Staff members’ negotiation of power in client engagement: Analysis of practice within an Australian aged care service

Abstract

With increasing focus on client control and active client roles in aged care service provision, client engagement is highlighted as fundamental to contemporary care practice. Client engagement itself, however, is complex and is impacted by a range of issues including the relationships and power dynamics inherent in the care context. These dynamics do not simply reflect the roles that are available to or taken up by clients; just as important are the roles and positions that staff of aged care services are offered, and take up, in client engagement. This paper presents the findings of a study that explored client engagement practice within a large Australian service provider. Analysis of interview and focus group discussions addressed the ways in which staff were positioned – by both themselves and by clients – in terms of the roles that they hold within engagement practice and the power relations inherent within these. Analysis of power from the dominant policy perspective of choice and control, and the alternative perspective of an ethic of care suggests that power relations within the care context are dynamic, complex and involve on-going negotiation and regulation by clients and staff members in aged care. The use of these two contrasting perspectives reveals a more dynamic and complex understanding of power in care practice than dominant uni-dimensional approaches to critique suggest.

Key words: engagement; care services; power; participation; ethic of care

Introduction

Client engagement – that is, interacting and communicating with clients effectively and providing opportunities to contribute to planning and decision making – is a vital part of care services. Increasing expectations of client involvement are linked to concepts of service user empowerment (Beresford & Branfield, 2006; Cornwall & Shankland, 2008) and citizenship in care (e.g. Scourfield, 2007; Valokivi, 2005). These changing expectations have been driven by shifts in perspectives about the roles of 'professionals' and 'service users' including a focus on the rights and abilities of service users rather than their limitations (Gilliard, Means, Beattie & Daker-White, 2005). Engagement at the levels of individual care, services, and the broader system is seen as vital to contemporary care (Cook & Klein, 2005).

Although client engagement is the espoused ideal in health and care services, this is not always effectively put into practice. This is especially the case when older people are assumed to be incapable of participating (Brannelly, 2011), or their participation is framed as 'problematic' (Baur & Abma, 2011). However, client engagement is a complex issue which is shaped by multiple factors regarding the attitudes, values, and knowledge of both clients and staff, as well as broader institutional factors relating to the structure of the service provider. These factors are necessary to consider in designing and implementing engagement strategies.

Particularly highlighted among these issues are power relationships; these are fundamental to understanding the dynamics of engagement and are inherent in the aged care environment (Baur, Abma, Boelsma & Woelders, 2013). The roles in engagement that are assumed and designated by staff, clients and the organisation both shape and are shaped by the engagement processes themselves. In another paper, we explored how clients in an aged care setting were framed and positioned in discussion about engagement practice (Petriwskyj, Gibson & Webby, 2014). However, understanding clients' positions within engagement is not sufficient to fully understand the power dynamics in everyday engagement practice. Staff also simultaneously assume, and are designated, positions within engagement.

Staff members are often positioned in the literature as powerful actors in this process. Indeed, staff have been criticised for assuming a dominant role in care, particularly in decision making (Lyttle & Ryan, 2010). Issues such as lack of communication, lack of consultation, and management of risk highlight the power that staff members hold over clients' choices and care (Penney & Wellard, 2007). Clients' power can be bounded by direct staff behaviour or by contextual constraints (Harnett, 2010). Therefore, the need to consider power relations and control over communication and interactions has been highlighted in both acute care and aged care settings (Baur et al., 2013; Lyttle & Ryan, 2010).

Through such discussions, power in the care context is presented as relative. This is a somewhat traditional power hierarchy which emerging models of care provision have sought to challenge. Thus the increasing focus on issues of client ‘voice’, ‘choice’, ‘control’ and ‘rights’ has brought issues of power – and particularly ‘power sharing’ and ‘empowerment’ into sharp focus in the care context. The prominence of personalisation or consumer direction is a strong example of this philosophy in policy and practice. A rhetoric that rejects ‘care’ as ‘dependence’ and as inherently problematic has dominated the disability rights space and increasingly is being applied to other care contexts (Fine & Glendinning, 2005).

At the same time, however, an alternative perspective developing from feminist critique of conceptualisations of care and justice (e.g. Gilligan, 1982; Tronto, 1993) and focused on care ethics has been growing in prominence. This perspective has been a focus for critique of personalisation policies and the emphasis on ‘choice’ and ‘control’ (e.g. Barnes, 2012; Barnes, 2011; Rummery, 2011). Proponents of care ethics seek to dismantle what is seen as the ‘moral boundary’ between these concepts. Through the ethic of care lens, the sole focus on rights, autonomy and choice is seen as both limiting and potentially dangerous; in Barnes’ (2012) view, for example, the “conceptualisation of what is required to meet needs as a choice over services is an impoverished view of what is necessary to enable well-being and social justice” (p. 65). An ethic of care sees such perspectives on power and power sharing in care, particularly the focus on independence and autonomy, as overly simplistic. Rather, it adopts a view of care as characterised by interdependence and relationality, rather than either dependence or independence, control or autonomy. Care ethics focuses on relationships and reciprocity within a set of fundamental moral principles (Tronto, 1993).

That is not to argue that an ethic of care need not consider power relations; indeed, this approach developed from debate about the relationship between care and social justice, and recognises the potential for disempowerment in the care relationship. Tronto (2010) highlights three things that need to be recognised for the organisation of good care, the first of which is “a clear account of power in the care relationship and thus a recognition of the need for a politics of care at every level” (p. 162). Kittay (1998) similarly emphasises the importance of interrogating power relations, but highlights the difference between inequality of power in the care relationship, which is not in itself seen as problematic, and the exercise of domination as the inappropriate use of power.

Given these different perspectives, it is important to fully understand the complexity of staff roles in engagement and their positions among other actors. The aim of this paper is to explore the positions that can be conferred on, or taken up by, staff in practising client engagement in the aged care context. This paper focuses on the positions of power within the care relationship and where inequalities exist or are either used or mitigated by staff. The paper uses these two contemporary theoretical lenses – first, the concepts of choice, autonomy and control that dominate recent policy shifts, and second, an ethic of care - to explore the potential reframing of the care relationship and the contrasting and unique understandings that can be offered by these different perspectives as they are practised in a dominant policy framework of consumer choice and control. This paper focuses on the practice of client engagement within the context of an aged care service in Australia, particularly in terms of how staff members and clients across the breadth of the organisational context perceived and negotiated the roles of staff in client engagement.

Research Approach

The aim of this research was to examine how client engagement is enacted within the context of a large Australian aged care provider, Blue Care. At the time of the study, Blue Care was implementing a new service model called Blue Care Tailor Made, focusing on flexible and integrated service delivery, which was designed to allow clients to easily navigate and choose the services they required. This research was designed to support the service model by independently identifying key issues and directions for client engagement. This required multi-dimensional qualitative analysis, involving the consultation of clients, staff, and organisational documents. This paper reports on the analysis of interview and focus group data from clients and staff.

Data Collection

Before recruitment began, the study was approved by the Human Research Ethics Committee (HREC) governing research within Blue Care. Staff and clients were invited to participate through a letter distributed by the service managers or directly by the researchers and were asked to contact the researchers to indicate their interest in participating. Interviews and focus groups were conducted by researchers who were independent of the organisation (Author 1 and Author 2), using an interview guide developed by these researchers.

Interviews and focus groups were conducted across 17 Blue Care services. These sites were chosen in collaboration with Blue Care to represent urban, rural/regional, and coastal services, and to include community, residential, and retirement-living services across the state of Queensland. Sites were chosen to ensure that each type of service was included from each geographic cluster of Blue Care. Interviews and focus groups were conducted at the site at which those clients or staff were located.

Nine semi-structured individual interviews and 13 focus groups were conducted with staff members across operational and strategic roles within Blue Care. Two interviews and 12 focus groups were conducted with clients. Thus, 11 interviews and 25 focus groups in total were held. Both interviews and focus groups were used to ensure that those who were not comfortable with a focus group setting, or who were in roles or locations which made participation in a group prohibitive, were able to participate. The groups and interviews planned to address the geographic and service diversity of Blue Care were found to be sufficient to reach data saturation.

Participants

In the final sample, ninety four staff volunteered to be in the study and participated in focus groups and interviews, including 89 women and five men, ranging in age from 22 to 67 years. Sixteen identified as born outside of Australia, and one identified as Aboriginal or Torres Strait Islander. The sample included staff in administration, activities and hospitality, as well as chaplains, assistants in nursing, personal carers, clinical nursing and allied health staff, service managers, managers of special programs and initiatives, and senior management staff, who had worked for Blue Care for between one month and over 30 years. Thirty-four staff participated from residential services, 46 from community services, and 14 from roles that crossed settings.

Eighty five clients participated, including 43 clients of community-based services, 32 clients of residential services and 10 clients of retirement living. Of these, 61 were women and 24 were men, aged between 28 and 101[1], and had been receiving Blue Care services for between two months and 20 years. Three clients identified as born outside of Australia and five identified as Aboriginal or Torres Strait Islander.

Analytic Strategy

The data were prepared and analysed by Authors 1 and 2. All discussions were digitally recorded and transcribed verbatim. Any identifying information was removed to ensure participants’ anonymity, and transcripts were stored in password-protected files which

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[1] Since this organisation provides services to clients of a very broad age range, and because focus groups took place in the care setting with established groups, the age range of the sample broad and includes those who would not be considered “older people”. Over 85% of clients who participated, however, gave their age as over 65, with only one client aged under 50. As all the clients who were younger in age participated in focus groups rather than individual interviews, it was not possible to separate their responses.

were only accessible to the researchers (A1 and A2). All of the interviews were read repeatedly for familiarisation and the data were analysed using QSR International's (2012) NVivo 10 qualitative data management software. The data were analysed using open and axial coding, to categorise and identify relationships between themes (Strauss & Corbin, 1990). This involved searching for themes relating to staff and clients' experiences of engagement practice, particularly the practical and organisational factors that facilitate or impede it.

The data were then further analysed using Davies and Harré's (1990) positioning theory, which involves analysing how people position themselves and others when speaking about a topic. Through social interaction, people have 'subject positions' that they can occupy (either by taking them up or being positioned by others), which shape the perspective that they take in responding to, and interacting in, the world (Davies & Harré, 1990, p. 46). Subject positions are imbued with varying degrees of power (Davies & Harré, 1990). This analysis entailed analysing staff and clients' discussion of client engagement and focusing on how staff spoke about the roles that they could, or did, take up in relation to engagement practices, or the ways in which clients positioned staff within engagement practices. Examining the positioning of staff provides a lens through which to understand the process of engagement on a deeper level and to consider the power relations within the practice of client engagement.

The researchers paid attention to the rigour and quality of the research by using direct quotations and ensuring that participants' views were not taken out of context, by using a semi-structured interview schedule which allowed for flexibility but also consistency, and by reflexively considering their positions as young Caucasian women interacting with older adults from a range of socio-cultural backgrounds. At times, this difference in socio-cultural positions enabled a shared understanding between the researchers and participants, while at other times required participants to elaborate on what they meant in discussions. Differences in socio-demographic positions can thus be advantageous in facilitating information sharing; however, the importance of the demographic characteristics of the moderator have been emphasised in the focus group literature (e.g. Krueger & Casey, 2000; Stewart, Shamdasani & Rook, 2007). The researchers therefore remained aware of their potential impact on the dynamics of the groups and on the data throughout the study.

Limitations

In interpreting the results, some limitations to the study must be acknowledged. First, it must be recognised that certain client voices were missing from these discussions; in particular, the sample was restricted to clients who were able to participate in a group discussion or standard semi-structured interview. Clients with cognitive or communicative challenges who could not actively participate in such a discussion were therefore excluded. It is intended that these clients will be the focus of additional research to ensure that their perspectives are given full attention, and this is an important future research direction. Similarly, the sample was limited in its demographic diversity; in particular, only limited numbers of staff and clients of Aboriginal and Torres Strait Islander descent were able to be recruited for the study and both staff and clients were predominantly women. Further, as an overarching exploration of engagement practice, it was not possible to explore different types or levels of engagement separately to ascertain whether different beliefs, practices, and roles were evident among them, nor was it possible to conduct detailed analysis of the differences between residential and community type settings. Future research should give more focused attention to the various types of engagement that occur in the care context as well as the different settings within aged care.

Findings: The Positioning of Staff in Client Engagement

The focus of this paper is on the various positions in client engagement that were conferred on, or taken up, by staff in discussions. We identified two broad areas in which power shapes staff roles: (1) staff are positioned as empowered, powerful, and active within client engagement; and (2) staff regulate and balance their power within client engagement. A third area, which describes how staff are required to negotiate constraints and work within an organisational and systemic context in terms of their ability to enact client engagement, will be addressed in a separate paper. These positions are analysed through two contemporary theoretical lenses. First, analysis considers what these positions suggest about power relationships in care, and what implications these positions have for client engagement practice, particularly focusing on the concepts of choice, autonomy and control that dominate recent policy shifts. Second, analysis adopts an ethic of care perspective to explore the ways in which care ethics are practised in this policy context.

Staff as Empowered, Powerful, and Active

Staff were positioned by both themselves and by clients in a range of ways that reflected an empowered, powerful, and active role in engagement and more generally in the care context. This empowered role was illustrated in discussions when participants positioned staff as (1) helpful experts or (2) as service providers. Both positions cast staff as playing a supportive role in relation to clients. However, these positions range in the degree of power afforded to staff, from traditional, authoritative roles, to consumer-focused roles, to more collaborative roles. When staff are positioned in these ways, they are seen to occupy powerful, albeit benevolent roles. This ultimately maintains staff in positions of power within engagement practice.

Staff as helpful experts

An important position for staff, particularly from the clients' perspective, was as helpful experts. This was reflected in clients' discussion of how staff experience and knowledge (both experience with engagement and clinical or professional knowledge) greatly facilitated positive interactions with them. For example, one care client emphasised the level of knowledge community care staff demonstrated, coupled with their role as helpers, as vital to their care experience:

> *Well they are so knowledgeable my dear. They know everything. And I mean they're there to help you so much. Everything is help with them isn't it? They're there to help you, it's not tell you. Everything they tell you, you know is what you need... So that's the knowledge you're looking for, don't you think? (Community client)*

Moreover, like the clients, staff also regarded knowing and understanding the client group as well as relevant community resources as important:

> *... when you see a need there, you do give them the information and if we can't service them we do tell them where they can access support groups and things like that, so a lot of that knowledge base comes with experience too (Community staff).*

In this quote, the staff member positioned themselves as knowledgeable through their experience over time; such knowledge and experience thus provides staff (like this staff member) with some degree of power, by enabling them to act as information providers to clients. On first assessment, both these quotes appear to reflect a passive role for clients; in the first, the client positions herself as the passive recipient of staff knowledge, expressing a sense of security in her belief in staff expertise and commitment to her interests. In the second, a staff member in turn appears to position clients as being on the (passive) receiving end of information and expertise. Provision of knowledge, however, is presented here as a mechanism for facilitating client decision making and control, rather than a purely passive aspect of the care experience. Further, considered through the lens of an ethic of care, these staff and client perspectives also reflect Tronto's (1993) third moral principle of care – competence – which emphasises the importance of the work of care being performed competently to ensure that care is provided, not just a need for care recognised. In these cases, competence is shown in the form of development and sharing of knowledge. For some clients, staff knowledge was also closely related to trust, with an implicit and explicit assumption that staff can and should lead decision making:

> *Yeah, and they ask you if there's anything that you want, they say are you happy with this? I say, "Well you're the boss. You're the boss and I'll work with you. I'm not here to tell you what to do. When you come in that door you're here to help me". And that's what they do. (Community client)*

This positioning by the client – 'you're the boss' – placed staff in an explicitly powerful, albeit caring, role in relation to clients. This is indicative of traditional care roles, in which staff make expert judgements and play a determining role in service provision (Wellard, Lillibridge, Beanland & Lewis, 2003). From an ethic of care perspective, Sevenhuijen's (2003) additional moral principle – trust – is reflected in the recognition of inequality and vulnerability by the client and the implicit trust in the staff member acting in her best interests. It is interesting that this role was conferred here by the client, rather than assumed by the staff member; this quote also exemplifies the changing relationship between staff and clients, in that there is an increasing expectation to consult clients regarding their needs and wishes ('are you happy with this?').

Staff positioned themselves as supportive of client engagement when they were seen to initiate two-way discussions with clients, and by taking note of clients' opinions and wishes. This advisory role, however, took on an interesting character in discussions about autonomy, where a challenging balance was evident between advising, making suggestions, and relinquishing control of decision making. Both clients and staff frequently implied that staff expertise should take priority in decision making; some staff referred to 'talking clients around' to decisions that were in their 'best interests'. Others, however, emphasised the importance of the client's expertise in their own needs and wishes, and the importance of staff deference to these despite their professional opinion, for example:

> *Getting their permission to talk to the doctor, getting their permission to talk to their relatives ... letting them - giving them the ability to make their decisions and if their decisions aren't in their best interest at least being able to explain to them reasons why another option may be a better suggestion for them, but at the*

> *end of the day it becomes - it is still what they want is what they get. (Community staff)*

From a traditional perspective on choice and control, this quote again illustrates the power staff members have in ‘letting’ or ‘giving’ clients opportunities to make decisions for themselves and in drawing on their expertise to justify being in a position to say whether or not something is in the ‘best interest’ of the client. This authoritative position therefore to some extent reinforces traditional care relationships, and reflects findings we have reported elsewhere (Petriwskyj et al., 2014) which highlighted the conferral of power and control by staff on passive clients. However, this staff member simultaneously suggests a ‘letting go’ of the expert role in deference to client preferences.

These examples demonstrate how the moral principles that form the basis of an ethic of care may be enacted to differing degrees in practice. Tronto’s (1993) understanding of the principle of responsibility - that is, recognising and accepting responsibility for providing care – requires negotiation and flexibility in how needs are met (Barnes, 2012). Further, in applying an ethic of care to paid care work, Barnes suggests that key to this construct is the notion of reciprocity and the importance of dialogue. In her analysis, Barnes draws on a number of sources to emphasise the importance of the interaction within the caring relationship and the need for dynamic learning and change on the part of both the care giver and the care receiver in light of others’ contributions. In addition, the principle of responsiveness requires that the care giver reflect on and understand how care is experienced by the care receiver. Such perspectives reflect the application of Iris Marion Young’s notion of asymmetrical reciprocity to an ethic of care, which rather than putting oneself in another’s place, emphasises being “together in one place” and “willingness to be open to everyone’s unique, embodied subjectivity” (Sevenhuijsen, 2003, p. 186-7). Each of these principles is reflected to differing degrees in the examples above. It is notable that where the care worker attempts to ‘convince’ or ‘talk around’ clients they fail to actively negotiate, learn and understand care from the client’s perspective. While they recognise a need for care and take responsibility for providing it, they do this in a way that assumes control rather than a reciprocal relationship of learning and seeking to understand the client’s own perspective. In the second example, however, a relationship of dynamic learning, sharing of expertise, and negotiation is emphasised. While the care worker takes responsibility for providing the care that is needed, this is undertaken in a relationship of dialogue and discussion.

By virtue of their professional roles, staff members were positioned in the discussions as helpful experts in relation to clients. The staff role as professional and expert was used by clients as both a knowledge source and a source of action on their behalf. This position was most often described positively by clients, and encouraged a sense of trust. From the perspective of power and autonomy, when positioned in this way, staff members can be seen to hold power, or potential power, in relation to clients. At times this led to staff negotiating a dynamic power relationship, for example by actively engaging with clients through open discussions and demonstrating a philosophy of client choice and autonomy. Nevertheless, the discussions highlighted how staff can continue to occupy traditionally powerful and active roles in the care context, while clients are positioned as recipients of care, information, and staff expertise. Conversely, staff can be seen as enacting an ethic of care within this policy context of autonomy and power sharing, albeit to varying degrees. Evident in both staff and client descriptions are examples of taking responsibility for care, providing care competently, and engaging in reciprocity, seeking to understand the client’s perspective and facilitating mutual learning. Retaining decision making authority, through this perspective, can be viewed as a failure to engage in this reciprocal relationship of negotiation and learning. While the end result remains a restriction on the client’s contribution to their care, a focus on ethics of care highlights a complex care dynamic.

Staff as service providers

Staff were positioned by participants as active agents of the organisation, and as providers of customer service. This position of staff as service providers mirrors the shift in health care whereby clients or patients are viewed as health ‘consumers’ who make choices and participate in decision making about their care (Wellard et al., 2003). Rhetoric of consumer-oriented care was evident in the discussions of client engagement, which highlighted a move away from more traditional understandings of staff-client interactions; nevertheless, talk of ‘consumers’ in aged care implied a focus on providing care *for* rather than *with* clients. Service provision often required staff to continually assess clients’ needs:

> *... you have to ascertain ... what is the need, and then how you are going to achieve it. And for some it might be a repeated explanation and demonstration, like many, many times. And if that’s what it takes, that’s what you need to do ... and I suppose it’s just re-evaluating your assessment as you go on ... So you can sort of expand on your assessment a little bit more because it all just fills in to create the big picture I think. (Community staff)*

In this quote, this staff member describes the continual process that staff members need to undergo in explaining care provision to clients, as well as gaining an understanding of clients' needs. Thus, the onus is placed on staff to identify clients' needs, rather than clients occupying an active – or proactive – role in making their needs or wishes known to staff. Similarly, in the two quotes below, one staff member recounted her experience in working with a family from a non-English speaking background, while another discussed reading a client's body language to gauge their needs:

> *... they don't speak a word of English and I said, 'Would you like me to do this?' 'Yes, yes', smiling up big. And then you do it and they sort of look at you like, 'What are you doing?'... They'll take you to what they want you to do for them ... We got through it and they were smiling in the end so they must have been happy but it took a lot to sort of work out what they wanted. (Community staff)*
>
> And:
>
> *And the body language ... and you can see the triggers, if something is not going right, there will be a trigger and a behaviour may occur because they're not happy with what's actually happening, so as staff we have to go in and "Righto, what can we do differently" ... (Residential staff)*

The staff position themselves here as responsible for identifying needs and solutions – that is, actively seeking out opportunities to engage clients - not only for responding to explicit requests. Similarly, this client emphasised the need for staff to actively engage with clients to ascertain their needs and understand them:

> *Individually I think it's a four step process. Get the facts from the people, decide what you're going to do, follow it all up and… if they get the facts for the first time and observe everything that's going on so they can understand the person. (Community client)*

Thus the participants positioned staff as providing customer service, while clients were positioned as seemingly holding power (although 'active' to differing degrees) as 'consumers' of care services whose needs and wishes needed to be met. This places a degree of responsibility on staff to satisfy clients, which departs from traditional notions of health care as something that is determined by health professionals (Cook & Klein, 2005), and simultaneously positions staff in an active role of service provision. Implicit in some of this discussion was also a passive role for clients as recipients of expertise and information seeking activities, rather than empowered and proactive agents in their care. Once again, however, the provision of this expertise can be seen as facilitating active participation.

When viewed from an ethic of care perspective, this position for staff can be seen as the manifestation of the principles of attentiveness, responsibility and responsiveness. In these examples, the staff member is seen as needing to identify a need for care, take responsibility for providing it, and to do so in such a way that reflects their understanding of the client's perspective and experience. Thus, while in the context of contemporary policy shifts, the staff here are active agents providing services to consumers and shouldering responsibility for ensuring needs are met, this same behaviour reflects the enactment of care ethics.

Staff Balancing Power

Both clients and staff frequently situated staff in active and empowered positions within the care relationship and context, which is evident through positions of staff as 'helpful experts', as 'service providers', and as 'community partners'. Although these positions emphasise the power inherent in active staff roles, it was clear through participants' talk that staff did not simply assume this power or always take it for granted. Instead, staff were positioned by themselves and clients as 'self-regulating' in the power they held, to ensure or promote client engagement. Staff were also described by participants as balancing their power in other ways, for instance, when they occupied 'liaison' positions within the care context.

Staff as self-regulating

Staff were viewed by participants as potentially powerful – given the active positions they occupy – but as self-regulating out of respect for clients' autonomy. For example, clients and staff discussed the growing emphasis on client autonomy and frequently referred to the 'giving' of opportunities for clients to act autonomously or engage in decision making:

> *... we are given the choices to decide where we want to go and what we want to do. I find it very good really, if I don't want to come down to something, then I just don't come. They don't try to persuade you ... So you are really very free to choose. (Residential client)*

In this quote, the participant emphasises how clients are offered options regarding their daily activities, which they are 'really very free to choose'. This notion of choice complements the practice of consumer-oriented service provision (as discussed earlier), in which clients decide what activities they wish to participate in and when, with staff acting as facilitators. As also illustrated above, however, staff members continue to occupy positions from which to distribute power to clients ('we are *given* choices', emphasis added). This constructs an unequal, albeit benevolent, power dynamic between staff and clients. Contrasted with the earlier findings that staff sometimes engaged in ‘persuading’ behaviour, this finding particularly highlights the concept of control and autonomy in practice.

Although staff hold positions of power by virtue of the care provision relationship, they described themselves as understanding the importance of negotiation and opportunities for participation, as well as the need to regulate their use of power. In the following quote, a staff member discussed the way in which staff need to negotiate with clients in order to help them feel empowered and in order to adhere to client-centred care:

> *I’ve negotiated with her a piece of equipment that makes her feel safe, it makes her be able to get on and off the toilet ok without grabbing the shower and all these sorts of things. And she feels good about herself as well, and about our interaction together. And the goals are achieved … (Community staff)*

Similarly, clients recounted experiences of collaborative decision making and respect for their autonomy in a range of situations. For example, one residential client explained how decisions about hospitalisation are made as a team, with the client’s preference respected:

> *...(T)hey come and discuss it with you. [staff member] will say ‘[client] do you think you should be admitted to hospital?’ because they can’t force you to go and it’s all discussed in a nice manner and there is no forcing and things like that and if you say, ‘Yes I feel I should’ then you usually go within a fortnight of that, because they know you need to go and you know... some people don’t like to go. So we all co-operate and it works well... (Residential client)*

These quotes demonstrate how staff can work in collaboration with clients to identify solutions in meeting clients’ needs. For these staff, their role provides the potential to control and manage client wishes and behaviour; however, as shown in the above extracts, their responses are to regulate their power and ‘negotiate’ with, or try to better understand, the client so that they can adapt to their needs and ensure decisions are made collaboratively. Similarly, one staff member discussed the need to engage with clients and respect them as people with an ‘understandable’ desire to control their space or the services they receive or think appropriate:

> *I think the worst thing you can do is go in and state an ultimatum with people. There has to be that both sides of you know, both parties agreeing to what is best for them … And usually it is just a lack of knowledge and it is just a lack of consequence ... people like say, “That’s not going to happen to me”, so you know, that’s life. I do that as well, so I can fully understand that. And you can*

> *fully understand people come into your own home you go, "Don't go changing my home. This is my haven, this is my kingdom". (Community staff)*

This highlights the need for staff to regulate their role and to practise respect for clients' wishes, instead of assuming a controlling role. Staff members frequently discussed the need to develop partnerships with clients, thereby recognising clients as autonomous individuals and collaborators whose responses are understandable human reactions to their circumstances.

Seen through an ethic of care lens, such examples highlight the contrast between 'reciprocity' as a key component of an ethic of care, and the 'choice and control' approach to care decision making (Barnes, 2012). This reciprocal approach is described by Barnes in terms of a collaborative relationship in which both professional and client are active participants and in which each are open and receptive to reciprocal contributions. In these examples important decisions are made in collaboration through the sharing of expertise – staff expertise in the clinical issues at hand, and the client's expertise in their body and its responses, and their perceived need. While client choice, autonomy and control are promoted, this is achieved through the practice of the principles of an ethic of care.

One of the less explicit ways in which staff could be seen as regulating the power of their position was through demonstrating caring and compassionate responses to challenging situations. Staff members in particular positioned themselves in this way:

> *Sometimes their reactions to things change when they get closer to death, if they all of a sudden find that they are full of cancer or they know they've got the cancer and the pain, the stages are getting worse, so the pain is getting worse, then you'll find a bit more aggression, a bit more attitude, and you just have to totally understand that, jeez, you need to put yourself in their shoes. (Residential staff)*

Implicit within these discussions is the importance to staff of empathy; in these quotes, staff position themselves as empathetic and caring in response to challenging client interactions, rather than adopting the role of powerful and controlling managers of client behaviour. This could also be seen from an ethic of care perspective as the manifestation of responsiveness, with the staff member taking on the responsibility for understanding what the care experience is like for clients who otherwise appear to be unco-operative or 'difficult'. Thus enacting an ethic of care becomes the basis for engagement that recognises the lived experience of the client, rather than staff taking control of the interaction – and the client – in response to challenging behaviour.

Some staff members discussed the importance of helping clients to feel empowered, by learning about and accommodating their abilities and interests. For example, one staff member described working with a client with dementia to ensure they could act in ‘meaningful’ ways:

> *If I’m trying to do a dementia resident’s care plan and I’ve got afternoon behaviour, I’m wanting to know why we’ve got afternoon behaviours - what did they used to do in their life before in the afternoon, were they preparing dinner, were they cutting firewood ... so we can put something in to distract them that is going to be meaningful to them ... So it’s making sure that what they’re doing, to the best of your knowledge is what they would like to do within reason. (Residential staff)*

In this quote, the staff member positioned themselves as actively trying to promote the client’s personhood and trying to meet their needs within the framework of client engagement. Whilst the staff member is still positioned in a relatively traditional role of determining what is ‘within reason’, it also signals the constraints that staff have to negotiate (e.g., the extent of their knowledge about the client’s preferences and wishes) in trying to promote client engagement. From an ethic of care perspective, this example demonstrates attentiveness, responsibility and responsiveness in practice. Through their response to this client’s ‘afternoon behaviour’, the staff member recognises a need for care in the client’s behavioural responses, taking responsibility for providing this care by seeking out information about what is meaningful to the client and will meet their needs and actively attempting to understand the experience of care and the experience of meaningful activity in that time and place for the client.

Staff members were often positioned by both themselves and by clients as actively caring, and generous, often beyond the expectations of their job, thereby using benevolently the control they have over the level of service that is provided. Clients and staff also recounted experiences of staff doing small favours for clients or undertaking extra tasks outside of their work, as well as demonstrating a caring and welcoming attitude. Similarly, staff members also positioned themselves as helpful, compassionate and caring sources of support for clients. A number of clients commented on the caring attitude of staff and their apparent willingness to go above and beyond their job, for example, as one group discussed:

> *Speaker A: More than what you would be expecting them to do. They’re doing more for you than what you would think.*
>
> *Speaker B: But they don’t make you feel like it’s a job. (Community clients)*

One client in this group then went on to explain:

> *Yes I think that is it the caring part that I like. They seem to care for you, you know. They really do try to please us, the staff. (Community client)*

When staff were described as being caring or generous, this was seen especially by clients as promoting positive relationships between clients and staff and fostered client-centred care. In turn, this encouraged clients' feelings of being recognised and included by staff, which could enable clients to feel empowered. At the same time, this positive behaviour positioned staff as having the ability to actively meet clients' needs and being in a position of power to do so, as opposed to clients taking up active roles. This highlights the way in which positions (that staff can take up, or be located in) can be simultaneously productive and restrictive in how they shape client engagement.

These quotes provide an interesting perspective on what it means to 'care'. While in much of the discussion care was seen as something that was provided, and about which clients and staff engaged, these examples suggest that care is simultaneously a less tangible concept that reflects an attitude or approach to the "work" of care itself. In the first quote in the paragraph above, care is reflected in wanting to, rather than being obliged to, provide help; care is "more than just a job", and is therefore more than the "work" of care. In the second example, similarly, care is presented as an emotional response while simultaneously being manifested in the desire to "please". Meeting client needs is therefore more than a requirement of the job; it is "caring" in the dispositional sense.

The regulation of the power dynamic was also evident in the central themes of trust and relationships within the discussions. Relationships were seen as taking different forms; for example, the client-service provider relationship was both explicit and implicit in discussions, in which clients were referred to as customers, and in which fulfilling client requests and providing options for their consideration were prioritised. Deeper, more personal relationships were also identified. In particular, relationships between clients and staff were often described by both as being family-like. In these discussions, staff members were positioned as trusted, and as being in a close, warm relationship with clients.

> *When they come to my house, well I treat them just like family or friends and I think that's really, really good ... They come over my house and sit down, "Want a cup of tea or coffee?" whatever, and we sit down and have a talk, and I feel like I can speak to any one of them ... Then if something goes wrong, they are somebody you can get in touch with. (Community client)*

Building relationships was seen to help staff to be responsive and to provide appropriate care. In addition to the significant emotional connection this implied, this also enabled a shift in power relations between staff and clients, when clients were able to do something for staff (offer a cup of tea), as well as receive something (support when 'something goes wrong') from staff. This highlights possibilities for developing reciprocal relationships, which could then foster active partnership in care services. It is interesting to note, however, that very limited discussion on unethical or unprofessional crossing of boundaries occurred. Relationships were presented in the main as a positive part of engagement, with only isolated instances of behaviour – largely on the part of clients – that crossed personal boundaries. Further, as we reported elsewhere (Petriwskyj et al., 2014), not all staff-client relationships extended beyond a superficial level or reached the 'family-like' depth. It was also noted in that paper that some staff used controlled information sharing strategies to build rapport while controlling their personal boundaries. Thus power is regulated by staff in the type and depth of connections they build with clients.

Such examples present a variation in how reciprocity is manifested in care. In this sense reciprocity is not manifested in decision making, but in the relationality and interconnectedness that characterises care relationships. It is clear that the relationships between staff and client vary considerably, and while for some these suggest an understanding of care as reciprocal, for others they demonstrate a perspective on care as service provision – "work" that is done to provide "care" to a consumer.

It must be acknowledged that the notion of implicit, and accepted, self-regulated staff power was not universal among respondents; indeed, some clients recounted experiences of staff control or attempted control that they deemed unacceptable. For example, some clients recounted experiences of feeling disempowered, controlled, or managed by explicitly controlling or 'bossy' staff behaviours, or feeling ignored in the care space. One client expressed his outrage at a level of control by staff that he deemed unacceptable:

> *...(T)here's the odd one that thinks they've got the authority to tell you what to do, when they want you to do it. Whereas it's the other way around. They should do what you tell them to do... I think that virtually the residents of this place pay the staff wages. And they have the audacity to boss the residents around. I don't say the residents should boss the young ones around. But the staff shouldn't boss the residents around either. (Residential client)*

Such instances highlight how traditional power relations can still be perpetuated within the care context, when these are not actively questioned or negotiated. They also highlight the importance of clients being able to recognise and challenge power imbalances. As this example also demonstrates, clients too expressed an understanding of the care relationship as one of control. For this client, one or the other party was, or needed to be, in control – to tell the other “what to do”. This contrasts with the reciprocal relationship that characterises an ethic of care and suggests that a lack of demonstration of an ethic of care on the part of staff members may perpetuate a combative, rather than collaborative, care environment.

These perspectives on staff roles – in particular the regulation of potential staff power through demonstration of compassion and empathy, and the building of relationships beyond traditional service relationships – contrast with traditional care roles. Indeed, they resonate with many aspects of an ethic of care in which care is understood in a dynamic of interdependence rather than a relationship of dependence versus autonomy (Barnes, 2012). However, at the same time, this focus on staff members’ response to client behaviour can be seen to reinforce the potentially dominant role of staff, who regulate the development of this dynamic. Thus, the powerful, empowered and regulated roles of staff were juxtaposed simultaneously in discussions.

Discussion

Through this analysis of staff and client positioning of care service staff, two contrasting but not incompatible positions for staff can be identified. First, staff are empowered, powerful and active, but generally benevolent towards clients, potentially holding and wielding power in care. They were positioned by clients and themselves as ‘helpful experts’ and ‘service providers’. Second, staff were seen to occupy mediating positions. This entailed staff balancing their power, which they are seen to do when they position themselves as ‘self-regulating’. The positions that staff can take up, or are located in, are fluid and dynamic. This is firstly in terms of the degree of power that they offer and, secondly, as shown in the discussion, staff can occupy multiple positions at any one time. Moreover, these positions are very often simultaneously productive and restrictive in terms of what is made possible for staff members’ roles within client engagement.

In considering the implications of this positioning for power relations in the care context, it is clear that both staff and clients experience and perpetuate patterns of power. Considerable similarity was evident between these groups in the positioning of staff; however, some divergence also reflects tensions in the dynamic of care and of autonomy in the care context. First, the findings suggest that both staff and clients positioned staff as knowledgeable and expert, as active, helpful customer service agents, and as caring and generous. Thus, both clients and staff placed staff in positions of power in relation to clients. Interestingly, both staff and clients reflected positions for staff as active in both providing *care* and providing *customer service* – a juxtaposition that is also evident in policy and service rhetoric. Both staff and clients also often positioned staff as needing to respect clients' wishes above all; however, this was not universal. In particular, some clients explicitly placed staff in roles of decision making authority on their behalf. More subtly, both staff and clients positioned staff as self-regulating of their power, but with the implicit assumption that power was something for staff to 'give' or 'allow'. Client power was largely couched in terms of positions as "consumers" or "customers" rather than active citizens, with some exceptions – most notably in retirement living in which governance arrangements are more akin to a micro-community rather than an institution. In this sense, the extent to which clients understood themselves to hold inherent power, or desired to wield it, was variable.

This highlights an important difference between staff and client discussions. Staff descriptions of their power largely presented this balance as unproblematic; likewise, some client descriptions saw staff control over power sharing or indeed, over decision making altogether, as acceptable or even desirable. Some clients, however, problematised this power balance and presented active resistance to staff control and ownership of the care space. This reflects a similar finding in the analysis of client positions published in another paper (Petriwskyj et al., 2014).

These findings reflect the varying positions that can be identified in the literature regarding staff roles in the care dynamic. Staff have been criticised for playing a dominant role and their potential for control over client choices and care have been highlighted (Lyttle & Ryan, 2010; Penney & Wellard, 2007). Additionally, however, it has been argued that it is important not to oversimplify the understanding of client influence, and rather, deeper explanations of how client influence is negotiated should be considered (Harnett, 2010). The findings of this study suggest that these positions of power and constraint exist simultaneously with other active, but positive, roles. Thus, they suggest that active roles for staff do not necessarily reflect a wielding of power, although they frequently hold power or potential power in client interaction. What these findings suggest is that a dynamic process of role adoption, power use and power sharing takes place in a network of multiple actors and within structures and agendas defined outside the care dyad. Therefore, the positions that staff are offered, and take up, are both various and fluid.

The findings also suggest that the notion of a power hierarchy that seems to be indicated by the literature is overly simplistic; indeed, while some client accounts support such a hierarchy and actively perpetuate it, staff mainly presented a complex and dynamic picture of their relationship with clients. This was also supported by many client accounts. This suggests a complex and dynamic sharing of power among clients and staff, reflecting to some extent the changing practice and policy rhetoric and indicating that power is not simply relative, but relational. Such a finding resonates with an ethic of care in which interconnectedness and relationality are fundamental characteristics of care. This contrasts with the assumption in much policy rhetoric – and also evident in some of the focus group discussions reported here – that power relations are dichotomous and that control is something that is kept, shared or taken. In such an understanding, power is manifested in choice and autonomy, each of which carry with them assumptions about who holds power and to what degree. This understanding was certainly evident in these findings, among both staff and clients. However, also evident was a perspective on care and on power that emphasised relationships, collaboration and reciprocity, and that reflected the notion of care as something other than either services that are chosen and provided or as activity that is performed. This reflects an ethic of care in practice alongside and within the policy-driven focus on choice and control. Indeed, throughout the findings examples of an ethic of care in practice were identified. Staff were described as enacting the principles of an ethic of care in a variety of contexts. It is notable that whilst at times a seeming failure to promote client control was evident in behaviour that reflected an ethic of care, in others cases it was this ethic that promoted client choice and autonomy, albeit in a collaborative rather than absolute sense.

In practical terms, the findings highlight the potential for increasing partnership between clients and staff, and between staff and the organisation in which they work. The roles staff take, and are given, in engaging with clients demonstrate both active use of power and active regulation of it. Further, the relationships and roles demonstrated in the discussions signal existing strengths in the care dynamic that could be harnessed to promote and facilitate client partnership in the care context. Recognition of power dynamics is key to forming active partnerships and opportunities for client engagement in the care setting (Baur et al., 2013). The power relations evident in this study demonstrate the potential for building greater partnership and collaboration between clients and staff, within an organisational environment that supports and facilitates this. Such an approach is consistent with both policies that promote client control and an ethic of care approach.

For aged care service provider organisations like Blue Care, the findings highlight the role that organisational structures, policies and processes play in the staff – client dynamic and in the engagement roles that staff adopt. In particular, guidance and leadership for staff in regard to their roles as conflict managers, liaison and solution negotiators was highlighted. On a practical level, these supports facilitate the practice of engagement by staff; in a broader sense they represent an understanding by the organisation of the complex nature of engagement roles and positions that staff occupy in the care space, and the tensions staff negotiate in relation to power dynamics. In this way, the organisation provides both the necessary skills and knowledge to promote client empowerment and the supportive environment needed to facilitate an ethic of care in practice.

Conclusion

The practice of client engagement in aged care has undergone comparatively little interrogation in the published literature to date; however, it is clear that critical reflection on this practice reveals important opportunities. An understanding of the complex and fluid nature of staff roles in engagement with clients has significant implications for the ability of organisations to facilitate and support effective engagement in practice. It also has implications for the ways in which staff roles in the care context are defined, discussed and positioned in research on engagement. A perspective on staff positions as uni-dimensional, or even on different positions in isolation, provides only a partial and restrictive view of engagement in practice. Recognition of the fluid, dynamic and simultaneous positioning that takes place in practice, on the other hand, presents an opportunity to more fully understand, and therefore develop, the roles of staff in this fundamental aspect of care. Viewing the practice of care through different lenses - more specifically, the dominant policy perspective of choice and control, and the alternative perspective of ethics of care – demonstrates the complexity of the care dynamic and highlights the potential for a deeper understanding of practice.

Acknowledgements

The contributions to this project of the Blue Care staff and clients who participated and assisted with recruitment are gratefully acknowledged. Thanks go to Associate Professor Deborah Parker for her practical and methodological advice and to Robyn Batten for her comments on an earlier version of the manuscript. This research was funded by Blue Care as part of the Blue Care Tailor Made service model.

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