuff at home. if you want to hang out together, I cannot stop you outside. But we are professionals, this is your job, you know, you either work together or we have to do something, and one of you has to go, it's up to you guys, you got to work on that too. We tried to get them actually to talk each other, you know, and then we cannot deal with it, so we can the director, he will come in and have a chat to them, and he does what he does, I don't say anything on this, because I feel a manager a director, if you have three people here and one person, then they feel like (laugh) surrounded, you know, so I always be neutral, and this is my professional boundary, I'm neutral in everything. I offer for advice if they ask for advice, I say you don't have to take it, I always recommend to go see um outside organisation that provides advice. Go speak to them, if you are unhappy about something, and you are not getting any word from us or husband. Go see this person, you know, go see your doctor. Have you seen your doctor? Why don't you make an appointment with your doctor? Do you want a letter to your doctor? You know, I will try all my things there, but I won't get involved with it, anyone here, personal problems or anything like that, I will try to get them help, but I won't become a mediator or things like that, if I can avoid it anyway.

I: So what about the boundaries between carers and the residents?

M09: Okay, professionalism, it must be professional. This is not their mother or father. I know we want them to give them on faith, we want them to do everything to… as if they were their mother and father. But they must also remember this is not their mother or father. They do have siblings, they do have children and they do have grandchildren. We had occasions where a carer put an armour on them, why does she do that?' 'because this is my mother, not hers. Listen, it's very difficult, very difficult, we just try to tell people you got to be professional yeah, you cannot, cannot be feeling people up and things like that, but I have never even thought about that, you know, my staff, I never had that problem, so I don't know how to deal with that if something like that did come up. I had situations where I have done a night shift here, and I said, 'come on whoever, let's go to the bed'. 'I'm not going to the bed with you.' (laugh) 'no, I mean you're gonna sleep.' 'no, no, no, you are a dirty old man' (laugh). 'Sorry, sorry' and then I walked away, 'okay, I get the lady carer to come to take you'. (laugh). I mean you get the men residents will ask the carers 'so you are going to stay and sleep with me now?' you know, things like that, I think our carers are very well trained, they don't take things too personal, especially when they know the person got dementia. When the one resident who has no dementia etc. makes comments does upset my staff, and that's why we have two carers, so we deal with that, this situation when they come. Professional boundaries, there are boundaries, okay, you don't kiss people on the lips, or

things like that, you give them a kiss on the cheek, fine, you put your arm around them while walking or give them a little bit of hug. Who doesn't like a hug? Um put your hand on their leg? No, when you sit there and put your hand on their hand, that type of thing, there is a boundary, things like that.

I: Do you encourage to develop the relationship?

M09: To develop relationship? Definitely, this is where our key worker system comes in, we, every resident has a key worker, sometimes two key workers now, say key worker, when they are on duty. Say I'm on duty and my resident is B, at least half hour in that shift, sometimes I got to sit and chat to him, speak to him, you know. Just joke around with him, find out how he is or.. you know, sometimes a little story comes out and you know, try to make conversation with him, or to check his room to make sure he's got his soap and toothpaste, everything is right, nothing is broken, that will be my job, as a key worker, and we encourage all the staff to do that, um we don't encourage people to hug or kiss or anything like that. But if um if someone says I need a hug, give them a hug, you know, you can see they are upset. 'are you okay? Do you need a hug or something' and the they will hug you, you know, (laugh). Very difficult. It's very difficult.

I: How do you inform your carers about professional boundaries?

M09: I think it's part of training, part of their training, I think it's part of NVQ2 or something like that, I know NVQ5 has it, you know, these boundaries and things like that. We do it just by speaking to people you know, when you speak to the family you don't discuss problems that you're having with the father or mother, it's part of your job you know, you just speak about good things and all that. If they ask you a specific question, then say 'speak to the senior, sorry, speak to the senior, I don't want to get anything wrong'. I think it's part of observation, you know, the actual CQC inspection, he said 'it's so nice watching that when a carer went in, you know, and saw one of the residents looks a bit down. Then he sat there and put his hand on her hand and said 'what's the matter? Xx are you okay?'.' Just the way, just touching the arm, when they are talking, putting their arm around them and things like that, just a bit of intimacy but no crossing the line. He said (CQC inspector) It's lovely, and it's so nice to see that people have got that. I think it's the observation when the new carers come in and they see what other carers are doing. Um I don't think we ever had anyone um crossing the line or gone too far. We had one or two carers speaking out of turn with family members, you loose lips sink ships. You know, now family member comes up here (knocking the door) you know. 'oh who told you that?' 'he told me'. 'oh, he told you that, oh my god. Okay.' Then I called he up, 'why are you tell them that? Is that your job? The confidentiality. What is confidentiality?'. Then they tell me. So why did you do it? 'oh I didn't think, it just came out.' You know. 'you got to be careful'. (laugh).

I: What do you do to help them to maintain the professional boundaries?

M09: Listen, if we feel what they are doing is wrong, we'll tell them. If we feel that they did something nice, and really genuine sort of affection for an older person to help them, we will tell them as well. like positive feedback, and also um just telling them where they've gone right and where they've gone wrong. I think that's the most important for continuation, training them the development of any, any boundaries, you know, you came close to boundaries, when you kiss him on the cheek without asking and thing like that you know, so it's part of observation, and monitory and as I said all day watching, you know, there is always someone watching, senior is always down there, the other manager is always down there, my wife is normally always down there during the day, so there is always someone seeing something, and also the cameras. If someone does say something, I can always go to that time, that day and I will check. Um otherwise we don't check the cameras at all.

I: Do you think cameras help?

M09: Oh yeah, definitely, they help us. We had a lady had very serious skin tear on her hand, completely hanging off like that, we thought someone grabbed her hand, one of the carers, because the skin is very thin. So, I checked on the cameras. Coz I read the handover book about it, and the care plan about it. I think they came and they saw it and they dealt

with it, they phoned the district nurses and all that, and it was suggested that this person maybe a little bit of fib, you know. So anyway, I looked the cameras and I saw her, it was that 11 o'clock, at least two carers were walking up and down, and you can see everything, and she walked out, and the carer was busy in the lounge, I could see her working there, and she cannot keep 24… you know, eyes on them all the time, and they walk out the dining room, through the staff station, and they came back a minutes and half later, back in, and I see on her hand, it was, it was a slight, you can see a little bleeding, you can see the blood dropping there, like I said, somewhere between walking out and come back in, she either knocked it or another lady grabbed her hand, and she walked in to the meddle of the dinner room, and stood there and peeled the skin back of her hand until it was like this and blood everywhere. I said, 'there we go'. You know, because of the severity of it, the district nurses thought that was abuse, so they started safe guarding, but I said I have looked the camera, evidence in and my statement in, and it was closed, you know, unfounded, but just to show you, does it help? Yes. Second one was that resident, the carer I said, lifted the person like that, okay. I heard about it, I investigated it. So, I brought him in, I said 'it has come to my attention, and I have looked the cameras and this is what you did. And he was quite shocked, he thought no one would've seen him, (laugh) he thought he was doing the person a favour. Okay, you don't do that again, I will keep checking the cameras now. So, he knows he got to be very careful. I said, 'you know, it's not like no one will see it, I look the cameras, no one looks the cameras, but when something happens, the police is going to come here, they are going to see these cameras, and they're gonna say oh, what's that carer going? Look at that! Oh, look at that, oh, look at that, oh, look at that, you know, you have to follow the rules'. So, there were two. Two things I have used the cameras for, I used the third time was um… someone passed away, and family left a lot of clothes and that things, and what we normally do is we keep a little storage of clothes, because we get often… we get residents come from, directly from hospital, no family, nothing, no clothes, just a hospital gown. So, we keep a small supply here, you know, we give it … as long are normal height. (laugh) We give them clothes until such time as we can get the social workers to go to their house and bring their own stuff and things like that. Anyway, in regard to this lady's stuff and--we take out what we want, the rest we put in a black bag and we put it, outside, in the front foyer, to take to the charity shop. Anyway, we came in the next morning and it was gone. And no one touched it, no one saw it, no one did … and I found out who moved it and they put it in the bin, and they were too scare to say they put it in the bin, they thought it was refuse. (laughs) So, yeah, three things. {unclear]. Otherwise I don't look at it. It's not fair. I'm going to keep check on my staff and start monitoring them and things like that, you know. There's got to be trust, you know, and I think my staff know that I got trust in them, you know. If they know that, then they've got pride in their work then their professional standards come up and everything … their motivation, you know, as long as you've got trust. But if you lose my trust then I will be starting to monitor you and check on you.

I: Right, okay, but um, in terms of your trust --

M09: And everyone else, no, not only mine --

I: No, no, no. I mean --

M09: Yes .

I: I mean when you talk about trust, do you think it is in place at the very beginning or it needs to be.

M09: Well, you know, trust in the beginning, they think it is in the beginning because you get a new staff member you don't know what they're going to do, how they going to do it, how they going to deal with any situation, are they going to be … uuh … upset about anything or are they going to squeeze too hard because the resident said something, or pushed them, they retaliate, you don't know. So, trust has got to be earned. You know, once you've earned that trust then you've got my trust. But if you lose that trust it's very hard to get back. Yeah, you've got to work for that trust again. And I think that is for everything. And it also works for residents, you know, if a resident isn't treated properly or anything,

you lose their trust and that carer can't care for that person anymore because they feel uncomfortable. Uhhh, we have one or two ladies who won't have this one carer and she's, it's just she's Italian, you know. Italians have their manner, the way they speak and that … she's a good carer! You know, she doesn't do anything wrong, just the way she speaks. And they take exception to the way she speaks. You know, uhh, they feel 'she's telling us what to do, I don't want to be told what to do!' You know, because, you know, Italians are loud, well she's loud, (laughs) just the way she's … So, you know, she doesn't provide care for that person anymore, you know, so, yeah. She lost the trust of that resident. To get it back, she'd have to change her ways. So … we say to her, you know, whenever you speak to her you have to speak softly. You have to speak slowly … and you have to ask her, not tell her, what to do. And you'll slowly regain her respect and then you can start caring for her again. And that's how we … go on about it. But until such time she will say, I don't want that person, or, okay I'll have that person again, because I've got their trust again, they won't provide care anymore.

I: Right, okay. That's interesting.

M09: It is (laughs). Right, you never think about it.

I: Well, well, the thing is, every time when I heard um, like manager or whoever talk about this, they sometimes tell you it comes like … like naturally, like, as time goes by and --

M09: Oh yeah, it does. It has to be earned though. You know, so if someone's going to let me down, you know, cancel shifts and that, you've lost my trust, you know. Am I … give you forty hours shifts or am going to give you twenty-four hours of shifts? I'm going to give you twenty-four because I can't trust that you're going to be here for the forty hours because I know you're going to cancel half of them. So, trust is earned, but it does come naturally over a while, yeah, but it is earned. Yeah, you know, you don't hire someone, ah, I trust that person implicitly, you don't know them. So over time you get to know them and the more you get to know them the more you can trust them. That is earned, and I think you can lose it very quickly.

I: Okay. So, um …

M09: Especially if you lie, and, and I hate people who lie. They should get caught out in the lie then you never trust them again within their lies. I also give them the benefit of the doubt because everybody lies, you know. Everyone tells a lie, some even if it's just a little white lie, or whatever, someone always tells lies. But some of them are blatant. (laughs).

I: Right. Um, okay last question ('sure' says tim gooding)). So, if you can change one thing as deputy manager, what will that be?

M09: In respect of what?

I: Um …

M09: I , I would change my, my result to be outstanding instead of just good (laughs) No. Uhh. No, I think, you know, it's something I think we've got is a very good home. Umm, I think we learn something new every day. I know I do. Every time I, I, I do a policy or procedure ummm, I'm learning something. Umm, how to deal with people. Whenever I fail a test I learn something I learn something new from them. To change, if I could change it now, my salary, I get a bit more money, you know, but basically, I, I love my job. You know, I, I enjoy coming to work, put it that way. I don't wake up in the morning and say: Ahh, I got to going to work. I'm actually quite … I'm actually not eager to get here but I'm actually sometimes a bit … what's going to be waiting for me here today (laughs). Ummm, I don't think I would change anything. You know, maybe one or two staff members … you know, get one or two back that we had that were excellent but left because there was no prospect of promotion above a senior, there's really good staff. Ummm, but … no. But I think everyone has got regrets, you know. You do something today and think, I shouldn't have done that. Maybe I should have done it different way. I would like that to be changed. Um, to have the knowledge to deal with the things without any afterthoughts, you know. That my first thought is the right thought. [DING].

I: Okay.
M09: That's me.
I: Okay. Uuuh, well, um, thank you very much.