P E A C H

Promoting Excellence in All Care Homes

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Disclaimer

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The full report can be found at: **http://www.panicoa.org.uk**

P E A C H

EXECUTIVE SUMMARY

Background

The Promoting Excellence in All Care Homes study focuses on the position of staff in care homes, and the influences upon them. The care home workforce has a pivotal role in the quality of care provided to residents of care homes, which in turn is a major influence on quality of life. This large work-force, of probably over a half a million people, carry out work that is often seen as unattractive, at rates of pay that are seen as under-valuing the contribution made, without a clear career structure, in a sector that is marked by constant change. Individual staff members are influenced by their personal attributes and resources, their own families, relationships and social networks, but also by the social climate in their work-place and by the organisational environment. Burn-out and low job satisfaction have been related to negative attitudes to residents and lower quality of life. The sector often attracts unfavourable publicity in relation to reported instances of abuse and neglect, although estimating the extent of such problems is challenging. Training is often viewed as a vehicle for reducing the risk of abuse and neglect, and to increase the value afforded to those undertaking this work.

Aims and Objectives

The aim of the study was to explore the needs, knowledge and practices of the care home workforce in relation to abuse, neglect and loss of dignity and to provide a preliminary evaluation of an evidence-based training package.

The objectives were to:

1 Identify positive and negative factors in relation to abuse, neglect and the provision of dignified care.
2 Explore the views and experiences of the care home sector workforce in relation to best practice, training, job satisfaction and wellbeing.
3 Determine organisational, personal, and practice contexts in which abuse, neglect and lack of respect may occur between staff and residents.
4 Develop and evaluate an evidence informed training package.
5 Make recommendations for policy development, training and regulation in care homes.

Methods

The study used a variety of methods to achieve these aims and objectives:

- Desk research: to identify existing training materials.
- A postal survey of 250 care workers was planned regarding their training needs and experiences. Despite sending out 2000 questionnaires, response rates were disappointing with: 37 managers and 56 care workers
  responding. The sample was drawn from a variety of sources, including the CQC database of registered homes.
- Ethnographic observation – eight homes from across England, including a mix of urban and rural locations, with and without nursing, independent homes and members of small and large chains, ranging in size from 35 to 106 residents, some specialising in dementia and some not. At least 60 hours of observation was undertaken in each home, over a three to four week period, covering the whole 24 hour period. An agreed observational guide and brief was followed, and detailed field notes taken. Observations were made only in 'public' areas of the home; no intimate personal care was observed.
- Interviews were conducted with a total of 33 staff working in the eight care homes; where possible these were tape recorded for transcription. The interviews covered a range of issues relevant to dignity, training etc.
- The ethnographic field notes and interview transcripts were analysed together, using an inductive, thematic analysis with constant comparisons, using N-vivo 8 software to assist in data management and analysis.
- Validated questionnaires were completed by 73 staff working in the eight homes. The measures used assessed burnout, job satisfaction, a sense of mastery and attitudes to ageing and dementia.
- Focus groups with 29 care home managers and trainers and (separately) with 15 members of the Relatives & Residents Association. In total, eight groups were held in two waves, before and after the development of the initial version of the training materials, which were then adapted in the light of the feedback obtained.
- The training materials were piloted and evaluated in eight training sessions in seven of the care homes, and structured feedback obtained from the 77 participating staff.
- Stakeholder involvement included a Project Advisory Group and three workshops with around 85 participants at the end of the project where emerging findings were discussed, the training package reviewed and draft recommendations considered.

Results

Postal Survey

The postal survey results, based on a much smaller sample than planned, cannot be taken as definitive. Even in this limited sample, a wide range of available training was cited as being taken up in the care home sector. The majority of these managers stated that staff in their homes had training on dealing with abuse, but over half reported that staff did not have training on dealing with challenging behaviour in their home. The majority of the small number of care workers who responded, wanted further dementia training including communicating with people with dementia, managing aggression and performing activities.

Validated Questionnaires

The validated questionnaires completed by 73 staff members, (a sample size of 76% of the planned target) confirmed the relationship between attitudes, aspects of burnout and job satisfaction. Although the majority of staff had low levels of burnout, 29 per cent had a high level of emotional exhaustion and one in five members of care staff reported high levels of depersonalisation, where care recipients begin to be seen as objects rather than people. Significantly, 41 per cent reported a low sense of personal accomplishment, which is associated with a low sense of mastery and negative attitudes to ageing and dementia. Low self-efficacy is clearly prevalent in care workers, and could be an important target for training.

Qualitative Results: The Organisation

At the macro level, those participating in the research with roles in home management or administration presented the social care sector as being characterised by constant change, e.g. in relation to the inspection framework, training requirements and the paperwork and attendant bureaucracy and by inconsistency, with a lack of standardisation noted in relation to fee structures, staff numbers, inspection, staff training and qualifications and in the interface with the NHS. Thus at the macro organisational level, there is a sense of not being able to keep up with the pace of change and of a potential lack of clarity or even unfairness.

At the micro level, considering the home as an organisation in its own right, the home may be viewed as a physical and emotional space, which may meet residents' needs for example for privacy, personalisation, choice and control or for support with physical or cognitive needs, to a greater or lesser extent. Some of the homes clearly attempted to create an atmosphere of 'homeliness' and assisted residents to feel that they are 'at home', and to avoid the more institutional atmosphere still evident in some homes. The physical layout of the home served either as a barrier or facilitator to exchanges and interactions between residents and was an important contributory factor in determining the home atmosphere.

Qualitative Results: The Work

The difficulties in recruiting and retaining staff were evident from this study. These added to the pressure on existing staff, who often worked long hours, and on junior staff who received less supervision than would be desirable. Staff were often recruited from overseas, which in some instances raised issues regarding effective communication in a second language. Staff also reported experiencing racism, and there were clearly tensions between different cultural groups in some homes, which had an impact on teamwork. There were also, tensions in teams between different staff groups, most notably between nursing staff and care staff, and also between older and younger staff. The importance of effective leadership and supervision in fostering good teamwork was clear.

Whatever the staff resource – and staff shortages were repeatedly raised as a major issue – each day there was a job to be done, or rather a whole series of tasks, largely around fundamental care relating to eating and drinking, elimination, washing and dressing and administration of medication. Staff were hampered in achieving these tasks by a lack of information and related resources (e.g. Zimmer frames, adapted cutlery), as well as by shortage of staff. In the homes observed, there were also efforts made to support residents in managing pain and to offer opportunities for social interaction and activities. However, the hours of observation made clear that each home had its own rhythm, its own routines, and that this would often have priority over the rhythm of the individual residents. It was clearly difficult to achieve a move from task-centred care to person- or relationship-centred care.

Qualitative Results: The People

In each care home, three major groups of actors play key roles, which interact and influence the experience of life in the home. Residents' attitudes and behaviour have a major impact on other residents and the staff. Positive attitudes to staff were observed as were examples of residents showing empathy and understanding to each other. On the other hand, residents were at times challenging to staff, and occasionally aggressive to staff and to other residents. This often occurred in the context of dementia.

Staff also showed empathy and understanding, and there were many examples of staff empowering residents by offering choices, and providing support so that the resident could retain as much independence as possible. Less often, there were clear examples of staff disempowering residents, most notably through patronising communication, often described as 'elderspeak' and through giving priority to routines rather than to individual needs and preferences. No instances of staff being aggressive to residents were observed, although these were reported as having been witnessed by staff when working in other homes.

Relatives also had an important, largely positive, role in the homes. For a number there was important involvement in the continuing care of the person. Another key role was in monitoring the standard of care received by their own relative, and acting as advocate for him or her. A few instances were reported of residents being at risk of relatives who disempowered or even abused the resident.

Developing a Training Package

Based on the emerging findings from the study, an evidence-based training package was developed and a preliminary evaluation undertaken. Dissatisfaction with both the content and delivery of much existing training was identified by all parties and topics that were thought to be inadequately covered by current training included dignity, respectful communication, responding appropriately to the needs of people with dementia, and end of life care issues. It was clear that any new package to be developed must demonstrably contribute to excellent care, whilst being low cost and being capable of being delivered 'in house' in a variety of ways. The package needed to reflect the day to day realities of life and work in the care home, whilst at the same time comply with and promote the new CQC Essential Standards and Skills for Care Common Induction Standards. Accordingly a vignette based set of materials was developed, engaging staff in considering situations relevant to the identified target topics, where there were not necessarily clear cut answers or solutions. The vignettes were all based on situations that had been observed during the ethnographic research. This approach promotes reflective practice, in contrast to a 'tick box' , checklist approach to learning. By using the vignettes in the context of a group discussion, the opportunity for developing team working, group cohesion and a shared, person-centred culture arises, with the opportunity for learning from each other's experience in a peer group context.

In addition to the vignettes, the package includes material and exercises on attitudes to ageing and a broad conception of dignity. The package has been piloted in seven care homes, and evaluative feedback on the content and the delivery mode has been obtained. This has largely been positive, with some staff wanting more time to work on the package than the three hours or so that was feasible for the pilot in most homes. Most of the material is currently presented as text, requiring reasonable literacy levels; a next stage of development would be to present the vignettes in a pre-recorded DVD format. The materials are capable of development to form the focus for regular group reflective practice supervision sessions in a home, rather than as a one-off training session.

Issues for Consideration

From the evidence in this study we recommend the following issues for consideration:

1 Given the general high turnover of staff in the care home sector and the varying costs associated with training provision, we would advocate that mandatory training should include specific themes beyond those that are task focused and which promote a more holistic approach to understanding residents' needs. In particular the following aspects should be included: Respectful communication; dignity and dignified care; dealing with challenging behaviour; understanding risk management.

2 All care workers working with older people should be trained in caring for people with dementia. This is supported by the findings from a survey of what is important for the quality of life for people with dementia (Alzheimer's Society, 2010). This training should include an understanding of the significance of the Mental Capacity Act for day-to-day care practice.

3 Ideally care workers should complete a recognised pre-entry training before entering the workforce, however the researchers recognise that this would involve a considerable cost. Consideration should therefore be given to ensuring that care workers complete the induction training before working with residents.

4 Valuing staff, building their sense of self-efficacy, self-worth and personal accomplishment would have potentially a great impact on quality of life for residents. Staff often do good work, but this is less likely to be acknowledged than the lapses in care. Consideration should be given to developing a recognised career structure and pay structure for care workers which would help to promote a sense of accomplishment and increased self esteem and ultimately reduce burnout.

5 Measures to increase standardisation in terms of required staffing levels, fee structures and training, would make a positive impact on providers, service users and their families, as well contributing to improved quality of care.

6 Training to enable managers to support workers, promote team working, promote quality outcomes together with an environment that enables residents to feel at home should be considered. Leadership and modelling of appropriate attitudes and behaviour are key to improving care quality.

7 Greater attention should be given to developing positive relationships between relatives and care homes, so that residents may benefit from the involvement of their relative(s). This might take the form of a structured programme as well as more informal contacts and communication.

8 The PEACH training materials could be further developed, with consideration given to issues of accreditation, attitudes, skills and training needed by group facilitators, and reducing the reliance on text in delivery. This would benefit from a thorough evaluation of effectiveness. In addition, exploring how PEACH could link in with My Home Life would be extremely beneficial and avoid any unnecessary duplication of efforts.

9 Greater emphasis in training for care staff needs to be placed on non-managerial supervision and reflective practice, rather than 'tick box' approaches to the acquisition of skills and knowledge. There are aspects of the work that are difficult, and may have an emotional cost, especially when it seems that nobody - residents, relatives, colleagues or the wider community - appears to value the work undertaken. Staff should have the opportunity to reflect on, and discuss with colleagues, the impact on them of their work.

10 Attention needs to be given to ensuring that a broad perspective on dignity is brought to the fore in the care home sector. This needs to go beyond important issues of privacy and dignity during personal care, to consider also the maintenance of personal identity and preferences and the avoidance of 'elderspeak'. Further research on the impact of 'elderspeak' in the UK context would be helpful.

CHAPTER 1

STUDY BACKGROUND

Introduction

Before describing the Promoting Excellence in All Care Homes study, it is important to examine some of the broader debates regarding the social care sector and care homes in particular, including the recent history as well as the context and background against which this work was commissioned and carried out. To do so, the following sections will briefly investigate the contemporary social care sector under the following headings:

- The Fabric of Social Care and the Ageing Population.
- The Social Care Workforce in Depth.
- Abuse, Neglect and Lack of Dignity in Care Homes.
- The Social Care Policy Landscape.

The Fabric of Social Care and the Ageing Population

Examining the rise of the ageing population, life expectancy has grown from 45 for males and 49 for females in 1901, to 77 for males and 82 for females in 2008 (Wise, 2010). In terms of future projections, the number of people aged 60 or over is anticipated to rise by over 50 per cent in the next 25 years, with the number of people aged over 85 set to double in the next 20 years and treble in the next 30 (Office for National Statistics (ONS), 2009). With such notable rises in this social group, debates around the ageing population have come to focus on how well-equipped the health and social care sectors are to cope with an inevitable increase in demand.

This growth in population should not necessarily be taken on face value given that there are considerable variations between individuals. For instance, 50 per cent of 90 year olds live in their own homes (Oliver, 2010). That said, it is widely recognised that an older population brings with it an increasing set of often chronic or long-term age-related conditions. Such conditions tend to result in functional, sensory or cognitive impairment, increased disability, dependence, increased frailty, as well as an increased need for specialist equipment and a reliance on informal or institutional care of some nature (ibid). For example, the increase in the population aged 80 or over leads to a projected increase of 38 per cent in the number of people with dementia by 2021 (Alzheimer's Society, 2007). With this in mind, it is necessary to explore the characteristics of older people in the care home sector.

Older People in Care Homes

The reasons for older people entering care homes are varied. The Office of Fair Trading (OFT) (2005) reported multiple explanations for admission in which physical health problems were the most common (69 per cent), followed by mental health problems including dementia (43 per cent) and functional disablement (42 per cent), while carer stress and lack of motivation were given as reasons in 38 per cent and 22 per cent of cases respectively. Other residual reasons such as loneliness, rehabilitation, family breakdown, homelessness and fear of being a victim of crime also contributed to less significant degrees. It is clear, then, that the reasons for admission are diverse with physical, mental, emotional factors and a combination of all of these contributing to the decision to move into a care home. Within each of these categories, there are also considerable variations based on the particular illness or impairment being experienced. For instance, physical health issues can relate to arthritis, as they did in 32 per cent of cases in a 2001 study, or cardio-vascular disease or stroke in 20 per cent of cases, with each instance offering different challenges in terms of the required care needs (Bebbington et al., 2001). A further challenge which will inevitably increase with the needs of the ageing population is that of end-of-life and dementia care. As Froggatt (2004) has pointed out, only four per cent of the population die in hospices compared to around 21 per cent who die in care homes suggesting that staff in the care home sector, who may be less well equipped to manage end of life care relative to hospice staff, need to be prepared to deal with such scenarios. Likewise, an awareness of how to support residents with cognitive impairment would seem appropriate given that it affects at least two thirds of the care home population with a third of those suffering from severe impairment (Bebbington et al., 2001).

Looking at the profile of residents in care homes, the My Home Life (MHL) review (2007) states that the percentages of people residing in a care home or long-stay hospital are 0.9 per cent for ages 65-74, 4.3 per cent for 75-84 year olds and 20.7 per cent for those aged 85 years old and over. Of these, women are more likely to be older than men with an average age of 85.6 years old compared to 83.2 years old (OFT, 2005). Using similar data, Bebbington et al (2001) built a set of characteristics based on the most common responses to their care home survey in which the typical long-term resident was:

- Aged in their 80s.
- Female.
- Unmarried.
- Living alone or, where living with others, living in their home.
- Living in a house rented from the local authority or housing association.
- Receiving income support and housing benefit.
- Receiving attendance allowance.
- Living in poorer neighbourhoods.
- Multiply disabled.
- Experiencing a limiting longstanding illness.

(Bebbington et al., 2001; 2)

Bebbington et al's survey also helped to outline significant differences between nursing and residential homes in terms of the dependency of the residents with much higher levels being found within nursing homes. In total, however, around 75 per cent of all care home residents were classified as being severely disabled (OFT, 2005). Even those who were not suffering from severe disablement were still likely to require assistance to carry out some tasks with getting dressed, using the toilet, bed to chair transfers, washing and feeding all being commonly cited (ibid).

Care Homes and Care Workers

The Care of Elderly People UK Market Survey (Laing and Buisson, 2010) stated that as of April 2010 there were 474,400 older and physically disabled person care home beds within the UK. Ninety per cent of these were in the independent sector with the remaining 10 per cent within the public sector (ibid). The size of the homes providing care could vary dramatically from those providing less than 10 beds which represented approximately 40 per cent of Care Quality Commission (CQC) registered homes, to those offering 75 or more beds equating to approximately one per cent of CQC registered homes (Skills for Care, 2010). Hussein (2009a) broadens this analysis to examine the volume of staffing in the different types of care home. Her figures show that the majority of care homes (53 per cent) are 'small' organisations employing 11-49 staff, around a quarter (23 per cent) are 'micro' organisations with less than 11 staff, 13 per cent were classed as medium sized organisations with 50 to 199 employees, while less than one per cent employed more than 200 staff.

Hussein (2009a) also helpfully provides an indicative figure of staff turnover within the social care sector suggesting that it is, on average, 15 per cent, although this includes data from the slightly more stable children's services.

The number of full-time equivalents working is difficult to quantify precisely, given the large volume of part-time workers, varied and incomplete data sets, as well as high staff turnover and the outsourcing of labour (Skills for Care, 2010). Nevertheless, Skills for Care's (SfC) 'The State of the Adult Social Care Workforce in England, 2010' provides an indication of the levels of staffing in the residential sector; the number of jobs being estimated at 596,000 with the actual numbers working estimated at 563,000 (ibid). This shortfall is corroborated by Hussein (2009a) who states that vacancies in social care are, on average, double those found in public, industrial and commercial employment. These figures hint at a number of broader issues: firstly, given the increasing demands associated with the ageing population there are well-founded concerns as to whether the sector is prepared for a growth in the numbers entering care homes; secondly, it suggests that care work is not widely perceived as a 'glamorous' career choice, a point which will be further explored in the following section.

Within the workforce there is a notable diversity in demographics. Hussein (2009b) carried out an interrogation of the National Minimum Data Set for Social Care (NMDS-SC) in order to confirm the widely held view that women constituted the large majority of the social care workforce with 84.3 per cent compared to only 15.7 per cent men. Age offered a broader range of data with NMDS-SC data ranging from 16 to 65, with the median age for the whole sector being 42 years old (Hussein, 2009b). The NMDS-SC also offered data on the ethnicity of social care staff, albeit with missing data for around a quarter of all employers. The majority (82 per cent) of those in the data set were white, eight per cent were black or black British, five per cent were Asian or Asian British, two per cent were of mixed ethnicity and three per cent of other ethnicities (ibid). While these figures are not indicative of the levels of migrant labour, there is an acknowledgement among many critics that such workers are of particular importance to the care sector (Hussein et al., 2010; Hussein, 2011). The ONS (2006) stated that non-UK born individuals comprise around 16 per cent of all paid care workers in England. Hussein (2011) broadly corroborates this figure with the NMDS-SC data suggesting 15 per cent of all returns being from non-UK workers. Of these, the vast majority are from non-EEA countries with more than 25 per cent coming from the Philippines or India, with Poland, Zimbabwe, Nigeria and South Africa also offering significant numbers (ibid). It should also be

noted that the 15 or 16 per cent quoted for migrant workers masks a substantial level of geographical variation. As Rawles (2008) points out, within London approximately 68 per cent of care workers are believed to be non-UK born, while there are far fewer migrant care workers found in the north of England (Cangiano et al., 2009). For those areas in which the migrant workforce is at its largest, the recent changes to immigration rules (UK Border Agency, 2010) will offer considerable challenges for the recruitment of staff to the sector.

The Social Care Workforce

There are many factors that influence the quality of life of older people living in care homes, and the extent to which they experience dignity and maintain self-respect. These include the physical environment, which may pose threats to dignity through a lack of private space, for example. Health conditions and the older person's functional ability may increase dependency on others for help with basic day-to-day living, again running the risk of dignity being lost. External relationships – with family, friends and other members of the resident's social networks will also have an influence.

In this study, the focus is on, arguably, the key players in the care system – the staff who provide care on a daily basis. It is in their interactions with residents and in their behaviour towards the resident that dignity and respect are most evidently upheld or lost. We ask the question: what are the influences leading to staff providing care in a manner that strips the person of dignity, or that shows a lack of respect for the resident's human value and worth?

It is tempting to simply attribute lapses in the promotion of dignity enhancing care to either the number of staff available or the qualities of the front-line staff. The staff may be seen as over-stretched, forced to cut corners, to deliver care without proper regard for dignity, simply to fulfil the basic care tasks required. Alternatively, they may be seen as having insufficient or inadequate training, resulting in deficiencies in skills or knowledge; or their attitudes may be seen as negative, or failing to have embraced a person-centred approach; or there may be concerns that some staff are 'burnt out', experiencing stress to an extent that results in emotional exhaustion and a tendency to depersonalise those in their care. The stressful nature of the work undertaken by care workers, with residents who may be challenging and difficult, is often noted in this respect.

However, as Innes (2002) points out, it must be remembered that care workers are under-valued, lack status in society, are poorly paid, are often offered little training and experience poor conditions of work. A more systemic view is clearly required. In a theoretical context, a care home can be viewed as a complex system, or rather a set of overlapping and interlocking systems. Moos and Schaefer (1987) describe the influences on an individual member of staff as arising from two major systems:

1. Environmental system:

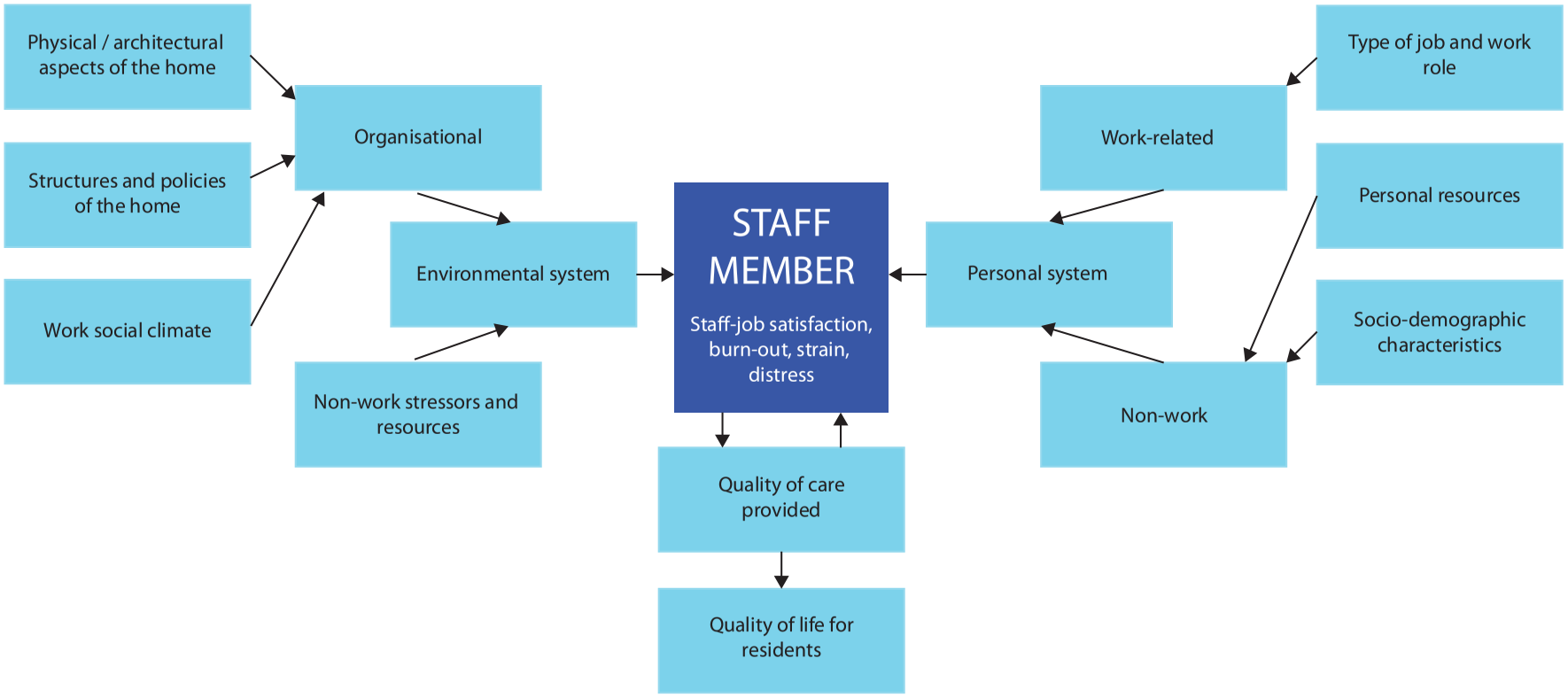
    (a) organisational
    physical/architectural aspects of the home
    structure and policies of the home
    work - social climate
    (b) non-work stressors and resources such as child care, relationships and financial security

2. Personal system:

    (a) work-related
    type of job and work role
    (b) non-work
    personal resources - self-esteem, values, intellectual abilities
    socio-demographic characteristics

The way in which the staff member experiences these two systems and their interaction influences the staff member's coping responses and accordingly, the quality of their work and job satisfaction. This in turn is seen as affecting the quality of care and quality of life for the resident. See figure 1 below:

Figure 1: The Influences on Care Staff



Moos and Schaefer emphasise the importance of the work social climate, the "atmosphere" of the workplace, in relation to staff morale. This is evident, for example, when a member of staff reports that the residents are no problem, for all the complexity and diversity of their care needs, but that it's the other staff (and managers) who make life difficult (e.g. Edberg et al., 2008).

The work social climate will be influenced by the nature of the staff group and their characteristics, values, and commitment to the work and the residents. The extent to which staff support each other and foster a warm, friendly work climate will depend on the individual characteristics of staff, such as temperament and communication skills, but also important are the organisational structure and policies and the clarity with which these are communicated. The style of management and leadership is a key factor; the extent to which staff are enabled to have autonomy and make their own decisions, and feel supported, as opposed to being controlled and pressured is one dimension; clarity of roles and expectations is another. Cole et al. (2000) report that the psychological well-being of staff is related to the level of staff support in the home.

The contribution of residents to the social climate within a home should also be acknowledged. Mozley et al. (2004) from their study of 30 care homes in England conclude that good quality care homes are those low in conflict (where staff report that residents do not express anger or criticise each other or the home) and high in cohesion (the extent to which staff see themselves as helpful to residents and residents are helpful to each other). Moniz-Cook et al. (2000) similarly found that staff who report being able to relate to residents as individuals, and being able to offer help and support to them, find difficult behaviour less challenging.

The model emphasises that non-work stressors and resources are influential. The work performance of a member of staff who is under stress outside work may well be affected, but in turn stress at work may also impact on the staff member's personal life and relationships. For staff, the care home is not insulated from the rest of life.

Staff members' perceptions of the expectations placed upon them are likely to influence areas of stress and difficulty. For example, staff in three different care facilities were asked to rate a number of potential stressors (Benjamin and Spector, 1990). In a unit where the philosophy encouraged the expression of psychological and emotional needs, staff rated items

relating to communication difficulties with residents, or residents being unresponsive, as particularly stressful, compared with staff in units where physical care was given emphasis.

The individual staff member's values and personal characteristics will interact with organisational factors. Different people may benefit from different management styles; not all will welcome more autonomy, some will prefer a more hierarchical structure. Job satisfaction and morale must be seen as an interaction between an individual's needs from the work setting and what the environment offers, not a fixed feature of the workplace. Wright (1988) argues that negative attitudes among staff in nursing homes are determined by the socio-cultural environment of the nursing home; it is not that staff simply bring with them negative attitudes towards older people, rather that the culture and ethos of the home, characteristics of the staff group as a whole and the nature of the residents' difficulties interact dynamically to shape the repertoire of available skills, coping strategies and management techniques of staff members which "translate attitudes into actions". Baillon et al. (1996) indicate that organisational factors may be as stressful for staff as caring for residents, and the need for a careful consideration of the whole system is reinforced by Moniz-Cook et al. (1997) who suggest each home may need an individualised staff development programme.

The type of work, the interaction with residents, and the problems to be dealt with have an influence on the environmental and personal systems, but again are mediated by the individual staff member's perception. For example, the staff member's perception of a resident's challenging behaviour, say, verbal abuse, will affect its impact on their morale; it will make a big difference, for example, if it is seen as directed at them personally, rather than as arising from their condition. This is illustrated by the findings of Brodaty et al. (2003), who reported that nursing home staff often thought that difficult behaviour was deliberate, rather than an aspect of dementia or illness.

Burnout, Distress and Strain

There has been particular concern that staff burnout might lead to poor-quality care. Burnout involves physical and emotional exhaustion, demoralisation, negative job attitudes and loss of concern for clients; it may affect the staff member outside the work setting as well as within it. It is sometimes thought of as arising from intense involvement over a long period of time, perhaps with difficult clients, where improvements are limited or non-existent, and where there is little support from colleagues and superiors. The overall conclusion from a recent systematic review (Pitfield et al., 2011) was that there was no clear evidence that care home staff were reporting higher levels of distress than the general population, but from a resident's perspective, if say 10 per cent of staff are seriously distressed and / or burnt out, this may have a significant impact on the experience of care received on a day-to-day basis.

Mozley et al. (2004) report data from 440 staff members drawn from 30 care homes in England. Using a brief version of the General Health Questionnaire (the GHQ-12), only 15.7 per cent of the sample scored in the range associated with significant psychological distress, a proportion similar to the general population level on this measure. However, the response rate in this survey was relatively low (37 per cent). Significant distress on the GHQ was associated with having experienced a major life event during the previous six months and being aged less than 30. Higher GHQ scores were correlated (at a modest level) with a number of features of the work climate: more role conflict, less clarity about roles, less support from leaders, more work demands, less control and autonomy in the job etc. Less than a tenth reported having received any training in care of people with dementia, or depression or in terminal care.

Earlier studies, with higher response rates, have reported slightly higher levels of distress e.g. Macpherson, Eastley, Richards and Mian (1994) administered the GHQ to 188 staff working in a varied sample of 16 institutional care settings for older people. Just over a quarter of the predominantly female sample were over the threshold for significant distress. Similar levels of distress using the GHQ with residential care staff have been reported by staff of two out of three homes evaluated by Baillon, Scothern, Neville and Boyle (1996). In the third home, which had been under threat of closure, 63 per cent scored above the relevant GHQ cut-off point. However, when compared with population norms, the authors concluded that, on average, the staff in these three homes were

no more subject to emotional upset than the general population. It must be borne in mind that even with a 67 per cent response rate, as in the Macpherson study, it may be the more stressed individuals who choose not to respond, or are already on long-term sick leave.

Macpherson et al. (1994) found that GHQ scores were positively related to staff reports of assaults by residents over the previous week, and distressed staff were more likely to report shouting back at aggressive residents and to feel less supported at work. The association of higher levels of distress with both higher reported levels of assaults by residents and greater likelihood of shouting back could reflect the likely vicious-circle interaction of the staff member's mood and behaviour with their perceptions of the resident's behaviour. However, other studies have reported no association between staff stress and levels of behavioural disturbance (Cole et al., 2000; Brodaty et al., 2003); it may be that the severe challenge posed by an assault is particularly stressful.

Moniz-Cook, Millington and Silver (1997) also report different levels of distress among staff in different homes, and indicate that moderate levels of burnout may be reported even where GHQ scores are low. It can be argued that one way of protecting against distress arising from burnout is to distance oneself from the care recipients, not to become involved in their lives or to empathise with them. Someone adopting such a distancing coping strategy might appear to have some aspects of burnout (such as negative job attitudes or low involvement with residents), but without any emotional distress. For example, Brodaty et al. (2003) found that staff with more negative attitudes had lower stress levels, as well as lower job satisfaction. On the other hand, someone initially with high empathy and an ability to identify with the residents' experience, might develop burnout, which would reduce their ability to empathise, but which would be accompanied by emotional and somatic upset. Astrom, Nilsson, Norberg and Winblad (1990) reported that just over a quarter of a sample of 557 nursing staff working in dementia care in Sweden were assessed as being at risk of burnout. Qualified nursing staff had lower levels of burnout than nurses' aides. A weak negative correlation was identified between burnout and empathy. Higher empathy scores were related to more positive attitudes (Astrom et al., 1991).

Perceived workload does emerge as a major source of stress in a number of studies (e.g. Chappell and Novak, 1992; Astrom et al., 1990). Benjamin and Spector (1990) similarly reported that "there have been insufficient staff on duty" was the item most frequently rated as stressful in their study of three different care environments. The lack of resource, and the difficulty in balancing competing needs, also emerged in an international study examining strain in staff working with people with dementia, using focus group methodology (Edberg et al., 2008). The experience of the 35 nurses participating could be understood as 'a desire to do the best for the people in their care by trying to alleviate their suffering and enhance their quality of life'. Strain arose from not having the resources, opportunity or ability to fulfil this desire. As well as the difficulty of balancing the competing needs of different residents, staff also found it difficult when they could not 'reach' the person with dementia i.e. when it was difficult to make person to person contact, because of the extent of the cognitive and/or communication deficit; they also found it difficult when they wanted to protect the person with dementia – often from indignity – and failed to do so. As well as these sources of strain arising directly from caring for residents with dementia, these staff also emphasised the complexity of their situation and referred to environmental factors such as 'the system', community attitudes, other staff, residents' family members and also their own family as contributing to strain.

Job Satisfaction

In a large-scale study of nurses' job satisfaction and quality of care received by people cared for in hospital psycho-geriatric wards, Robertson et al. (1995) identified a strong relationship between nurses' job satisfaction and the quality of care provision (as evaluated through direct observation). However, they concluded that this association was best understood as arising from ward and hospital management practices, contributing to both quality of care and staff morale, with the latter two variables then reinforcing each other through a mutual feedback system. Thus high quality of care may lead to high job satisfaction, which may lead to higher quality of care and so higher job satisfaction, and so on.

Staff Attitudes

The importance of staff attitudes in relation to residents' quality of life is highlighted in a UK care home study, using the Approaches to Dementia Questionnaire (ADQ) (Lintern et al., 2000) to evaluate staff attitudes; this scale has two sub-scales, reflecting recognition of personhood and hopefulness regarding dementia respectively. Where staff had lower average scores on the hopefulness scale of the ADQ, residents rated their quality of life as lower (Spector and Orrell, 2006). This supports the findings of a larger study reported by Zimmerman, Sloane et al. (2005), involving 421 residents in 45 residential care/assisted living facilities and nursing homes in the USA, which also utilised the ADQ. The authors concluded that 'from the resident's perspective, quality of life was higher for those in facilities… whose care providers felt more hope' (pp. 144). As well as being related to two resident self-report quality of life measures, 'hope' was also related to observations of well-being (using Dementia Care Mapping methodology). The total ADQ score and recognition of personhood attitudes were also related to staff reports of the quality of life of the person with dementia. Todd and Watts (2005) also found that optimism regarding the potential for the person with dementia to change was related to a greater willingness to help the person and lower burnout.

Zimmerman, Williams et al. (2005) reported that attitudes recognising personhood were related to job satisfaction, in particular enjoyment of contact with residents. Staff who perceived themselves to be better trained in dementia care reported more person-centred attitudes and more job satisfaction. The role of self-efficacy in care staff, the person's belief that they are capable of making a difference in their work is also beginning to be evaluated (Mackenzie and Peragine, 2003).

The Staff-Family Relationship

One gap in the Moos and Schaefer model that should be highlighted is the role of relatives in the care home (Woods et al., 2007). The relationship between care home staff and relatives can be problematic. Relatives may be seen by staff as constantly critical, or interfering, or as having abandoned the resident. In fact, relatives may be experiencing considerable stress (Zarit and Whitlatch, 1993; Gaugler, 2005a) and guilt feelings may be strong (Woods and Macmillan, 1994; Woods, 1997). There is some evidence that relatives' distress is related to negative perceptions of staff functioning and to negative interactions with staff. There have been numerous attempts

made to establish a more collaborative, partnership relationship between staff and relatives (see Gaugler, 2005b; Woods et al., 2007).

From Gaugler's (2005a) review, it is clear that, in general, families do remain involved, and far from abandoning the person with dementia, they visit, and continue to visit, although this is made less easy by the changes brought about by conditions such as dementia. Family members take on a variety of roles. They provide companionship, they are especially concerned to preserve the identity of the person with dementia and they advocate for the person. Some relatives wish to provide hands-on, direct care, and this may lead to tension with staff regarding whose responsibility a particular task is. Some care homes see meeting the needs of family members as a key part of their role and these are most likely to achieve a collaborative partnership with families.

There is some evidence that family involvement may also be linked to important outcomes especially for the person with dementia. In a large study in the USA of 400 residents with dementia, Dobbs et al. (2005) found that people with dementia were more likely to be engaged in activity when the family are involved in engaging socially with the resident and when the home involves the family in the assessment of the person's preferences. From the same study, Zimmerman et al. (2005) report that family involvement is significantly associated with some aspects of quality of life for the person with dementia.

Abuse, Neglect and Lack of Dignity

While media coverage, public perceptions and academic debate on abuse, neglect and lack of dignity suggest its broad prevalence within institutional care settings (Hussein et al., 2007), until recently very little research had been carried out in the field. One area which has offered more debate than others is in relation to the barriers to appropriate care, some of which have emerged from the 2005 Dignity and Older Europeans study in which the views of older people, professionals and the public were examined in relation to dignified care (Woolhead et al., 2004; Bayer et al., 2005; Arino-Blasco et al., 2005). Calnan and Tadd (2005) suggested the barriers to appropriate care included the following:

- Values and motivations of the practitioner.
- Organisational factors such as task-orientation.
- Available resources.
- Little provision of education or guidance.

While the Dignity and Older Europeans study offered indicators of the reasons care standards could be compromised, the absence of statistical evidence in relation to care homes has continued to provoke issues. A House of Commons Health Select Committee report (2004) highlighted particular concern for the social care sector given that residents in care homes were more likely to spend most of their lives away from the public eye. It was suggested that residing in a care home could potentially expose older people to organisational, cultural and attitudinal dangers within the setting itself. This was coupled with a broader lack of statistical data on the abuse and neglect of older people across the United Kingdom evidenced in the fact that statistics were largely derived from unrepresentative sources such as telephone help-lines manned by the charity Action on Elder Abuse (House of Commons Health Committee, 2004) or on a survey dating back to 1992 (Ogg and Bennett, 1992). On this basis, research was commissioned by the Department of Health (DH), to explore the prevalence of abuse and neglect in the guise of the 'UK Study of Abuse and Neglect of Older People Prevalence Survey Report' (DH, 2007). This considered the levels of abuse and neglect experienced by people aged 66 or over living in private households. More than 2,100 respondents took part in the survey across England, Scotland, Wales and Northern Ireland with a prevalence rate of 2.6 per cent being returned (DH, 2007). This roughly equates to 227,000 older people being abused in one of the following ways:

- Neglect – 1.1%
- Financial – 0.7%
- Psychological – 0.4%
- Physical – 0.4%
- Sexual – 0.2%

In addition, around six per cent of those who reported some form of mis-treatment reported it across more than one of the above categories (ibid). In a follow-up project, a secondary analysis of the data was carried out which suggested that the prevalence rate would have been higher had the criteria been altered to include single incidents of mistreatment and to also incorporate neighbours and acquaintances as perpetrators (Biggs et al., 2007). With this shift the prevalence rate increased from 2.6 per cent to

8.6 per cent (ibid). While this research has greatly contributed to awareness of abuse and neglect within the community, the absence of older people in residential care homes from the sample meant that this specific area of institutional care largely remained free from analysis both through government funded research and more broadly. Indeed, in a systematic review of research into the prevalence of abuse and neglect, Cooper et al (2008) identified only five care home studies carried out up to October 2006, none of which were based within the United Kingdom.

A major issue in implementing a large-scale prevalence study within the care home setting has been that of definitions. Following on from the UK Prevalence Study of 2007 was a qualitative project consisting of 36 in-depth interviews with survey respondents (Mowlam et al., 2007). The aims of this study were to examine risk factors associated with abuse and neglect, the impact of mistreatment on older people, their families and carers, as well as the coping mechanisms developed to deal with this and to explore issues regarding the definition of abuse and neglect (ibid). In regard to the latter, the report stressed the difficulty associated with conceptually defining terms such as 'abuse' and 'neglect' given that incidents could be interpreted in different ways by different people (ibid; Dixon et al., 2009a). The recommendation was for further definitional scrutiny to be applied to these terms prior to the funding of future surveys, a point which was synonymous with previous commentaries on the issue (e.g. Brammer and Biggs, 1998). The result of these recommendations was the 'Abuse, Neglect and Loss of Dignity in the Institutional Care of Older People' report which specifically examined the potential for developing firm definitions for each of the concepts (Dixon et al., 2009b). While the report offered guidance on the application of descriptive definitions for the purposes of implementing surveys within the care home sector, there was also broad acknowledgement that with regard to universal definitions there will always be the potential for them to remain contested concepts (ibid).

Regardless of these definitional issues, a wide range of documentation and guidance has been produced by the government in relation to abuse and neglect. For instance, the 'National Service Framework for Older People' (DH, 2001) suggested standards relating to care and services for older people, with priority areas being seen as age discrimination, person-centred care, and the mental health of older people. This was followed by the Protection of Vulnerable Adults scheme (now known as the Safeguarding of Vulnerable Adults from Abuse scheme) which has produced a series of practical guides for the health and social care sector (e.g. DH, 2000b; 2009)

and has since been complemented by sections on protection of older people in documents such as 'A Vision for Adult Social Care: Capable communities and active citizens' (DH, 2010) as well as the more recent Care Quality Commission's 'Essential standards of quality and safety' (CQC, 2010). Additionally, legislation has been approved in regard to regulation in the Care Standards Act of 2000, the Safeguarding Vulnerable Groups Act of 2006 and the Health and Social Care Act 2008 (DH, 2000a; 2008; Office of Public Sector Information (OPSI), 2006), though, this will be examined in more depth in the next section.

Policy Landscape

To fully engage with recent policy shifts in the social care sector, it is important to have a brief contextual knowledge of developments over the last 50 years. As the report of the Social Care Review by Sir Derek Wanless 'Securing Good Care for Older People: A long-term view' (Kings Fund, 2006) states, much of the modern-day policy landscape has been influenced by the 1948 National Assistance Act and the ongoing expansion of the welfare state through the 1960s and 1970s. That said the report points to the 1980s, and particularly the 1988 Griffiths Review report, as having a more direct effect on contemporary policy issues (Kings Fund, 2006). The Griffiths Report, entitled 'Community Care: Agenda for action' acknowledged issues of funding but also noted the patchy provision of services within a 'complex network of relationships and responsibilities at the local level' where authorities, voluntary groups and government departments would each involve themselves (Griffiths, 1988). With an emphasis on resource efficiency, Griffiths made a pivotal recommendation stating that the entry of those on supplementary benefit (or income support in contemporary terms) into care homes with their fees paid by social security should be reduced (ibid). As Wanless (King's Fund, 2006) establishes, the unabated growth in provision of social security means that between 1978 and 1988 there was a rise in expenditure from £10 million to around £900 million. This was attributed to Local Authorities (LAs) and health services moving increasing numbers of patients into voluntary or private sector care homes so as to shift financial responsibility onto the social security budget (Glennester and Korman, 1989; Henwood et al., 1991).

This shift in funding emphasis within the 1980s ran in parallel to attempted improvements in regulation and standards. The Registered Homes Act (Department of Health, 1984) suggested more regulatory rights for health and

Local Authorities in both the private and voluntary sectors. Nazarko (2000), however, argues that this was left open to interpretation resulting in broad discrepancies in its application from one local authority to the next. These geographical differences would not be formally addressed until 2000/01 with the Care Standards Act in England and Wales, the Regulation of Care (Scotland) Act, and the Health and Personal Services Act for Northern Ireland which will be discussed in more depth later (MHL, 2007).

Through the 1990s, both the Griffiths Report recommendations and the Registered Homes Act meant that LAs came to have greater involvement in deciding the goals of the sector, as well as brokering and regulating care without having to automatically provide it (Kings Fund, 2006). This was most clearly laid out in the 1989 White Paper 'Caring for People' which suggested the following objectives for social and community care in the 1990s and beyond:

- To promote the development of domiciliary, day and respite service to enable people to live in their own homes wherever feasible and sensible.
- To ensure that service providers make practical support for carers a high priority.
- To make proper assessment of need and good case management the cornerstone of high quality care.
- To promote the development of a flourishing independent sector alongside good quality public services.
- To clarify the responsibilities of agencies and so make it easier to hold them to account for their performance.
- To secure better value for taxpayers' money by introducing a new funding structure to social care.

(DH, 1989; para 1.11)

The White Paper was formally ratified through the NHS and Community Care Act in 1990. The Act itself, though only coming into force in 1993 following several setbacks, also emphasised the importance of partnership working between health care, i.e. the NHS, and social care – a point which is referenced within this study on a number occasions, and which has been emphasised in the history of adult social care policy-making. However, as many commentators have pointed out, the act also implicitly pushed for a greater market-focus in the sector through encouraging competition and contractual, economic relationships often at the expense of alliance towards

a common goal (Wistow and Hardy, 1996; Wistow et al., 1996; Hudson and Henwood, 2002). Such authors regard this disjuncture as a pivotal reason for the failure of the reforms to take hold and, in the current context of political reform and the emergence of the Health and Social Care Bill in 2011, offer continued resonance.

In 1997, the government established a Royal Commission to examine and offer recommendations on the funding strategies associated with care. The result of this was the 'third way for social care' which spurned the previous push for privatisation, as well as the alternative approach which was believed to offer only one system across a multitude of diverse needs (DH, 1998). Instead, the focus was stated as being on the 'quality of services experienced by, and outcomes achieved for, individuals and their carers and families' (ibid, para 1.7). While this re-iterated the significance of social care in modern society, the legislation was broadly similar to the policies outlined from the 1980s onwards. As the Wanless report (King's Fund, 2006) states, however, the emphasis within the third way was significantly different in that it viewed the idea of supporting those in greatest need, inherent in prior strategies, as limiting the breadth of people at whom services were targeted. Instead, the White Paper outlining the changes, 'Modernising Social Services: Promoting independence, improving protection, raising standards', suggested that a key aim should be prevention and rehabilitation so that independence, and the individual's ability to remain at home, should be maintained for as long as possible (DH, 1998).

Again, the collaboration between health services and social care services was also emphasised in this White Paper and in the subsequent Health Act (DH, 1999) with increased partnership working encouraged through the removal of legal restrictions. These included the sharing of health and social services budgets and the merging of services to provide a single integrated care pathway (DH, 1999). While this approach to partnership working appeared superficially to offer new means of integration, it also brought problems. The major issue raised by the Wanless report (Kings Fund, 2006) was the distinct charging strategies associated with the 'free' health services and social care services with their variable costs. Beyond this, even within the social care sector there were vast discrepancies in the charges being levied with non-residential, local authority managed care being the most prone to difference. It should be noted, however, that this has been addressed to an extent by the 2011 Pembrokeshire ruling in which Local Authorities have been requested to demonstrate more clarity when

determining the fees paid to providers for supported residents (Pitt, 2011).

Another perceived issue with partnership working through the late 90s and early 2000s, however, was the number of partners who became involved. The NHS Plan (DH, 2000b) stated the requirement that NHS and LAs become more intertwined through local strategic partnerships and neighbourhood renewal strategies. Additionally, as Wanless (King's Fund, 2006) mentions, there were, and continue to be, multiple government departments involved in the development of policy with the Department for Work and Pensions, (DWP) the Office of the Deputy Prime Minister (OPDM) and the DH, all offering input into a partnership-driven model, with lines of demarcation often being less than clear.

As mentioned previously, regulation was also dependent on multiple LAs and health authorities working uniformly if a balanced provision of quality care was to be achieved nationwide. This was, however, addressed to an extent with the Care Standards Act 2000 (DH, 2000a) which set clearer guidelines through the development of the National Minimum Standards (NMS) and then, as of 2004, instigated a single regulatory body with the Commission for Social Care Inspection (CSCI). While this ran in contradiction to the broader view of a joined-up approach described in the numerous green and white papers developed, with the Healthcare Commission (CHAI) still taking responsibility for regulating health services, it did apply more clear rules within the care sector. This was extended also to the social care workforce with the establishment of the General Social Care Council (GSCC) in October 2001 which aimed to set uniform guidance on levels of education and training, as well as the development of the sector more generally (King's Fund, 2006).

Further policy change soon followed with the arrival of a Green Paper, 'Independence, Well-being and Choice: Our vision for the future of social care for adults in England' (DH, 2005), which emphasised the importance of more individualised service provision and reiterated the broad reach of social services into everyone's lives. Recognition of the ageing society and its knock-on effect to the number of places required in care homes, led to the suggestion of additional key outcomes which social care services were expected to fulfil including:

- Improved health.
- Improved quality of life.
- Making a positive contribution.
- Exercise of choice and control.
- Freedom from discrimination or harassment.
- Economic well-being.
- Personal dignity.

(DH, 2005; p. 26)

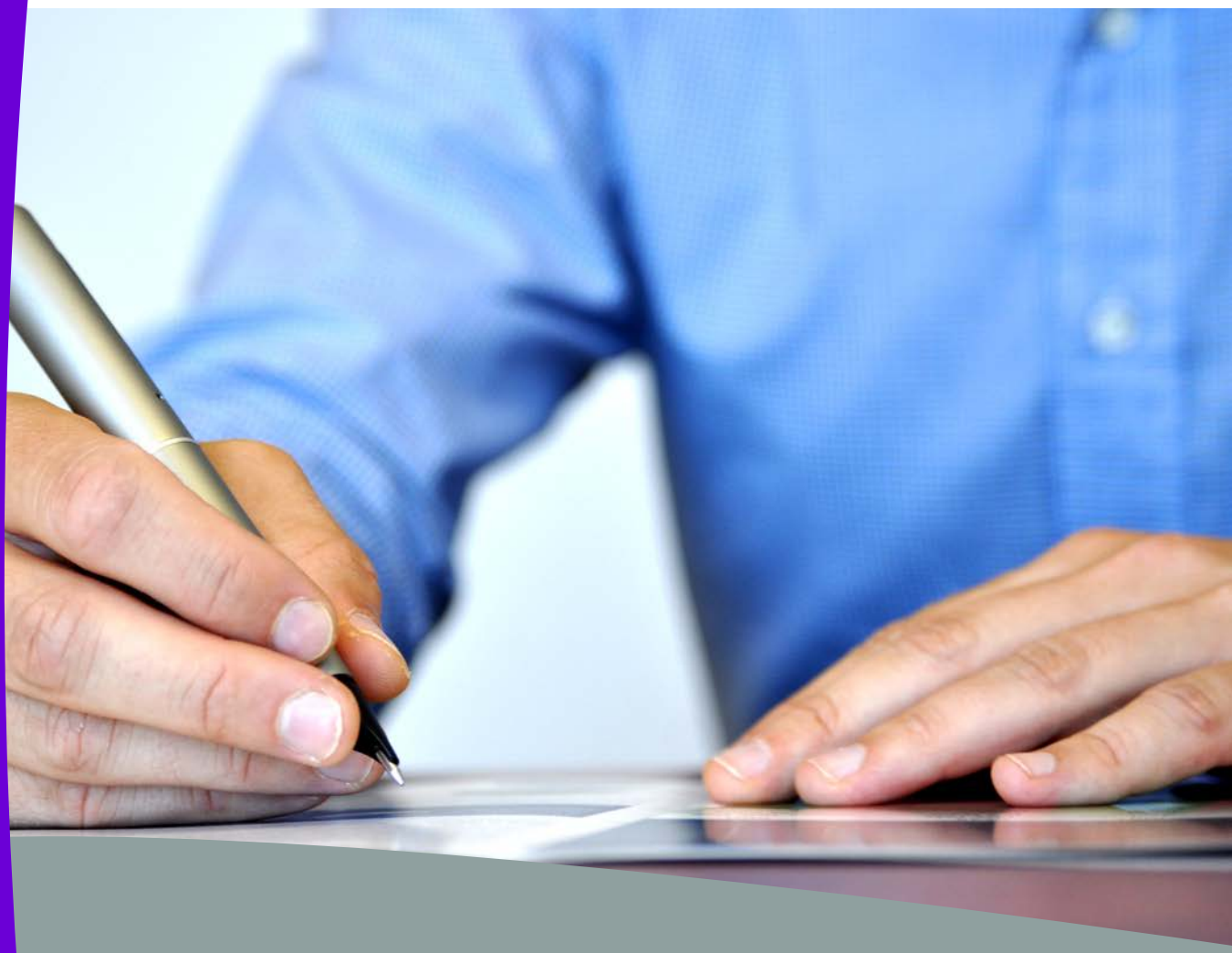
Underlying this were similar principles to those established in the legacy of policy documents within the sector, those of increased independence, prevention and rehabilitation, and improved partnership working. The latter of these was again stressed by the subsequent White Paper entitled 'Our Health, Our Care, Our Say: A new direction for community services' (DH, 2006) which offered an unprecedented level of integration between health and social care services, with the paper addressing both sectors. Within this the four goals were laid out as: better prevention services with earlier intervention; more choice and a louder voice for patients and service users; tackle inequalities and improved access to community services; together with more support for people with long-term needs (ibid). The paper's emphasis on integration spread to an alignment of planning and budgetary exercises, as well as greater consistency within performance assessment and regulation.

This latter point was further developed with the Health and Social Care Act 2008 which saw the amalgamation of the regulatory bodies across the mental health sector, health services and social care services (DH, 2008). The Mental Health Commission, (MHC) along with the CHAI and the CSCI were amalgamated to become the CQC as of 2009. This was soon followed by the issuing of the 'Guidance About Compliance: Essential standards of quality and safety' in March 2010 which laid out a fabric of what was required for both health and social care providers to comply with section 20 regulations of the Health and Social Care Act 2008 (CQC, 2010). Bringing both health and social care under a single regulatory umbrella offered a means of ensuring consistency across both sectors but this too comes with challenges given that conjoining fragmented sectors requires more than pure regulation. The strategies evoked to address such challenges have varied from paper to paper but more recently this has tended to look towards funding restrictions for health and social care, with an emphasis again being placed on prolonging an individual's independence

and ability to stay in their own home. This has been suggested across the history of social care policy but recurred again under the guise of resource efficiency in 'A Vision for Adult Social Care: Capable communities and active citizens' (DH, 2010) where long-term residential care was de-prioritised so that the funding could be targeted at alternative areas.

A prominent feature of the contemporary policy landscape, with the Health and Social Care Bill of 2011 looming at the time of writing, is that the basic premise of health and social care provision has progressed very little since the reforms of the 1980s. Largely the debate has focussed around prevention, rehabilitation, partnership and prolonged independence of individuals. Yet while, there is consistency in these messages across all of the policies that have emerged, subtle deviations in how they are funded, the bodies regulating them, and the emphasis of their shifts, have meant that the social care sector has also been characterised by incessant change (a point further described in Chapter 4). The difficulties of adult social care have remained largely the same over the past 20 years and the fact that policies still orientate around them, demonstrates how difficult they have been, and continue to be, to resolve.

CHAPTER 2



METHODOLOGY

Introduction

This chapter describes the study, its aims and objectives, methods, study sites, participants, data collection methods and analysis together with some of the challenges faced by the researchers. It is important to emphasise that in doing so pseudonyms have been used throughout to ensure anonymity and protect confidentiality. This practice will be followed throughout the remainder of the report so that no individuals or care homes can be identified.

Study Aim

This study explores the needs, knowledge and practices of the care home workforce in relation to abuse, neglect and loss of dignity. It also provides a preliminary evaluation of an evidence-based training package.

Study Objectives

The objectives were to:

- Identify positive and negative factors in relation to abuse, neglect and the provision of dignified care.
- Explore the views and experiences of the care home sector workforce in relation to best practice, training, job satisfaction and wellbeing.
- Determine organisational, personal, and practice contexts in which abuse, neglect and lack of respect may occur between staff and residents.
- Develop and evaluate an evidence informed training package.
- Make recommendations for policy development, training and regulation in care homes.

Involvement of Stakeholders in the Research Process

It has been argued (Entwistle et al., 1998, 2008) that users should be involved throughout the research process because they make research more relevant to users' needs. As such, stakeholders including older people, relatives/carers, representatives of the organisations of the care home sector, representatives from advocacy organisations such as Age UK, the Stroke Association, Relatives & Residents Association, Alzheimer's Society and Crossroads, the regulatory body CQC, SCIE, and policy makers/

advisers, have been variously involved as members of the project advisory group, participants and/or involved in a series of workshops discussed at the end of this chapter.

The research proposal was developed in consultation with older people and carers of older people with dementia and other conditions often leading to admission to institutional care. This has been achieved through individual contacts and by holding meetings of carer members of local groups (Crossroads, Parkinson's disease and dementia). These meetings were invaluable in discussing approaches to data collection, recruitment strategies and for piloting interview schedules.

An older person and two former carers of older people with direct experience of their relative residing in a care home participated as members of the advisory group to ensure due account was taken of user concerns. In particular their advice was sought on information sheets, interview guides, interpretation and analysis of data and dissemination activities. In addition representatives from the Relatives & Residents Association were invited to attend a series of focus groups which greatly influenced development of the training package and ensured user views and experiences were fully taken into account.

Three stakeholder workshops were held in Birmingham, Bristol, and London towards the end of the project. Each of these brought together a range of care home owners and managers, care staff, voluntary organisations including Alzheimer's Society, Age UK and others interested in or advocating for older people, as well as policy makers (95 in total) to discuss the tentative findings emerging from the study and determine how these resonated with their experience. Participants' views on the training package were sought and how this might best be advanced, together with their views of policy and organisational changes they believed necessary to effect change and ensure the workforce were best prepared to meet the needs of residents in ways which promoted dignity and avoided neglect and abuse.

Each workshop consisted of an outline of the study background, methodology, emergent themes, and the training package. The presentations were interspersed with discussion sessions where participants were invited to discuss the following:

- Any surprises in the findings?
- Any burning issues that have been missed?
- What key messages should be taken forward
  - to policy makers?
  - to care home inspectorate?
  - to care home managers?
  - to care home staff?
  - to residents and relatives?
- Comments on the format of the training package
  - Feasibility
  - Barriers to its use
  - What would facilitate its use?
  - Who might act as facilitator?
  - Is group discussion enough to produce changes in attitudes?
  - Additional ways of embedding in practice?
- Comments on the content of the training package
  - Should there be correct answers for each vignette?
  - Are there other areas that should be considered in the future?

A report of the workshops is included at Appendix 1.

Study Design

Choice of Methods

The choice of study design was the subject of considerable debate, including with the funding body before submission of the final research proposal and during the early development of the research protocol.

To achieve the study objectives a multi-method design was adopted. This involved desk research to identify available training in relation to abuse, neglect and the provision of dignified care; a postal survey of care home managers and staff; standardised questionnaires with care home staff; focus groups with care home owners/managers and members of the Relatives and Residents Association; ethnographic observation in eight care homes in England, and in−depth interviews with care home staff to identify the key factors impacting on care quality, abuse, neglect and loss of dignity in care homes. From these findings, an evidence−based training package was developed, piloted and evaluated.

A postal survey of 250 care workers was planned and was extended to include care home managers as an additional means of identifying current training provision and materials, models of training delivery and any unmet training needs from a spectrum of care homes. This was carried out early in the project, alongside the desk research, to ensure the research team were as aware as possible of the current situation regarding care home training. It complemented the desk research, which surveyed the field more from the perspective of those providing training. The postal survey was an attempt to gain the perspective of the recipients and consumers of training. The survey was further augmented with in-depth focus groups with care home owners/managers/training managers (eight) and representatives of the Relatives & Residents Association (two). These sought to identify the educational needs of the workforce from a range of perspectives; determine the core components of the training package and how it might best be delivered; comment on the first two iterations of the training package; and explore the promotion of excellence in care delivery.

The choice of focus groups as a method of data collection was carefully considered and selected as an appropriate research vehicle. Kitzinger (1995) has argued that 'focus groups reach the parts that other methods cannot reach'. Morgan (1988) and Kitzinger (1994) further point out that whilst surveys might be useful for eliciting what people think, focus group work is necessary to discover the reasoning behind why people actually think as they do. Johnson (1996) speaks of the advantages in terms of gaining access to tacit, uncodified and experiential knowledge, actor's meanings and knowledge from individuals as part of a collective. Morgan (1993) further argues that focus groups provide a particularly effective means of comparing the experiences of different population sub-groups. Plaut et al (1993) highlight the point that social research has not done well at reaching people who are routinely isolated from mainstream life, and that focus groups are good at researching such individuals – partly because the 'representativeness' of samples is not an issue (Prior et al, 1998), this is especially important in exploring the views and experiences of relatives. Focus groups are also efficient by being able to collect data from larger numbers than individual interviews would allow. In all, they can generate a rich understanding of participants' experiences and beliefs especially where there are complex contextual factors, such as the expression of values.

An ethnographic approach was chosen as the most appropriate methodology to identify the key factors impacting on care quality, abuse, neglect and loss of dignity in the eight care homes across England. Ethnography is usually associated with a combination of qualitative methods (Bryman, 2008) primarily observation, interviews and documentary analysis and this study adopted two of these methods of data collection. Interviews were used to explore the views of care home staff (N=33) about dignified care and the factors which influence it, whilst observational methods were employed to appraise behaviour and practices and investigate the discrepancies between what people say they do and what they actually do (Calnan and Tadd, 2005). Van Maanen (1979) describes it as useful to "uncover and explicate the ways in which people in particular work settings come to understand, account for, take action and otherwise manage their day-to-day situation" (p. 540). When applied in the study of the workplace, such an approach takes account of the complexity of activities, communications, social and organisational relationships that facilitate or obstruct care delivery.

In order to evaluate the factors identified in Chapter 1, such as attitudes to ageing and dementia, job satisfaction and burnout, a range of validated, standardised questionnaires were used. These were completed by 73 care staff within the same eight care homes as took part in the in-depth observations.

Finally, the training package was developed and piloted in seven of the participating care homes.

Organisation of Data Collection

Prior to any recruitment or data collection, ethical approval for the study was gained from the South East Wales REC where the procedural issues such as seeking informed consent, avoiding harm, confidentiality, and anonymity were addressed. The data collection was undertaken by two research teams from the universities of Cardiff and Bangor and will be described in three phases:

Phase 1

- Desk research: to identify existing training materials.
- Postal survey of care home managers & care workers.

These strategies were adopted to a) familiarise researchers with available training b) to identify what training resources were currently being used within the care homes and c) to inform the development of the focus study topic guides.

Desk Research

In September 2009 a search of the government website (www.direct.gov.uk)) entering a variety of key words and the suffix 'courses' was initially undertaken. These facilities have now moved to the Skills for Care website. Following this a wider internet search for care sector training materials was undertaken. The results are described below.

Keyword: 'care' (courses)
This produced 16,444 care courses from 2,313 providers. A search under health care sector for 'short courses' resulted in 940 courses being identified with 77 of these being added into the spreadsheet.

Keyword: 'dignity' (courses)
Thirty-three dignity courses from eight providers were identified. Most were to do with 'dignity at work' and included bullying and harassment. Three courses were about dignified care and these were included in the spreadsheet.

Keyword: 'abuse' (courses)
Two-hundred-and-fifty-five courses dealing with abuse and or safe-guarding issues were identified from 60 providers. The majority concerned children and covered sexual abuse, domestic abuse or substance abuse. Thirty-two courses relevant to adult safe-guarding were included in the spreadsheet

Keyword: 'neglect' (courses)
Only one course was identified which was to do with the neglect of children.

In total 139 courses (including those concerning care of older people, palliative care, induction to care) were identified and included in a spread sheet (see Appendix 2).

In addition both the Skills for Care (www.skillsforcare.org.uk) and Social Care Institute for Excellence (SCIE) (www.scie.org.uk) were searched for training resources. The results can be found at Appendix 3.

Since completing this desk research there have been changes in relation to training standards and the qualifications framework is currently undergoing considerable change. These changes will be discussed in Chapter 7 in the discussion of the training package.

It can be seen from the results of these searches that there is a plethora of available training courses for care home staff. Some of these courses are necessary for reaching national standards and others extended beyond that. The providers vary from private organisations to recognised charities, such as the Alzheimer's Society. The costs vary widely, as does the content of the courses. Some of the qualifications are nationally recognised (NVQs), whilst others are certificated relating to the specific course. Such variability in available training potentially creates difficulties for care home managers and training organisers in identifying and selecting the most appropriate training to meet the needs of the care home and/or those of the residents being cared for. This will be discussed further in Chapter 7, which discusses training within the care home sector.

Postal Survey of Care Home Managers and Care Workers

A postal survey to ascertain the care home workforce training experiences and needs was undertaken in September 2009. Initially this was planned to target 250 care workers in England, selected from homes not included in the main study. This was then extended to include care home managers. All data from the completed questionnaires were entered into Excel spreadsheets. The questionnaires are reproduced in Appendix 4 where the descriptive analyses are also presented.

Respondents were identified through the membership of four care home organisations, English Community Care Association (ECCA), National Care Forum (NCF), Registered Nursing Home Association (RNHA) and the National Care Association (NCA), through colleges providing NVQ courses, and through random sampling of the CQC database of the 18000 or so registered care homes. One thousand questionnaires were distributed to care home owners/managers and 1,000 questionnaires were sent out to a second random sample of 200 care homes with a request to distribute these to care workers. All potential respondents received an information sheet about the study, a copy of the questionnaire and a prepaid envelope for its return. Unfortunately an extended postal strike was called immediately after the questionnaires were mailed and this impacted significantly on the number returned. To maximise the response rate, members of the research team telephoned care homes requesting non-respondents to return the questionnaires. This resulted in few additional questionnaires being returned and a considerable number of care home managers claimed to have returned the completed questionnaires. Other typical responses to the request resulted in comments such as:

'I'm sorry I don't have time to complete it'.
'The company doesn't respond to questionnaires'.

Characteristics of Respondents

The postal survey was returned by only 37 managers, a 3.7% response rate. The majority (94 per cent) were female and, of these, 39 per cent had been in their current role for more than five years. The minimum qualification was an NVQ level 4. Most of the homes they managed were privately owned, whilst 36 per cent were part of a larger group. Half of the homes were at the time, registered for old age care only and half for people with dementia or what was termed 'Elderly Mentally Infirm' (EMI).

Of the 37 respondents who provided information on the number of residents, 10 cared for between 10 to 19 people, seven for 20 to 29 people, six for 30 to 39 people, four for 40 to 49 people, and one for 50 to 59 people. Twelve respondents stated that less than 20 per cent of their residents had dementia / Alzheimer's Disease, seven noted 20 to 39 per cent, two noted 40 to 59 per cent, two noted 60 to 79 per cent and six noted 80 to 100 per cent.

The survey of care workers was distributed to colleges who offered NVQ courses in social care and to a second sample of 200 care homes randomly drawn from the CQC database. Fifty-six respondents completed at least part of the survey (a 5.6% response rate) just over 25% of the intended sample size. The majority (82 per cent) were female, their first language was English (87 per cent) and they had been in their current role between five to 10 years. Most had work related qualifications; 30 (54 per cent) had an NVQ (2 – 5), 10 (18 per cent) had a nursing qualification, one had a social work diploma and four had a degree.

Despite the poor response rate some useful information was elicited which helped inform the discussions within the focus groups.

The results of the surveys are discussed in Appendix 4.

Phase 2

- Ethnography of eight care homes in England involving semi-structured interviews with staff and observation of practice.
- Validated questionnaires with care workers.

Ethnography of Eight English care homes

Selection of Study Sites

Eight care homes were sought to participate in the in-depth ethnographic study. Selection criteria aimed to reflect diversity in terms of registration; resident numbers; resident characteristics; urban and rural locations; diversity of local populations; provider types and star ratings by the CSCI.

Participants attending the initial round of focus groups with managers and owners were invited to participate in the study and information about the study was sent to individual homes through the care home organisations. In addition, Local Authority homes (of which there are very few) were contacted, as were charitable trusts and other not for profit organisations. No Local Authority homes agreed to participate, however, one home run by a charitable trust did participate. Other homes included one small and one medium independent provider and the remainder were small, medium and large chains (see table 1). Additional information about the care homes is included in Appendix 5.

Table 1: Care Homes Included in the Study

Home	1	2	3	4	5	6	7	8
Location	Devon Urban	Somerset Rural	Norfolk Semi Rural	Home Counties Urban	Lancashire Urban	Shropshire Semi Rural	Cheshire Urban	Cheshire Rural
Type	Small chain Care home with nursing	Large Charitable Trust Care home with nursing	Medium Care home with nursing chain	Large Care home with nursing chain	Small independ-ent Care home	Medium Care home	Large Care home with nursing chain	Medium Care home with nursing chain
CQC Rating	2 Star	2 Star	2 Star	3 Star	2 Star	3 Star	2 Star	2 Star
Beds	44 over two units	71 over 5 units (50 currently occupied)	106 over 4 units	71 over three units	35	45 over 4 units	67 over 4 units	45
Staff	36 (26 care staff)	150 (110 Care Staff)	91 (Care Staff 61)	83 (Care Staff 68)	35 (24 care staff)	58 (41 care staff)	Not disclosed	70 (50 care staff)
Care Staff per Shift (min)	10/7/4	25 /7.5 night	16/10 night	12/4.5 night	5/4/3	6-7/3 night	14 /8 night	9/8/5
Residents per Care Worker (rounded to nearest)	5/9/12	3/8 night	5/8 night	6/12 night	7/9/12	8/19 night	5/8 night	5/6/9 night
Proportion of Residents Requiring Feeding	25% to 33%	25%	75%	33%	25% to 33%	None	Approx 75%	Approx 50%
Proportion of Residents Unable to Walk Without Staff Assistance	33%	25%	66%	25%	30%	16%	Approx 65%	Approx 50%
Proportion of Residents with Dementia / Cognitive Impairment	25%	100%	75%	100%	50%	30%	100%	Approx 50%

The ethnic origin and language skills of the staff working in each care home are shown in Table 2 below:

Table 2: Ethnic Origin and First Language of Care Home Staff

Home	1	2	3	4	5	6	7	8
Ethnic origins of staff and English language as first of second language	Majority of staff are from Eastern Europe, the Philippines and India with English as a second language	Majority of staff English - significant minority from Eastern Europe (all with English as second language)	Majority of staff English but most nursing staff from India with English as a second language. Some care staff from Philippines and Eastern Europe with English as a second language	Majority of staff are from the Philippines with some Eastern European, Chinese and African staff; all with English as a second language	Most staff from UK, all first language English	Most staff from UK, all first language English	Majority from India with English as a second language	Majority English; a few from the Philippines and Eastern Europe, with English as a second language

A detailed observation guide was produced with the help of the advisory group and was discussed at length within the research team to ensure a consistent approach and shared understanding. For day to day use in the field a short observation brief was developed from the initial document to act as an aide memoir. This was piloted and found to be appropriate without any changes. The brief was intended to assist researchers to focus down onto key events, activities, interactions and resident/staff/resident relationships (see Appendix 6).

Consistency across the study was further promoted by the researchers undertaking simultaneous observation sessions in each other's sites and comparing field notes. This confirmed that there was a reliable approach to the interpretation of the observation brief and documentation of events. Observation of care practices and dynamics between residents and providers took place in each of the homes.

All residents and staff were notified in writing of the observations and informed of when researchers would be available to answer their questions. Particular aspects of the observation were discussed with residents and staff as a means of triangulation to check on the interpretation of events by researchers. There was an initial discussion with the home manager before

any observation commenced to decide on the practicalities of the observation sessions and, if requested, a verbal feedback was given at the end of the period of observation to discuss the overall impressions gained by the researcher and any specific issues, which they may wish to address.

Because a researcher's presence may affect interactions, the first set of observations in each home was discarded to take account of reactive effects, which are reduced with subsequent exposure, particularly if the researchers are as unobtrusive as possible (Mays and Pope 1995). The effect of the observer's presence erodes over time and so four hours were spent in each home before recording observations to promote observer habituation.

Observation sessions of between two to four hours were undertaken, throughout the 24 hours, on each day of the week. The exception to this was night duty when researchers usually remained for the duration of the shift. Approximately 60 hours of observation was undertaken in each home over a period of three to four weeks as the longer the observer is in the setting, the more in-depth knowledge of the setting, the interactions and practices can be gathered. Considerable time is necessary to gain the trust of care home staff.

The non-participant observations totalled 491 hours across the eight care homes (see table 3).

Table 3: Hours of Observation by Care Home

Home	1	2	3	4	5	6	7	8	TOTAL
Hours of Observation	60	62	66	63	60	60	60	60	**491**

Initial observation sessions were broadly focused enabling the researchers to get a feel for the home as a whole and allow any significant issues, both positive and negative, to emerge. Following this, researchers were able to 'funnel' their observations to ensure, for example, they were present at key times of activity or when particular staff were on duty.

The observations identified aspects of care home activity, care processes and organisation and interactions between residents and staff that may impact on the residents' experience of care. Thus, conversations, critical and discrete events, contexts and interactions and researcher's feelings

and changes in these formed part of the field notes. An important focus was evidence of 'elderspeak', as this may be a key marker of general lack of respect. The observations were confined to public areas of the home and no intimate personal care was directly observed. For example researchers did not enter closed rooms as this in itself could infringe a person's dignity. Whilst a non-participant approach was adopted, in practice the observers did sometimes get involved with tasks such as helping residents move or ensuring their safety if they were in danger of falling, as well as conversing with residents or informing staff that their help was needed.

An agreed format for fieldnotes was used and each record was systematically logged and referenced. Concise field notes were written at each observation period including records of activities, conversations (where possible), critical and discrete events, contexts and interactions. Notes were made of who is involved, what is happening, where actions or interactions take place, when including the timing, and a record of the researcher's feelings and changes in views (Silverman, 2000). Following Spradley (1990), condensed notes were expanded as soon as possible following the observation period and fieldwork journals were kept by the researchers. By linking organisational data and contextual observations factors conducive and challenging to dignified care/abuse/neglect can be identified.

Prior to embarking on the fieldwork, much discussion took place in relation to appropriate actions should researchers either observe or be made aware of harmful or neglectful practices. These discussions involved the scientific advisor of the programme, home managers/owners, advisory board members and the research team. In non-participant observation and other observational methods such as dementia care mapping, non-interference is the standard unless serious harm is likely (www.nursing-times.net). If this was not the case evidence of 'inappropriate' practice would be difficult to gather. The human challenge of observing 'questionable' care is difficult for all researchers, but posed a professional challenge for two members of the team in particular. As registered nurses there is a duty under the NMC's (2008) professional code to ensure that the standard of care is appropriate and that there is no breach in the duty of care, which might result in individual harm. A protocol was developed (see Appendix 7) to deal with such events. It was agreed that where incidents would not cause serious and/or immediate harm, then the researcher should avoid direct intervention, but the home manager should be informed immediately following the event. Within the study, direct intervention was not necessary.

In-depth Interviews with Care Home Staff

It was intended to hold in-depth interviews with up to a maximum of 96 staff (12 in each home). Purposive sampling was used to ensure a broad range of staff were included. Information sheets including a declaration of interest in being interviewed were made available to all staff at the outset of the study. Staff were asked to return the declarations of interest to researchers who then sought written informed consent and arranged a time and location convenient to the staff member. There was a considerable reluctance of staff to be interviewed and only 33 interviews were conducted. A number of reasons can be suggested for this reluctance, including language difficulties by staff in some homes (see table 2). Other reasons include anxiety about immigration status, job security and, despite reassurances, concerns about management having access to what was said.

Once a staff member agreed to be interviewed, the right to withdraw from the study was made clear. All informants received assurances that their confidentiality and anonymity would be protected and their comments would not be shared with managers. They were also informed that the home would not be identified in any reports or publications. Permission to record the interviews was sought and verbatim transcriptions were made when permission was given. A small number of interviewees (three) did not wish to be recorded and so interview notes were taken. Once transcribed, all audio recordings were erased. Transcripts were coded so that all identifying information was removed to ensure anonymity and protect confidentiality. Specific permission to use anonymised quotes in reports or publications was sought.

Inclusion Criteria

- Employment in one of the eight homes selected for the study.
- Willingness to give informed consent.

Thirty-three staff from a range of occupational groups participated in in-depth interviews. The numbers from each home and their occupational categories are shown in table 4.

Staff Characteristics

As shown in tables 4 and 5, staff from a range of occupations and age groups participated in the interviews. Approximately 82 per cent (N= 27) were female, 33 per cent of staff (N=11) had no qualifications for their post and 21 per cent of participants (N=7) had been in post less than one year.

Table 4: Interviewee Occupations

Home vs. Occupation	Home 1	Home 2	Home 3	Home 4	Home 5	Home 6	Home 7	Home 8	TOTAL
Managers	1	1	1						**3**
Deputy Manager				1					**1**
Lifestyle Leader				1					**1**
Activities coordinator				1					**1**
Trainer				1					**1**
Administrator		1	1					1	**3**
Senior Carer	1	1			2	2			**6**
Care Assistant	2	2	2	1	2	3	2		**14**
Catering Assistant		1							**1**
Hairdresser			1						**1**
TOTAL	**4**	**6**	**5**	**5**	**4**	**5**	**3***	**1**	**32***

* 1 missing data

Table 5: Interviewees' Age/Gender/Education/Qualifications/Time in Post

Age	N
16-20	**3**
21-30	**8**
31-40	**2**
41-50	**12**
51-60	**7**
60 or over	**0**
Missing data	**1**
Gender	
Males	**6**
Females	**27**
Education Level	
Degree	**5**
Tertiary Level	**2**
A or O Level	**15**
Secondary School	**9**
Missing data	**2**
Qualification for Post	
Nursing	**4**
NVQ Level 4	**0**
NVQ Level 3	**5**
NVQ Level 2	**10**
None	**11**
Deemed not applicable *	**2**
Missing data	**1**
Time in Post	
Less than 1 year	**7**
1-5 years	**22**
6-10 years	**2**
11-15 years	**1**
Missing data	**1**
TOTAL	**33**

*Denotes the number of participants who deemed that their role did not have a specific qualification.

The interviews explored:

- staff experiences of care delivery and work within the sector (motivators and inhibitors).
- standards of care.
- knowledge of institutional policies regarding abuse, disclosure and dignity.
- what constitutes abuse/neglect/indignity/dignified care.
- strategies for enhancing care and the experience of dignity.
- the institutional or resident factors acting as barriers to respectful care.
- training needs and opportunities.
- the availability of guidance.
- broader influences on the organisation's ability to provide appropriate care.

Validated Questionnaires with Care Workers

To augment the interviews with staff in the 8 homes studied intensively, a range of brief questionnaires were selected, to address attitudes, job satisfaction and strain as important indicators of the care worker's relationship with the care system, as detailed in Chapter 1. Collectively we have called this battery of questionnaires the 'Well-Being and Job Satisfaction' survey.

To explore these areas questionnaire packs were distributed to staff for self-completion within the eight participating homes, and we have termed these collectively, the 'Well-being and job satisfaction' survey. Where there were language difficulties, a member of the project team assisted by administering the questionnaire. The questionnaires used (see Appendix 8) consisted of the following measures:

Attitudes to ageing scale (Fraboni et al, 1990). This 29 item self-report scale assesses cognitive and affective components of ageism, stereotypes of and attitudes towards older people. Scores range from 29 to 145, with higher scores indicating higher levels of ageism.

Environmental Mastery Scale (Ryff and Keyes 1995). A seven item self-report scale examining a sense of control over the environment. The scale ranges from seven to 49, with higher scores indicating higher levels of mastery. Mastery may be an important mediating variable in coping with difficult situations.

The Approaches to Dementia Questionnaire (Lintern et al., 2002) is a 19-item self-report scale, with two sub-scales - person-centred attitudes and hopeful attitudes. The total scale ranges from 19 to 95, with higher scores indicating positive approaches to dementia care. Previous studies indicate that staff scores predict a number of important variables, including quality of life of residents (Zimmerman et al, 2005).

The Short-form of the Minnesota Satisfaction Questionnaire (Weiss et al, 1967) is a 20-item self-report scale, with sub-scales reflecting intrinsic and extrinsic satisfaction with the working environment. The total scale ranges from 20 to 100 with higher scores indicating greater satisfaction with work.

The Maslach Burnout Inventory (Maslach et al 1996). This 22 item self-report scale represents three subscales (emotional exhaustion, personal accomplishment and depersonalisation). According to the manual, scores should be considered on each subscale, and not as a total scale score. Emotional exhaustion is examined with nine items, scores ranging from 0 to 54 with higher scores indicating higher exhaustion. Personal accomplishment is examined with eight items ranging from 0 to 48 with higher scores indicating greater achievement and competence. Depersonalisation is examined with five items ranging from 0 to 30, with higher scores indicating higher levels of impersonal response and unfeeling.

For each measure, cases with greater than 30 per cent missing data are excluded from any analysis. Data was imputed for those with less than 30 per cent missing data. Descriptive statistics and correlations are presented in Chapter 3.

Staff Characteristics

The Well-Being and Job Satisfaction' survey was completed by 73 members of staff, 76% of our target figure of 96. Sixty-four respondents provided information about their professional qualifications (a number have more than one qualification – the highest is reported here). Nine have no qualifications, or qualifications unrelated to caring; four have in-house

training only; two have NVQ level l, 13 have NVQ level 2, 13 have NVQ level 3, three have NVQ level 4 and 20 have nursing qualifications.

Most of the respondents had been in post for less than five years, with about a third in post for less than 12 months. Only one person (a home manager) reported working for 30+ years in the care-home setting.

The occupational and biographical data is presented in tables 6 and 7 below.

Table 6: 'Well-Being and Job Satisfaction' Survey - Respondents' Occupation

Occupation	Home 1	Home 2	Home 3	Home 4	Home 5	Home 6	Home 7	Home 8	TOTAL
Manager	1		1						**2**
Care Services Manager						1			**1**
Nurse	1	3		2			1	3	**10**
Lifestyle Leader									
Activities coordinator				1					**1**
Trainer									
Administrator			1					1	**2**
Senior Carer	6			3	4	3	2		**18**
Care Assistant	4	1	4	4	4	7	4	5	**33**
Cook or Catering Assistant			1			2		1	**4**
Hairdresser									
Maintenance / House keeper			1						**1**
TOTAL	**12**	**4**	**8**	**10**	**8**	**13**	**7**	**11**	**73**

Table 7: 'Well-Being and Job Satisfaction' Survey - Respondents' Age / Gender / Education / Time Qualified

Age	N
16-20	6
21-30	15
31-40	13
41-50	22
51-60	12
60 or over	6
Missing data	1
Gender	
Male	14
Female	59
Education Level	
Degree	6
Tertiary Level	15
A or O Level	21
Secondary School	28
Missing data	3
Qualification for Post	
Nursing	20
NVQ Level 4	3
NVQ Level 3	13
NVQ Level 2	13
NVQ Level 1	2
In-house training only	4
None or deemed not applicable *	9
Missing data	9
Time in Post	
Less than 1 year	20
1-5 years	39
6-10 years	3
11-15 years	5
16-20 years	0
Over 20 years	1
Missing data	5
TOTAL	73

* Denotes the number of participants who deemed that their role did not have a specific qualification.

Phase 3

- Focus groups with care home owners/managers and residents and relatives.
- Piloting of training materials.

Focus Groups

Invitations were issued to the membership of the four major care home organisations, (ECCA, RNHA, N/CA and NCF), to a variety of individual care homes selected from the CQC database and directly to group providers in an effort to ensure wide participation by the care home sector. In addition, invitations were sent to the membership of the Relatives & Residents Association so that user perspectives were well represented.

Inclusion Criteria

- Owner/manager/training manager of a care home.
- Member of the Relatives and Residents Association.
- Able and willing to give informed consent.

Written information about the study aims, the funder and sponsor, together with what participation would entail, was sent to potential participants. Once potential participants registered an interest in a focus group they were contacted by researchers and arrangements were made for them to attend an appropriate focus group. A contact telephone number was given to all participants should any questions not addressed at the initial contact arise.

Written consent was obtained at the time of the focus groups to ensure full understanding. Participants were informed of their right to withdraw at any time, without giving reasons. All participants were given assurances that their confidentiality and anonymity would be protected. Permission to audio record the group discussions was sought and participants were given a clear understanding that immediately following transcription of the focus group no identifying information would be associated with their responses. Permission to use anonymised quotes in reports or publications was also sought.

A series of three focus groups were planned, inviting the same participants to each. At the first round of focus groups for owners and managers, discussion centred on the following topics:

- Perceptions of staff attitudes towards residents (care staff and other senior level staff).
- Best practice within your care home - in relation to communication, managing challenging behaviour, personal care, caring for people with dementia, caring for physically disabled people, managing abuse/neglect, providing dignified care.
- Ways of promoting excellent care.
- Factors leading to poor care delivery including abuse, neglect and lack of dignity.
- The impact of abuse, neglect and/or loss of dignity in institutional settings.
- The extent of abuse of staff by residents and/or their relatives.
- Links between the provision of excellent care and staff training.
- Challenges associated with the recruitment and retention of staff.
- Key components of training.
- Existing training needs within the workforce.
- Effective training approaches / techniques.
- Considering any current training provision – what do you find works well/doesn't work well?
- Whether training provision should be standardised.
- Receptiveness of staff to training provision.
- Barriers to the provision of appropriate training.
- How the outcomes of training are assessed.

At the first round of focus groups for residents and relatives, the following topics were the centre of discussion:

- Perceptions and experiences of staff attitudes towards residents and relatives (care staff and other senior level staff).
- Views on the recruitment and retention of staff.
- Views of best practice in relation to communication, managing challenging behaviour, personal care, caring for people with dementia, caring for physically disabled people, managing abuse/neglect, providing dignified care.
- Ways of promoting excellent care.
- Factors leading to poor care delivery including abuse, neglect and lack of dignity.
- What constitutes dignified care.
- Views on the impact of abuse, neglect and/or loss of dignity in care settings.
- Views about the extent of abuse, neglect and lack of dignified care in care settings.

- Links between the provision of excellent care and staff training.
- Views about what the key components of training should be.
- Views about existing training needs within the care home workforce.
- Should training provision be standardised?
- Views about the barriers to the provision of appropriate training.

Despite recruiting help from the major organisations within the sector participant numbers for this first round of focus groups were disappointingly low (managers and residents & relatives total 25). Despite agreeing to attend the groups, many last minute cancellations due to work pressures were received from owners and managers. Future studies need to acknowledge that to take out a day to travel to a venue is a great deal to ask and arrangements for cover are difficult to make.

The views of focus group participants, results of the Well-Being and Job Satisfaction' survey, together with data from the in-depth interviews with care home staff and the 491 hours of observational fieldwork were all drawn upon to develop a first draft of the training package (A).

A second round of focus groups were held in July 2010, three for owners and managers and one for representatives of the Relatives and Residents Association. Similar problems were experienced in recruiting owners and managers despite offering a greater choice of dates, venues and considerable time for forward planning.

At this round owners and managers discussion centred on the following topics:

- Does this training package (A) address your concerns about staff training needs?
- Does this training package (A) reflect policy and practice guidance?
- Do you think it will facilitate implementation of policy and practice guidance?
- In what ways?
- What impact if any will the training package have on staff attitudes towards residents?
- What impact if any will the training package have on care delivery including abuse, neglect and lack of dignity?
- Views about whether the staff will be receptive to the planned training.
- Is the training package (A) pitched at the appropriate level?
- At what stage of the staff member's career should it be undertaken?

- What are the potential benefits to a) the residents; b) the various staff groups; c) care home owners and managers?
- What is the relevance of the package to day to day care delivery?
- Comprehensiveness of the package – is anything missing?
- Who might best deliver the training? e.g. internally or by external provider.
- Where should it be delivered?
- How long should it take?
- When should it be delivered?
- Does the package overcome any of the barriers to training provision?
- Outcomes – are the benefits of the training package easy to assess?
- Costs –how much will people/organisations be willing to pay for the training?

At the second round of focus groups for residents and relatives which was again well attended, the following topics were the focus of discussion:

- Does this training package (A) address your concerns about staff training?
- Does this training package (A) reflect policy and practice guidance?
- Do you think it will facilitate implementation of policy and practice guidance?
- In what ways?
- What impact if any will the training package have on staff attitudes towards residents?
- What impact if any will the training package have on care delivery including abuse, neglect and lack of dignity?
- How receptive will staff be to the training?
- Can you see any benefits of the training to staff and residents?
- Is it relevant to day to day care delivery (to the residents and to meeting their needs)?
- Do you think anything is missing?
- Would you be willing to take part in the delivery of a programme like this?
- How do you think we might assess the benefits of the training package?

Piloting of Training Package

Following this round of focus groups the training package A was modified and package B was piloted with 77 care home staff in seven of the care homes involved in the study in eight three-and-a-half hour sessions. Although the research team offered longer sessions for the pilot the half-day slots were more acceptable to the participating care homes in terms of staff release. Participants then completed written evaluations of the package. One home declined to participate in this phase of the project, in view of other changes occurring in the home.

A third series of focus groups was planned to enable participants to review training package B and see the evaluations of those who undertook the training. However, poor response rates to invitations meant that it would be uneconomic to hold a third round. Instead it was decided to hold three rather than the two planned stakeholder workshops where half of the day was spent exploring the training package and its evaluation.

The focus group schedules and the evaluation forms can be found in appendices 9 and 10. Biographical details of focus group participants are shown below in tables 8 and 9.

Table 8: Biographical Details of Care Home Owners and Managers Participating in the Focus Groups

Age	N
25-34	4
35-44	7
45-54	6
55-64	8
65 or over	4
Gender	
Male	6
Female	23
Occupation	
Care Home Owner	6
Care Home Manager	10
Training Manager	5
Care and Support Manager	1
Trainee Care Home Manager	2
National Training Co-ordinator	1
Occupational Therapist	1
Trainer	3
Professional Qualification	
Registered Managers Award	6
Nursing Qualification	7
CIPD Qualification	2
NVQ Level 3	2
NVQ Level 4	4
MBA	1
Chartered Physiotherapist Qualification	1
Degree	4
Missing data	2
Length of Time in Post	
Less than 1 year	3
1-5 years	11
6-10 years	2
11-15 years	3
16-20 years	0
Over 20 years	8
Missing data	2
TOTAL	29

Table 9: Biographical Details of the Relatives & Residents Representatives Participating in the Focus Groups

Age	N
25-34	0
35-44	1
45-54	0
55-64	7
65 or over	5
Missing data	2
Gender	
Male	5
Female	10
Missing data	0
Length of Time Relative / Friend / Spouse in Care	
Less than 1 year	0
1 to 5 years	6
6 to 10 years	2
11 to 15 years	2
16 to 20 years	1
Over 20 years	0
Missing data	4
TOTAL	15

Data Analysis

Quantitative Data

Survey responses were subjected to descriptive statistical analysis and the responses to the validated questionnaires (Well-Being and Job Satisfaction' survey) were subjected to descriptive statistics and correlations. The results of these are presented in Chapter 3.

Qualitative Data

It was intended that a new software package based on Framework Analysis (FA) (Ritchie and Spencer, 1994) due to be released in autumn 2008 would be used in analysing the data. This was because FA is particularly appropriate where the aims/objectives are established in advance (for example by funding bodies) rather than emerging from a purely reflexive process and where specific information or recommendations are required. Although the general approach in FA is inductive, it also allows for inclusion

of a priori understandings as well as emergent concepts. However, there was a six month delay in release of the software and when obtained, it was found to be unsuitable to use across teams in a non-networked environment. There were also significant 'bugs' and a low level of technical support, which made use of the package impractical. Because of the size of the data set (33 interviews and 491 hours of observation field notes) this was too large to manage using FA in a 'manual' mode across sites. It was therefore decided that an inductive, thematic analysis using constant comparison would be adopted, with N-vivo 8 software to assist in data management and analysis.

How a large data set is organised can influence interpretation and analysis and considerable discussion took place as to the optimum arrangements. It was agreed that the typed field notes, memos and verbatim interview transcripts from the eight care homes should be pooled and analysed thematically aided by N-vivo 8. This was particularly important for the approach which was not to maintain the specificities of 'cases' but rather to identify overarching themes that, pieced together, would form a comprehensive picture of the collective experiences of the care home workforce.

The approach to the qualitative data analysis was fundamentally interpretative, focusing on the processes by which meanings are created and negotiated. The objectives were to identify cultural, contextual, personal and practical factors influencing the existence or inhibition of abuse, neglect and dignified care; and to explore the views and experiences of members of the care home sector workforce in relation to best practice, training, job satisfaction and wellbeing; and, importantly, how these interact and influence care practices. In response to this a thematic analysis was undertaken ensuring the themes emerged from the data rather than being imposed by the research team. As is consistent with this approach, data collection and analysis took place simultaneously so that relevant literatures, past knowledge and experience of the research team and the processes of interviewing and observation themselves, all informed the analysis and development of themes. A selection of transcripts were independently analysed by individual members of the research team and codes applied. This initial coding was discussed amongst the team, justified and refined and an initial coding framework of 22 codes was agreed and defined. This was then applied to all of the transcripts and additional codes added or removed. This is essential to ensure the consistency with which codes are applied by different researchers on different occasions and therefore helps to ensure the reliability of the data. Frequent analysis

meetings were held to discuss interpretations and refinements. From these codes, themes consisting of groups of codes were identified. The research team defined the themes as units derived from patterns of talk or actions such as conversation topics, recurring activities, or feelings. Thus, themes were identified by "bringing together components or fragments of ideas or experiences, which often are meaningless when viewed alone" (Leininger, 1985, p. 60). When patterns emerged as a result of these emergent themes, feedback from participants was obtained as well as drawing on the resources available to us through our advisory group, which included service users, representatives from a range of voluntary and statutory organisations and practitioners in order to validate original interpretations. This was also done during the interview process by asking participants to reflect on the meaning of their responses in order to check researcher interpretation.

To complement this approach, the comparative method was used to ensure that data from different sources was compared and contrasted until the team was satisfied that no new issues were arising as well as validating themes that arose across the various sites and individual participants. Comparative and thematic analysis are often used together to enable researchers to move backwards and forwards between transcripts, memos, observations notes and the research literature.

As well as being in keeping with an interpretative approach to the data, thematic analysis was used to sieve and pare the data to communicate the findings simply and effectively. Given the large amount of contextually laden, subjective, and richly detailed data generated from the interview transcripts and observation fieldnotes, this needed to be pared down to represent major themes or categories that best describe care provision and workforce experiences within the care home sector. Ultimately the analysis identified three overarching themes: 'The Organisation'; 'The Work' and 'The People' (see Figure 9), which are discussed in Chapters 4, 5 and 6.

Methodological and Ethical Considerations

Recruitment and Access to Study Sites

Recruitment difficulties associated with the survey of care home owners, managers and care staff have been discussed above. This section will focus on the difficulties encountered in gaining access to the care homes themselves and to staff participation within the homes.

Four homes were recruited as a direct result of the focus groups with care home owners and managers. Contacts from two chains were also identified and resulted in two further homes being recruited. Two Local Authority homes were contacted and advice sought with regard to identifying the appropriate personnel to approach for permission to undertake the study in those homes. After lengthy discussions in which information about the study was given, the local authorities denied access to the care homes in question. A home in the north east of England initially expressed interest in participating in the study and discussions and information exchange took place, however no further contact was forthcoming. Two homes with one star ratings were approached but expressed no interest in participating suggesting the study would be disruptive for residents. A further large chain was contacted resulting in the seventh home being recruited. The eighth home, owned by a small chain was contacted and after a great deal of negotiation, including an insistence on the researcher undergoing a second CRB check, access was granted. Except for one three-star home the seven others were two-star rated. Although disappointing that it was not possible to recruit a one-star or zero star rated home, this was not surprising, as even the two star homes commented on the negative media reporting with which they were constantly bombarded and how this impacted on staff and increased the anxiety of relatives.

In the majority of homes, after the study was explained and opportunities given to both read the information sheets and ask questions, researchers were greeted warmly and welcomed by the staff. In the final home, the researcher sensed an open hostility and wariness on the part of staff who thought a) the researcher was there to spy on them and b) the money spent on research should go to improving staffing in care homes, as demonstrated in the fieldnote below:

> I sense a real reluctance, almost hostility towards my presence here – I think it will be tough to be accepted here. I meet the team leader on the middle floor, a nurse in her late 50's, possibly 60's. She asks a lot of questions and seems very annoyed that I'm here observing them – feels it's a waste of money and the money should be spent on providing more staff. The manager tries to reassure her that perhaps my observation will give them some ammunition to help them try to get more staff and that I can feed back that need to the powers that be. She tries to explain that I'm on their side and not 'spying' on them. I'm not sure how much she is reassured. The manager tells me that some staff have already complained to her that they don't have time to be interviewed and she has told them that it's not compulsory – she thinks I might have a better chance interviewing the night staff as they are not so rushed.
>
> **(Fieldnotes, Care home 8, Evening)**

Only one staff member in this home agreed to be interviewed.

In a number of homes, staff were reluctant to be interviewed and in some homes even where staff were interviewed, they did not want interviews to be recorded as they were afraid that either 'management' would learn what they had said or that the interview would be used in some way to send them back to their country of origin. Many immigrant staff were very afraid about the possibility of losing their jobs and being sent home. It was hoped to interview up to twelve staff in each home providing a maximum of 96. This proved to be unrealistically optimistic as only 33 staff agreed to participate in individual interviews. Despite this, in all of the homes, there was a great deal of consistency within the staff interviews with the same themes emerging repeatedly.

With regard to observational methods, there is always concern that staff may try to put on a 'display' of their activities. This was found not to be the case with the extensive observation used here. In the majority of homes, care was so regimented and clock bound, that staff rarely varied from the routines and practices that apparently take place throughout the day every day.

The Credibility of the Findings

Ensuring the credibility of findings in any study is essential. In presenting the findings, a spread of data from participants, and the care homes has been used to demonstrate that the findings and therefore the issues identified for consideration are based on an analysis of all of the data, rather than on a few well chosen examples. In this way the validity of the conclusions drawn can be assured. This practice also adds to the transferability of the findings in that they form a broad picture of the collective experiences of working and living within a care home, which can logically be said to 'represent' similar settings within England (Popay and Williams, 1998). For similar reasons, dramatic accounts, especially of negative examples of care, have been avoided as where these occurred they were the exception rather than the rule.

Thus the spread of homes, the similarity in the findings from the ethnographic observation and the congruence of interview data, together with the strategies outlined below suggest that despite limitations experienced with regard to recruitment, the findings offer a realistic and logically representative account in at least what were rated as two-star care homes. Although these ratings will no longer be used, this rating did refer to homes that offered a 'good' standard of care and service.

In addition, the study methods have incorporated:

- data triangulation from a range of sources including source triangulation by in-depth study of eight diverse care homes over an extended period of time.
- structured and unstructured approaches to data gathering, allowing key features to evolve through ongoing analysis.

Each of these factors add to the credibility of the findings.

Ensuring Rigour through Reflexivity

Every researcher's approach to data collection, organisation and analysis impacts on the results of the research and on how it is presented. There is no objective truth and different authors adopt different positions, for example, Husserl (1970) asserts that it is important to identify, examine and bracket out or reduce one's presuppositions and pre-understandings, in order to enter the lived experience of the participants and appreciate their perspectives. In comparison, Heidegger (1962) argues that it is not possible

or even desirable to bracket personal beliefs and complete reduction is necessarily impossible. However, researchers should at least attempt to make their position explicit to better contextualise their understandings.

Regular analysis meetings offered the opportunity for team members to offer differing and sometimes, conflicting perspectives and interpretations of the data and helped to facilitate enhanced reflexivity by supportive challenging. They also helped to ensure that team members moved beyond their preconceived beliefs and prejudices to better represent the many voices and conflicting opinions uncovered in the study.

Ethical Considerations of the Study

Studies such as this one are relatively low-risk as the care or services that people receive are not altered, the researchers have no control over study variables and merely observe outcomes, also participants are not in a dependent relationship with the researchers. Indeed it can be claimed that such studies can enhance the quality of service provision by identifying and reporting positive models of care as well as any deficiencies in services and audits and related activities such as observational work are essential for the high-quality delivery of services (CHAI, 2007, Dixon-Woods 2003).

Respect for people, and for their rights, entail at least the following fundamental principles:

- Autonomy, which requires that people who are capable of deliberation about their personal goals should be treated with respect for their capacity for self-determination.
- The protection of people with impaired or diminished autonomy, which requires that people who are dependent or vulnerable be afforded security against harm.
- Justice requires that, within a population, there is a fair distribution of the benefits and burdens of participation in a study and, for any participant, a balance of burdens and benefits.

Accordingly, the researchers having considered the features of the study in the light of these ethical considerations, set out the following guiding principles:

- All participants will be willing to give informed consent based on full information and freedom to choose whether or not to participate without giving any reasons for their decisions.

- No identifying personal data will be stored with the study data so that anonymity and confidentiality will be maintained and no individual or location will be identifiable from the information. Adequate physical and electronic security of data will be ensured by using locked filing cabinets for the storage of signed consent forms for example and password protection on all computers used for transcription even though identifiers will have been removed.
- An honest and thoughtful inquiry and rigorous data analysis will be conducted by the researchers.
- The researchers will respect and make due allowance for diversity among participants and their communities.
- All researchers will be properly trained and culturally sensitive, and will carry formal identification.
- Great care will be taken not to interfere with staff–resident relationships or the smooth running of the services/areas being observed.
- All researchers will be trained in relation to Protection of Vulnerable Adult issues, and will be provided with a clear protocol to follow in the event that for concern becomes apparent during observation in the homes.
- Study results will be communicated and disseminated in a timely, understandable and responsible manner, so that benefit is maximised and is fairly distributed.
- Results of the study will not be published in a form that permits the identification of individual participants or of the study sites, and publication will give due regard to cultural and other sensitivities.

CHAPTER 3

QUESTIONNAIRE RESULTS

Well-Being and Job Satisfaction survey

Introduction

The aim of this aspect of the project was to examine attitudes towards caring, levels of stress and job satisfaction of care home staff, using validated measures.

Care workers constitute 80 to 95 per cent of the workforce in long-term care/residential facilities (Eustis et al 1993). They have ongoing contact with vulnerable adults, providing personal and intimate care with minimal supervision (Appelbaum and Phillips 1990) and are relied on to notice changing health and functional needs, handle challenging residents and their families (Harmuth 2002). Yet they often have low educational attainment and minimal training. Understanding the potential factors that can lead to abuse/neglect or lack of dignity in care homes is critical. From the individual perspective of the care worker, the attitudes, knowledge and understanding of residents' needs, personal motivation, the extent of staff stress and subsequent 'burnout' will determine the level of care that the person receives.

Burnout is linked to the emotional strains of working with people, and is described as a syndrome of emotional exhaustion, depersonalization and reduced personal accomplishment (Maslach, Jackson and Leiter, 1996). Emotional exhaustion refers to feelings of being psychologically overwhelmed by work and having depleted emotional resources. Depersonalisation is the negative and indifferent attitudes people develop towards those in their care, often as a mechanism to cope with emotional exhaustion. Reduced personal accomplishment refers to a decline in feelings of competence and personal achievement; workers are generally dissatisfied with themselves and feel that they are under-achieving. In contrast job satisfaction, facilitated by the intrinsic rewards of helping others, predicts retention among direct care workers (Denton et al. 2007). However, these rewards are often accompanied by the physical and emotional demands of care provision, and by inadequate extrinsic rewards (Benjamin and Matthias 2001).

Dissatisfaction with work is then a factor in burnout. Burnout has been found to lead to negative outcomes for health care workers. Those experiencing burnout report low mood, fatigue and a loss of motivation (Schaufeli and Enzman, 1998). Negative outcomes for the care worker can also impact on the organisation in terms of absenteeism, lower productivity and high attrition rates (Cordes and Dougherty, 1993). Thus, possessing psychological resources that underpin emotional strength, for

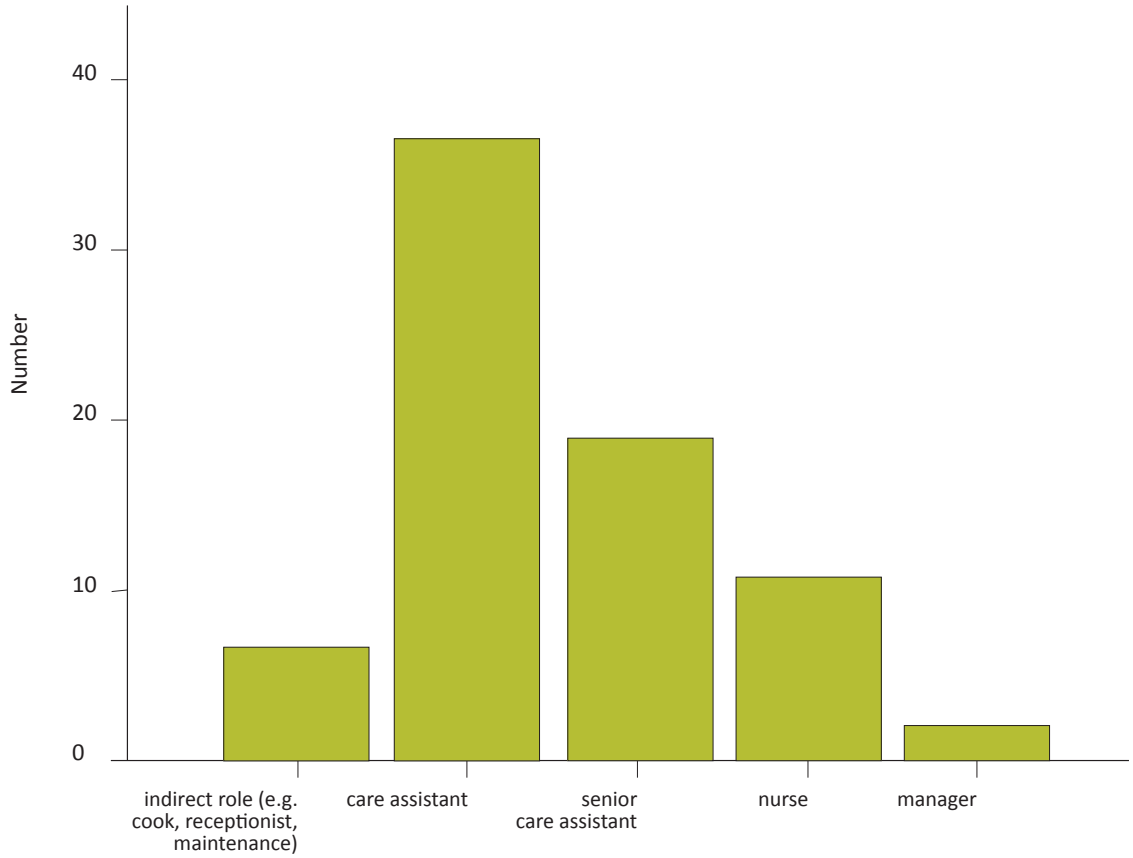
example a sense of mastery, are important for care workers' resistance to burnout and positive approach to work.

Given the above, it is hypothesised that higher scores on the measures of mastery, attitudes to ageing, approaches to dementia care and job satisfaction would be associated with lower levels of burnout.

Survey of Staff Attitudes, Stress and Job Satisfaction in Participating Care Homes

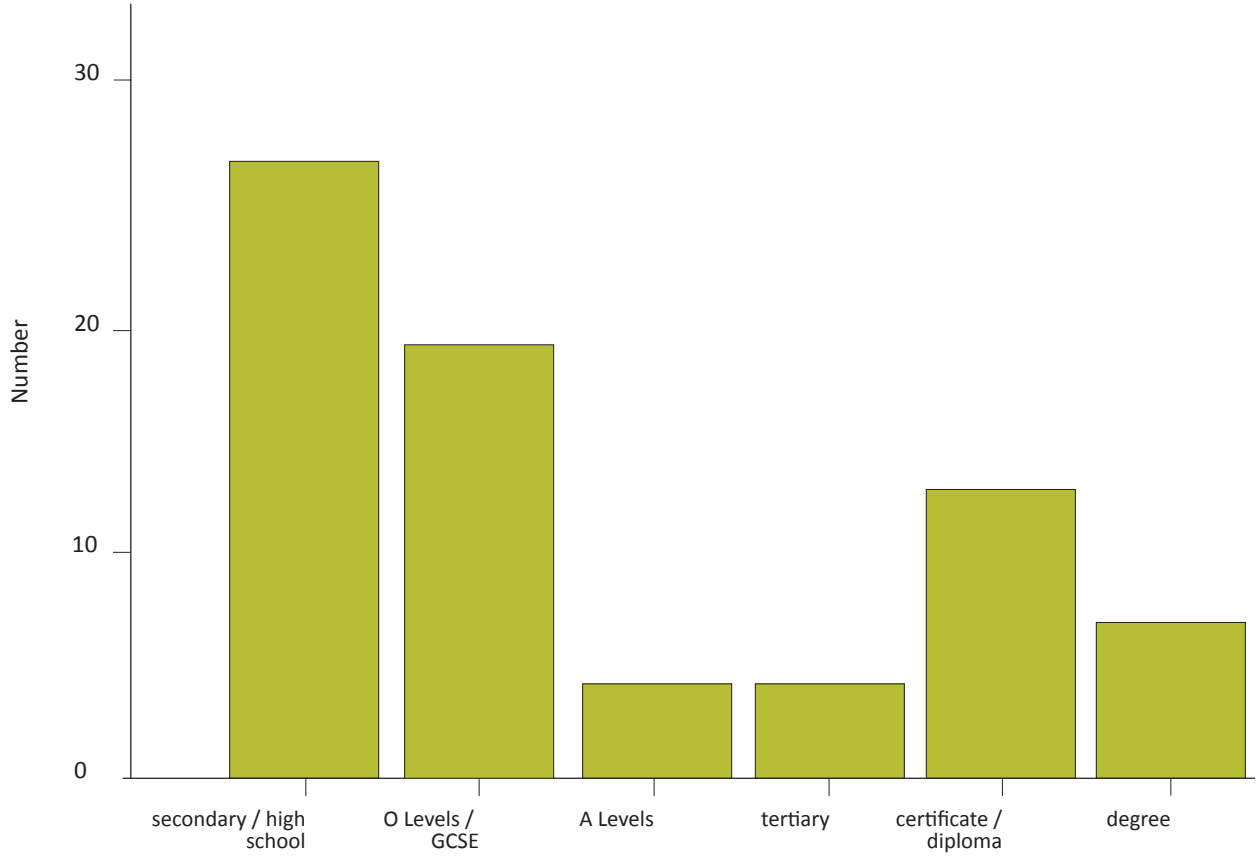
Seventy-three completed questionnaires underpin the following section. The age of respondents ranged from 15 – 69, mean age equalled 38.92 (standard deviation (sd) =12.95). The majority (n=59 / 81 per cent) were female. The most common occupation of the respondents was care assistant (see figure 2).

Figure 2: Number of Participants According to Their Occupation



Few respondents had completed further education (see figure 3).

Figure 3: Level of Education



Sixty-four respondents provided information about their professional qualifications (a number have more than one qualification – the highest is reported here). Nine have no qualifications, or qualifications unrelated to caring; four have in house training only; two have NVQ level 1, 13 have NVQ level 2, 13 have NVQ level 3, three have NVQ level 4 and 20 have nursing qualifications.

Most of the respondents have been in post for one to five years (see figure 4). Only one person (a home manager) reported working for 30 or more years in the care-home setting.

Figure 4: Length of Time in Post

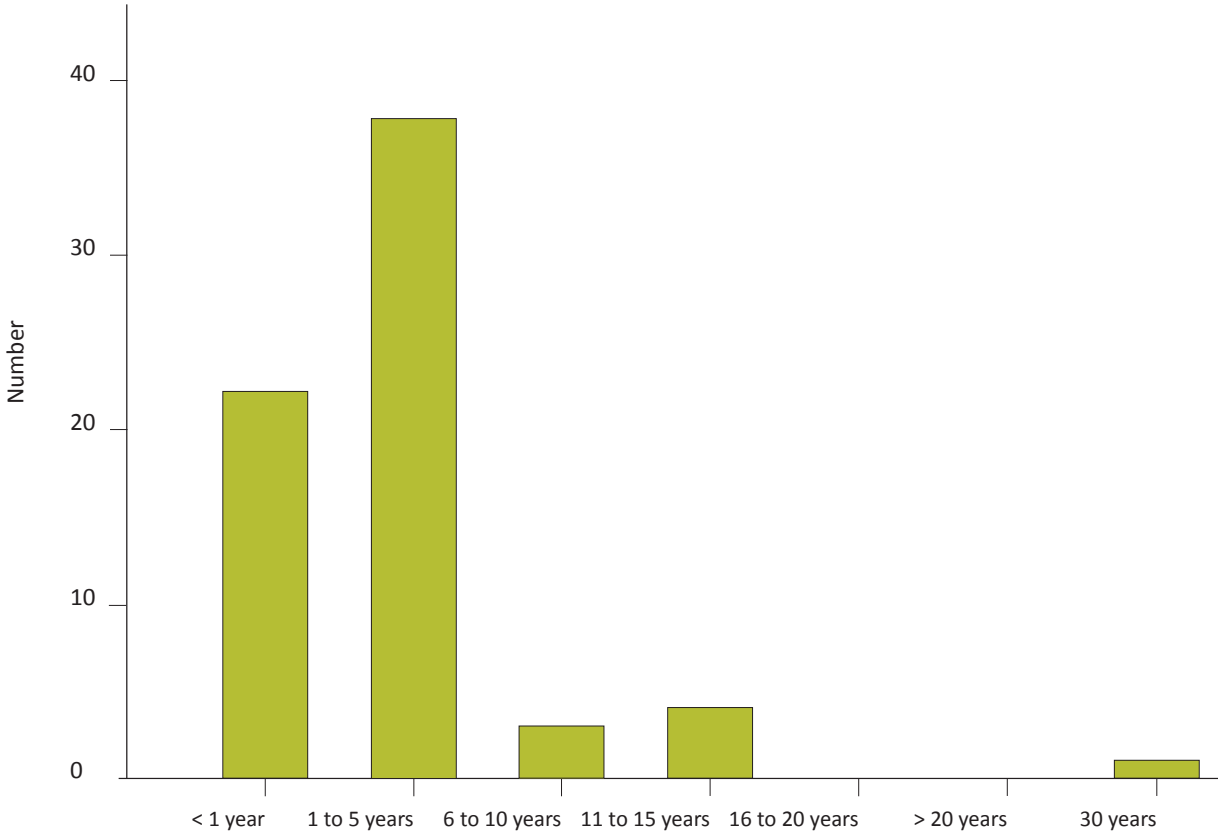


Table 10 below presents the descriptive statistics for the individual measures. Cronbach's alpha is given for each measure. This provides an indication of the internal consistency of the scale, which in most cases is good in this sample. The exceptions are depersonalisation and job satisfaction, where internal consistency is poor (<0.6). This may arise from a variety of factors, including the possibility that the scale has more than one underlying factor. It is possible to increase Cronbach's alpha by removing items from the scale, but as these are well-established, validated scales it was judged to be preferable to use the scale as published, to allow comparisons with other studies.

Table 10: Individual Measures of Questionnaires

Measure	Mean (standard deviation)	Internal consistency- Cronbach's Alpha
Attitudes to Ageing (range 29-145) (n=73) Higher scores = greater negative attitudes	60.99 (sd=15.57)	α = .81
Approaches to Dementia (range19-95) (n=67) Higher scores = better approaches to care	77.20 (sd=7.28)	α = .80
Emotional exhaustion (burnout) (range 0-54) (n=68)	13.14 (sd=10.00)	α = .89
Personal accomplishment (burnout) (range 0-48) (n=68)	37.74 (sd=8.82)	α = .81
Depersonalisation (burnout) (range 0-30) (n=78)	3.60 (sd=3.78)	α = .56
General satisfaction with work (range 20-100) (n=67)	70.34 (sd=18.68)	α = .57
Environmental mastery (range 7-49) (n=69) Higher scores = greater mastery	38.55 (sd=6.13)	α=.74

The scoring of the Maslach Burnout Inventory enables each subscale to be categorised as low, medium and high. The following figures show that the majority of respondents (79 per cent) had low levels of depersonalisation, a low level of exhaustion (71 per cent), and 57 per cent report high levels of personal accomplishment. But conversely nearly a third (29 per cent) had a moderate to high degree of burnout, in terms of reporting feelings of emotional exhaustion, 21 per cent in terms of feelings of depersonalisation and 43 per cent in terms of reduced personal accomplishment.

Figure 5: Personal Accomplishment

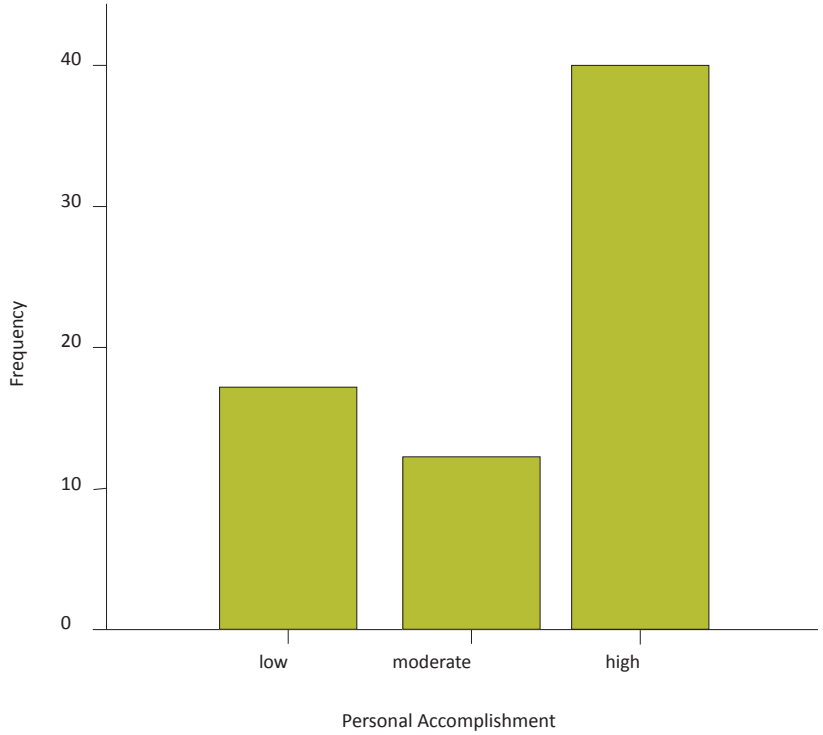


Figure 6: Depersonalisation

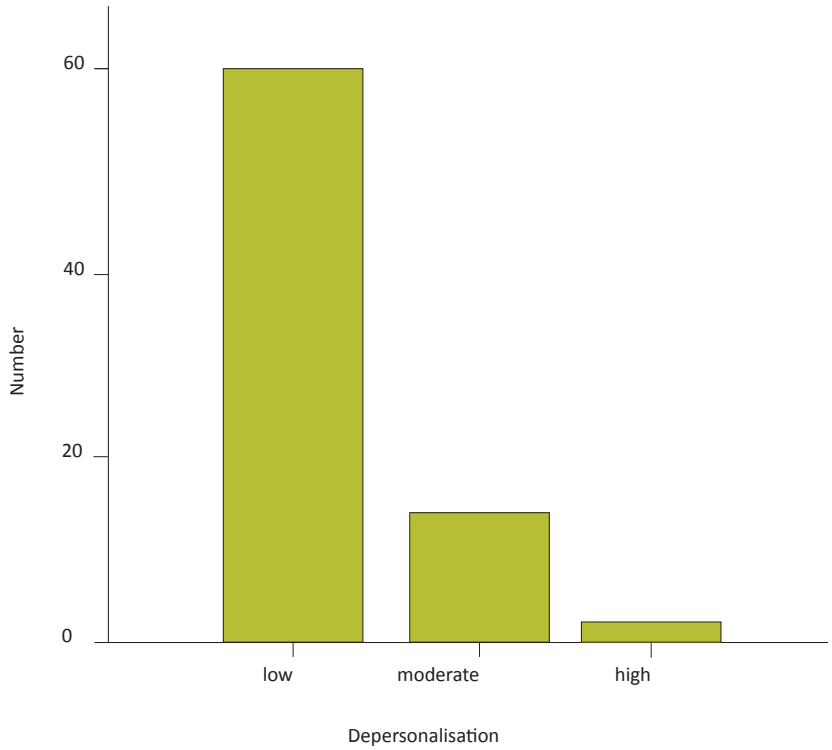
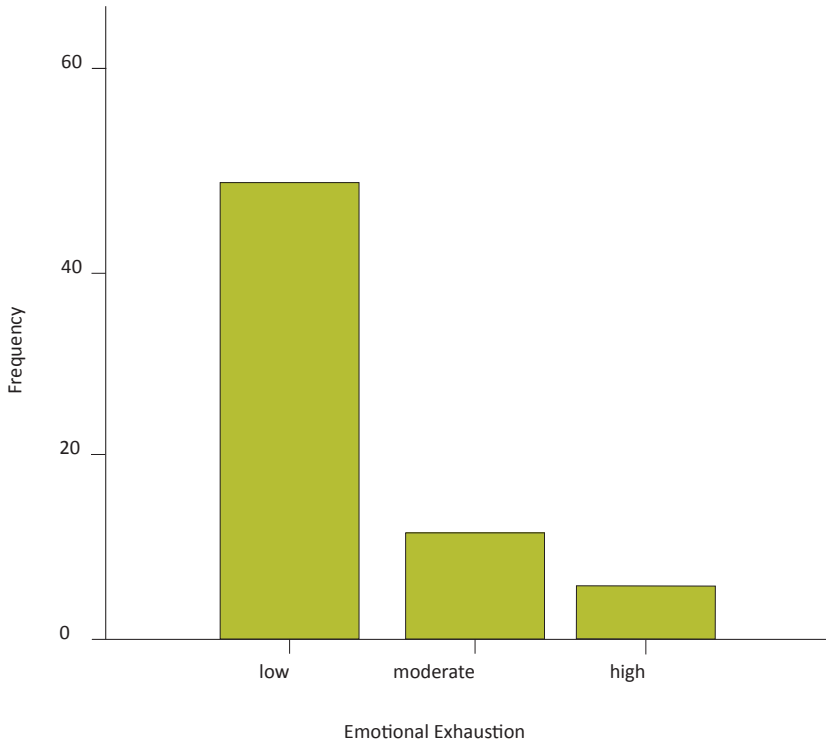


Figure 7: Emotional Exhaustion



The three groups for each of the burnout scales could then be compared in relation to the other measures, using one way ANOVAs. We were able to test whether there were significant differences in the continuous measures of attitudes to ageing, approaches to dementia, mastery and job satisfaction for those staff reporting low, moderate or high levels of each of the three measures of burnout (emotional exhaustion, depersonalisation, personal accomplishment).

For emotional exhaustion, there were no significant differences across any of the measures. There were significant differences according to levels of depersonalisation for mastery $F(2,73) = 4.631$, $p=.01$, attitudes to ageing $F(2,75) = 4.843$, $p=.01$; and approaches to dementia care $F(2,73) = 8.419$, $p=.001$ (but not job satisfaction).

Multiple group comparisons using the Bonferonni test at $p=.05$ indicated that the average level of mastery was significantly higher at the lowest level of depersonalisation ($M=39.31$ $SD=6.28$, $p=.01$) than at the moderate ($M=34.20$, $SD=4.45$) or high levels ($M=35.50$, $SD=3.53$). The average level of attitudes to ageing were significantly lower at the lowest level of depersonalisation ($M=59.35$, $SD=13.78$, $p=.008$) than at the moderate ($M=72.53$, $SD=18.94$) or high levels ($M=66.00$, $SD=2.82$). The average levels

of approaches to dementia care were significantly higher at the lowest level of depersonalisation (M=78.51, SD=6.45,p=.0001) than at the moderate (M=70.86, SD=7.43) or high levels (M=72.50, SD=2.12)

For personal accomplishment, significant differences between levels were found for mastery F(2,73) = 9.279, p=.0001 and approaches to dementia care F(2,73) = 11.15, p=.0001 (but not across attitudes to ageing or job satisfaction). Multiple group comparisons using the Bonferonni test at p=.05 indicated that the average level of mastery was significantly lower at the lowest level of personal accomplishment (M=34.45, SD=1.21, p=.0001) in comparison to the highest level (M=40.81, SD=5.79), and at the moderate level of personal accomplishment, mastery was significantly lower (M=36.62, SD=5.47) than the highest level. The mean score on approaches to dementia was significantly lower at the lowest level of personal accomplishment (M=71.28, SD=6.24, p=.006) in comparison to moderate levels of personal accomplishment (M=77.96, SD=5.51), and there was also a significant difference between the mean approaches to dementia scores at the lowest and highest levels of personal accomplishment (M=79.41, SD=6.87, p=.0001)

The following explores the negative and positive relationships between the measures.

Increasing age is associated with higher levels of professional qualifications (r=.26, p<.05) and higher levels of professional qualifications are strongly correlated with holding a more senior occupational position (r=.63, p<.001).

Table 11 below presents the significant correlations between the measures (**correlation is significant at the 0.01 level; *correlation is significant at 0.05 level), and between three of the demographic variables (education level, type of post held and length of time in post and the survey measures. In correlation analyses, significance is strongly influenced by sample size. A more useful approach to understanding the strength of the relationships is to apply the criteria of Cohen (1992) where large correlations are described as being >0.50, medium correlations range between 0.30-0.49, and small correlations range between 0.10-0.29.

Table 11: Significant Correlations between Measures

	Satisfaction	Approach	Attitudes	Emotional	Personal	Depersonal.	Mastery
Education		.29*			.27*		
Post held					.25*		-.25*
Length in post				.26*			
Satisfaction		.28*	-.33**	-.37**		-.28**	.27*
Approaches			-.64**	-.37**	.47**	-.42**	.28*
Attitudes					-.33**	.45**	-.36**
Emotional					-.33**	.47**	-.43**
Personal						-.58**	.48**
Depersonal.							-.38**

Negative attitudes to ageing are associated with lower levels of mastery, job satisfaction and negative approaches to dementia care, lower levels of personal accomplishment and higher levels of depersonalisation.

Higher levels of job satisfaction are associated with positive approaches to dementia care, fewer negative attitudes, less emotional exhaustion and depersonalisation and greater mastery.

Positive approaches to dementia care are associated with fewer negative attitudes, less emotional exhaustion and depersonalisation, greater job satisfaction, mastery, personal accomplishment and higher levels of education.

Higher levels of emotional exhaustion are associated with lower levels of personal accomplishment, mastery, job satisfaction, higher levels of depersonalisation and length of time in post (longer).

Higher levels of mastery are associated with greater satisfaction and personal accomplishment, fewer negative attitudes, lower emotional exhaustion and depersonalisation, and type of post (more senior position).

As well as the associations reported above, personal accomplishment was associated with higher levels of education and type of post held (more senior position).

Discussion

Before discussing the results, it is important to highlight some limitations associated with this chapter.

Clearly, the representativeness of the sample has some limitations, but as highlighted in the introduction (p.21) the focus of this study is on the staff who provide care on a daily basis. As such, we are able to provide a description, through analysis of standardised questionnaires, of some individual aspects that can potentially lead to staff providing care in a manner that contributes to loss of dignity. Where possible, we have tried to relate the findings from these questionnaires to the qualitative analysis throughout the rest of this report. It is likely that those with more positive attitudes, higher education, better English language fluency were more ready to complete questionnaires – however, the demographic details provided in Chapter 2 indicate a diversity of ages, qualifications and work roles across the sample.

From the 'Well-being and job satisfaction' survey of staff in the participating care homes, the majority of respondents were care assistants. On the whole, they reported positive attitudes towards ageing and dementia care, high levels of personal accomplishment, low levels of emotional exhaustion and depersonalisation, and a strong sense of mastery. However variability should be noted.

The correlations identified that negative attitudes to ageing were associated with lower levels of mastery, job satisfaction and negative approaches to dementia care, lower levels of personal accomplishment and higher levels of depersonalisation. Similarly, the ANOVA further demonstrates that the lowest levels of depersonalisation were associated with the highest mean scores on mastery, better attitudes towards ageing and better approaches to dementia care. A noteworthy minority of the respondents had high scores on depersonalisation.

Just over one quarter reported low levels of personal accomplishment. The ANOVA indicated that the lowest levels of mastery and approaches to dementia care were found at the lowest level of personal accomplishment. Although 31 per cent reported moderate to high levels of emotional exhaustion, there were no significant differences on this variable across the other measures. The analyses indicated that a number of the respondents were potentially experiencing some level of burnout, which affected their sense of mastery, attitudes to ageing and approaches to dementia care.

It is possible that this effect could be negatively influencing the level of care provided. It appears that a lack of personal accomplishment is most prevalent (49 per cent reported low to moderate levels).

Given the above, an aim of staff training could be to try to boost a sense of self-efficacy in participants' work. As noted above, improvements in confidence and competence are reported as a result of training.

The significance of some of the demographic variables suggest that a better education, greater experience and a more senior position are implicated in positive approaches to care, mastery and personal accomplishment. What our survey did not ascertain was how long the care worker was employed before any additional training (beyond the mandatory induction) was provided.

Conclusion

The questionnaire findings show the importance of attitudes – to ageing and dementia – in relationship to various aspects of burnout and job satisfaction. Although it is a minority of staff reporting significant levels of burnout, this may of course be an under-estimate given the likely bias in the sample, with less distressed staff being more likely to agree to participate. Previous work has demonstrated the links between the Approaches to Dementia Questionnaire and quality of life of residents (e.g. Zimmerman, Sloane et al., 2005), but also that more positive attitudes can be generated through training in person-centred care (Lintern et al., 2000). Recognising this, we have incorporated additional themes in the development of the PEACH training package that will facilitate dignified, person centred care. The proposed training could be delivered over a short period of time to all members of staff. This supports the findings from a survey of what is important for the quality of life for people with dementia (Alzheimer's Society, 2010). When those with dementia are asked to name key quality of life indicators, 'relationships or someone to talk to' was ranked as the most important factor with a peaceful, safe and secure environment ranked second. Evaluating issues around implementation is a next step to understanding the full effectiveness of the training.

CHAPTER 4

THE ORGANISATION

(Home is…) a place to return to… a refuge, a place to hang on to memories and events which give a rich meaning to life.

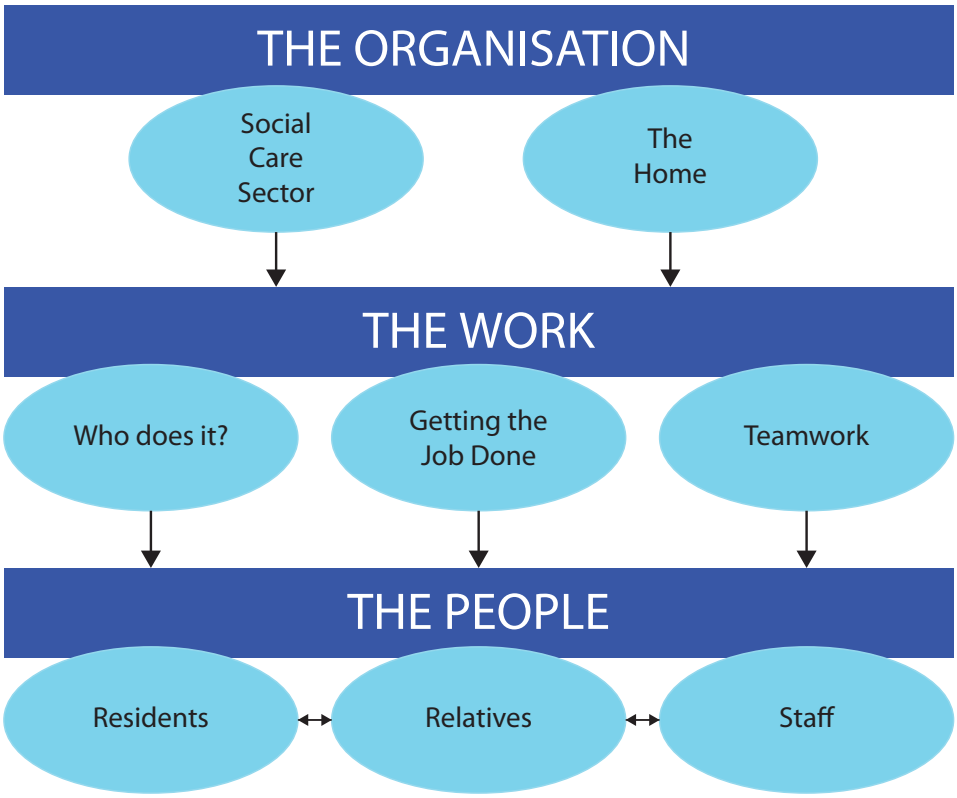
(Scharf et al., 2002)

Introduction

This chapter is the first of three that explore the qualitative findings from the study. The findings are presented under three overarching themes into which the data could naturally be placed:

- The organisation
- The work
- The People

Figure 8: The Key Themes



However, these three themes are necessarily inter-related and intersect as it is recognised that practices cannot be abstracted from the habits, routines and values of the institution in which they are performed or from the social and physical setting of which the institution is a part. Consequently, the approach adopted is not only to focus on care practices, but also to explore the wider cultures and influences in which practices are always embedded. Understanding the contexts of care is essential to reaching an informed and sustainable approach to changing practice.

In presenting the findings, a spread of data from all of the homes and focus groups has been used to demonstrate that the findings and therefore the recommendations are based on the analysis of all of the data, rather than on a few well chosen examples, ensuring that the conclusions drawn are valid.

This chapter explores the salient features of the 'organisation' at the macro level in terms of the social care system as well as the micro level of the individual home.

At the macro level two broad factors emerge. First, there is 'constant change' within the sector, and second, the sector and various aspects within it are characterised by 'inconsistency'.

At the micro level, a number of factors impact on residents' and staff experiences and the quality of care. The physical characteristics or 'the home as a space' together with the routines, philosophy and social milieu are extremely important in portraying whether from a resident's point of view the home is 'their space' or that of the staff.

The Social Care System

The findings are discussed under two headings: 'Constant Change' and 'Inconsistency'.

Constant Change

Chapter 1 details the considerable change that has taken place with regard to the organisation and regulation of adult social care. It was noticeable from discussions with participants, however, that there is a time-lag, especially with regard to terminology. For instance, the term 'EMI' which is no longer officially used by the CQC was used repeatedly by many participants.

> I meet with the manager who tells me about the home. She tells me this is a 45 bedded nursing home, although they don't tend to differentiate between residential and nursing so people can come in needing just residential care but if they become more dependent and require nursing care they don't have to move. They also have 7 specialist 'EMI' beds (the garden suite) for people with various forms of dementia.
>
> **(Fieldnotes, Care home 8, Afternoon)**

'Some of the, er, residents I don't think should be here and I think it's worse for us but also worse for them because some of them we're not actually qualified to look … well not qualified, but like we've not got the training to look after some of them. Some of them are like EMI and nursing we're supposed to be residential so it's harder in that sense because we get frustrated…'

(Interview with a Senior care assistant, Care home 5)

This must be confusing for new staff entering the sector especially at a time when further change is occurring. Many home owners and managers within the focus groups discussed the constant change that has taken place in relation to regulation:

Respondent 1: 'Governments and new people and every so often, they want to make changes, changes, changes and what are the changes doing? Look how many times we've changed since 2000, from local authority, to CSCI, to erm, what's the present one, CQC, and it will go, it won't last very long. There'll be somebody else changing, it will be amalgamated or something with somebody else's way, it's all change and you all have ideas.'

Respondent 2: 'But it's worse now than it has ever been, I don't know.'

Respondent 3: 'I'll tell you what I've started doing, now, I say my name and that I'm a nursing home owner since January 1984 and my home was registered under the 1975 Act. I think there was a 1984 Act, then it was the 2000 Act and now it's the 2008 Act. So I have a little experience of regulation.'

(Focus Group with Care home owners and managers, Birmingham, 24/09/2009)

Other participants highlighted the changes in the nature and dependence of residents; in inspection policies and processes; and the changes in training requirements.

Respondent 1: 'I remember when social services were the inspection unit and they'd come in and say "Oh you don't have anybody with um…'

Respondent 2: 'In a …in a care home, nobody who can't walk about…'

[Laughter]

Respondent 1: '"Incontinent, you can't have anybody who's incontinent in here, they'll have to go into nursing…"'

Respondent 2: 'That's it, there's a lot of people who still think that, yes.'

Respondent 1: 'But yeah, now most people are … you know so your workforce needs to be more skilled than they were …'

(Focus Group with Care home owners and managers, London, 29/09/2009)

Respondent 1: 'And, and the residents have changed so much in the last 10 years,I mean ten years ago when I was still the deputy you know, if there was a case of MRSA you know all sorts of things used to happen. The hospital would be on the phone and blah, blah, blah - but we used to have fifty per cent of my nursing unit was probably ambulatory. Now I don't. I go into homes you don't even see a patient - they're on peg feeds. We have ventilated patients they're … they're not even the same so…'

Respondent 2: 'People are coming in a lot later with more complex needs…

Respondent 1: 'So the training needs have changed…'

(Focus Group with Training managers, Birmingham, 16/09/2009)

In relation to inspection, various changes have taken place in recent years, and many providers felt that rather than inspecting the quality of care, the focus has shifted to inspecting the paperwork:

Respondent 1: 'You know, so you have to be equipped to cope with all this as well as everything … and now all the paperwork … what CQC want, I mean if you go down on your paperwork, you know, the – they seem to be more looking at that more than your residents sometimes … you know and …'

(Focus Group with Care home owners and managers, London, 29/09/2009)

The paperwork itself has grown and virtually all aspects of care and the home are subject to audit:

Moderator: You obviously know what good care is. How do you define that and how do you teach it to somebody else, or how can it be taught?

Respondent 1: 'The customer defines it for us ultimately, so our service users, our stakeholders, the commissioners who purchase the services. We are audited to within an inch of our lives aren't we?'

Respondent 2: 'Yes, CQC yeah.'

Respondent 1: 'One shape or another and we actually see quality, we actually have a quality assurance framework within work, but we actually do see being audited as a positive tool to continuous improvement. So we have well each of the managers actually is involved in, within our own services, developing their business plan, but that business plan, we call it an annual scheme review, which staff and service users are consulted on and feed into. So that then shapes the business plan. Against that then, our new business and quality manager comes out and audits each of the services, so what the managers say they're delivering, what they're saying they're working towards, they can, she can check to see that we are doing it. We have dementia quality audits, what other audits do we have?'

Respondent 3: 'Like 26s.'
Respondent 1: 'Oh we have monthly regulation 26 audits, which are part of CQC requirements, which we're regulated by…catering audits.'
Respondent 3: 'Yeah catering erm…'
Respondent 2: 'Health and safety.'
Respondent 3: 'Health and safety.'
Respondent 1: 'Health and safety audit, so all of that drives up, erm, best practice and good care delivery.'

(Focus Group with Care home owners and managers, Telford, 22/09/2009)

Training records rather than either the content or delivery of training are also documented and checked:

Respondent 1: 'Because you know the CQC don't come in and look at the quality of [training]…'
Respondent 2: 'They come in when it's done don't they '
Respondent 1: 'They look at the tick box! What proof have you that everyone in your home has attended SOVA, moving and handling….?'

(Focus Group with Training managers, Birmingham, 16/09/2009)

One home manager commented how change and the increasing bureaucracy had impacted on her role which had become solely administrative:

She told me the history of how she came to be manager over 30 years ago and how things have changed so much – 'everything's about the paperwork now - I used to be really hands on but now I never get to leave the office.'

(Fieldnotes, Care home 5, Afternoon)

Participants also commented on recent changes to inspection and the regulatory framework which has undergone considerable change in the last five years. As highlighted in Chapter 1, the Care Standards Act 2000 removed the powers of registration and inspection from local and health authorities and passed them to the Commission for Social Care Inspection (CSCI) (DH, 2000a).

The National Minimum Standards (NMS) were a product of the 1998 Modernising Social Services white paper issued by the Department of Health (DH, 1998). The National Care Standards Commission was set up to monitor compliance with the NMS in England, and in April 2004, was abolished and its functions passed to the CSCI. As part of its remit for inspection and regulation, CSCI brought in a star rating scheme in 2007, homes were rated from zero to three stars according to their performance against the NMS and their rating determined the frequency with which they were inspected. The Health and Social Care Act 2008 (DH, 2008) introduced a new regulator, the Care Quality Commission, in 2009 which took over all of CSCI's functions. In October 2010 the star ratings were abolished and new standards, the Essential Standards of Quality and Safety were introduced (CQC, 2010).

However, many providers felt that despite the changes, inspections still miss the point:

Respondent 1: 'You've heard a lot of frustration and despair amongst providers and that's going to be pretty universal.'

Respondent 2: 'And you look at the way in which the star ratings are worked out, training is one of those areas that don't, they don't put any value on it. The same as the staffing, there's no value on staffing. The weighted areas are, do not include staff or training.'

Respondent 3: 'Just an example, if you try and get an inspector to look at the letters that we get after mum or dad has died, not interested.'

(Focus Group with Care home owners and managers, Birmingham, 24/09/2009)

Similarly, staff working in the sector believed that inspectors know little about the reality of the situation in which they work:

> Marjory talks about a gentleman who is mostly self caring but who will come upstairs, as his room used to be upstairs and it can take 15 minutes to take him back downstairs again – meanwhile call bells are ringing. They talk about CQC inspectors and how they should 'shadow' a member of staff to get a real idea of what goes on.
>
> **(Fieldnotes, Care home 8, Morning)**

However, the greatest critics of the changes to inspection were the relatives who expressed concern both about the 'mediocre' standards that appear to be acceptable to the regulatory body and the tendency towards a reduced frequency of inspections:

> Respondent 1: 'I mean the one thing about a one star home it'll be inspected more often than a three star home … and they're now talking about three star homes getting inspected once every five years …once every five years.' [Agreement]
> Respondent 2: 'But, things change don't they?' [Agreement]
> Respondent 1: 'The day after the inspection, the manager goes [Agreement]… and within weeks it's downhill…'
> Respondent 3: 'And the reports are so bland you know that they mean virtually nothing anyway… [Agreement]…however many stars they give them.'
>
> **(Focus Group with Relatives and Residents, London, 28/09/2009)**

Changes in training requirements were also a cause of concern for home owners, managers and those responsible for training.

Respondent 1: 'There's lots of issues, and I think as well you know, just talking about NVQs I mean it's having an eye on what's happening next year with NVQs … because they're all going to change within the sector…so I meant we're potentially twelve months away from that now and really there's not great visibility as to what they're going to look like. You know Skills for Care don't seem to be ….' [Laughter]

Respondent 2: 'Skills for Care! – They are one of the worst….'

Respondent 3: 'So there's going to be some changes there next year, but what they're going to be like? You know how are they going to impact on the care home? We don't know, ideally you know twelve months out I would be liking [sic] I'd be looking to think about what that's going to mean for us as an organisation.'

(Focus Group with Training managers, Birmingham, 16/09/2009)

Respondent 1: 'Mmmm very disappointed when the new NVQ, the what's it called, er what, whatever it's going to be, we'll end up with a diploma. Why can't we have a degree? Hairdressers have a degree, the pharmacists …you can get degrees, but there's no degree…'

Respondent 2: 'The new credit…'

Respondent 3: '…for care'

Respondent 2: '…The new credit framework'

(Focus Group with Care home owners and managers, London, 29/09/2009)

Inconsistency

A common concern throughout all of the data collection was the apparent lack of any standardisation in relation to the fee structures, staff numbers, inspection, staff training and qualifications and in the interface with the NHS.

The following conversation within a focus group with care home owners and managers highlights some of the issues regarding the differences in fee structures:

Respondent 1: '… it's this differential of the money coming in you know, because whether you're privately funded or whether you're a charity or whatever, you know it's got – you've got to balance the books.'

Respondent 2: 'Even though we're a charity, we can't be seen to be using our supporters' money inappropriately and we're very lucky that we do have the amount where the charity does support us and we're – for example, we're able to provide a full time physiotherapist at our two centres that have nursing care, you know, whereas that is very, very rare. So we have things like that, that the charity is able to support us with, but it's got – it's still got to balance out. I would be hard pressed to see how anybody can actually make a profit out of good nursing or residential care. Because, as a charity, we struggle to make it balance.'

Respondent 3: 'Of course you do, you have to keep your standards up….So, when you look at it, our wage bill, is the biggest bill we pay. I mean, I think it's something like £35,000 a month, which is a lot of money out of a 35 bedded home, but we charge a top up. We have to.'

Respondent 4: 'I think as well, when we go back to staff, again it's all these changes that social care has seen, particularly over the years where the type of support has changed from you know, now we talk about supporting and enabling, instead of caring. So instead of doing things for somebody, it's supporting somebody to try and do it for themselves, or enabling them, in the best way possible and I think sometimes long established staff find that transition difficult …the old school.'

Respondent 1: 'It's getting away from the task orientated society isn't it, and so it's all part and parcel of the same challenge really isn't it, and looking at the real personalisation and person centred care that there needs to be.'

Respondent 3: 'Well this is what it's all about. I mean, and this costs money again, because you're employing people to come in. Like we have a lady comes in once a month, she's an OT at the hospital… she comes into the home and she'll set a task for the month for the residents to do and she'll also do personal profiles on a one to one basis with our dementia, but that costs me £150, for the afternoon, you know. So if you couple that with other people you get in, like we have a couple of chaps who come in doing a musical afternoon with them, so at the end of the day, for a medium sized home like ours, it's quite a lot of money we are paying out to bring people in, you know.'

Respondent 2: 'Per head it's a considerable investment isn't it?'

Respondent 1: 'Like we've got – what you're paid from social services, you couldn't afford to do that. So you have to charge a top up and you can't always say that your private residents should fund this for everybody else, you know. It's very difficult sometimes, especially these days, to keep your beds full, at those costs, but at the end of the day, if you look at the cost of care, what it should be, we're not meeting that yet, even with top ups.'

Respondent 4: 'It would just be good if they were all singing from the same hymn sheet.'

(Focus Group with Care home owners and managers, London, 07/07/2010)

Moderator:	What do you think are the burning issues?
Respondent 1:	'Funding and training.'
Respondent 2:	'We still don't know how, how training in the social care sector is funded. We've got a complete dogs breakfast of pots of money in DH, in communities and local government, in DFES that drip feeds its way down into various public voluntary bodies, scattered around the country and by the time you get down to the individual person with an individual need, you've got about a million to one chance of having the same funding package as the person in the next door county, because every county does it differently, each social care group does it differently and they all change with the wind.'
Respondent 3:	'So when you consider that the average payment around the country is approximately £520 per week, that's less than £2.96 an hour, for seven days a week, 24 hour care when you've got a lot of staff on. The staff, the whole industry is much more underpaid than the NHS, which is why we lose nurses and staff to the NHS or to Social Services, who can pay more. We have a staffing that works for less, …but that price being paid is still way below what our costs are in 90 per cent of the cases.'

(Focus Group with Care home owners and managers, Birmingham, 24/09/2009)

Whilst many owners and managers were concerned about inconsistencies and a lack of transparency in fees, many residents and relatives were exercised about inconsistencies in the quality gradings following inspections as the following discussion demonstrates:

Respondent 1: 'Well that was the point of our exercise … of our report into the hundred homes… [Agreement]…We just went onto the CSCI as it was then inspection report site and we just pulled out totally at random, one star homes…and we then extracted from their own reports phrases, like - what they can do better, what this home does well, what they could improve on sort of areas…and we actually extracted their own comments…so we didn't write anything…we didn't invent anything, from purely the reports, and the – the contrast between a hundred care homes all one star was just phenomenal. Somebody would look at it and think this should have been closed down yes…last year…others, why isn't this a three star home?...You know and it's a bit like hospital gradings, it's often nothing to do with the residents at all, it's about record keeping or it's something a bit esoteric if you like …and for some reason they're being marked down on some heavily weighted issues…[Agreement]…So the variety was phenomenal...But as I said earlier on, bear in mind that if a home gets a three star rating, it has established that it has matched all the minimum standards… [Agreement]…that's a three star home…so anything less than a three star…[hasn't met minimum standards].'

Respondent 2: 'Yeah, it was a brilliant piece of work.'

(Focus Group with Relatives and residents, London, 28/09/2009)

Since the focus groups were held, the star gradings are no longer being used but concerns about consistency remain. Another area where consistency appears to be lacking is that of qualifications, as this training manager highlights:

Respondent 1: 'And also the local Primary Care Trusts (PCT) don't support … if you're a nursing home, they don't support care staff taking on any extra responsibilities in some areas. For example, in NVQ level 3, you can do catheterisation as a carer. Now, in some of our PCTs they'd say "Yeah that's great, fabulous, we want to see training around it though, the district nurse has got to observe a lot of these national organisations, in some it's not a problem, in others; "You will not do that unit" they won't even let them do blood sugars in some PCTs.'

Moderator: So there's no standardisation?

Respondent 1: 'No there's supposed to be [laughs]. They'll ask for one thing in one region and up the road have something else.' [Agreement]

Respondent 2: 'You know and there are different takes on qualifications around, you know, for registered managers … you know depending on which inspector that you speak to. And even with Skills for Care, you know, as the, er, a national body, each region is very, very different … in terms of what they are supporting and promoting … in terms of, um, training and development, um, you know and I think if, particularly for – for national organisations where you're trying to have that consistent approach it makes it very, very … it makes it difficult to – to achieve.'

Moderator: If that person has got that NVQ do you know that they will have those specific skills?

Respondent 2: 'In an ideal world you would. But as you've raised the point, the thing with NVQs is it's down to the vagaries of the assessor…'

Respondent 1: 'But within that role you've got Skills for Care but then you've got Lifelong Learning UK, which is our sector skills for anybody that does training within our sector … They represent, I mean, how can you put care home industry in the same bracket as the colleges? You can't do it, but they do it. You

can't. OFSTED do it….There is no actual representation in my opinion for the ethos of care homes.'

Respondent 2: I mean you've also got, you know, apart from you know the likes of, um, Skills for Care, you've got 'Skills… you've got … you know, there's – there's a plethora of agencies that don't really seem to have a … don't have a joined up approach… to what – to what they're doing and that, you know, I think there needs to be some sort of rationalisation …there in terms of you know a very clear … you've got the Skills of Care, there's a national skills academy now …for the sector as well, I don't know. And it makes it – it makes it difficult, you know, as an employer with – with all of these initiatives going on … to think, well okay, you know – you know what you want to do as an organisation but you also have to have your eye …on what's happening 'cause you don't know quite … how that's going to impact, so yes there's – there's this leadership academy now that's, er, in the planning stage I think… I don't know, but again, that – that's happening, you know, how much representation there is on that, um, a body from um the employer, um, sector, I don't know, and what they're suddenly going to start mandating, who – who knows? So you've got these range of bodies, funded, government funded bodies, um, and there just seems to be a huge amount of overlap.'

Moderator: Yeah when I was looking into what's out there already I came across Skills for Health, Skills for Care, Learning Skills Council…

Respondent 1: 'Yeah, LSC, LES … You try and please everybody and end up pleasing nobody.'

Respondent 2: '… conflicting information out there and … there doesn't seem to be that joined up approach, you almost need to cut through all of those organisations and then one

organisation that is … that is truly representative of – of the sector… um, apart from you know, saving the taxpayer money, apart from anything else, you know, that, it would just be so much easier for people within the sector to – to find their way around and you know what are the training things that we should be looking at? Where can we go, what is accessible?'

(Focus Group with Training managers, Birmingham, 16/09/2009)

The comments from this final group of participants reflect the frustration felt by many within the sector at the huge variability and lack of standardisation, which makes navigating one's way through the regulations a little like driving through treacle:

Respondent 1: 'It's a standard, we'd like to see a standardisation of inspections, a standardisation of fees, of implementation, of standards. '

Respondent 2: 'So it's the variability, it's not having the workplace standards there and the other thing that frequently occupies us round this table is it changes every year, depending on what the politics are.'

Respondent 3: 'That's right, that's very, very true there seems to always be a flavour of the month issue, but whilst to a certain extent, we have to respond when the pressure is upon us, we also need to look, stand back and think and be proactive about what we think we should be doing and indeed and I'm sorry to say this, what we have to do to survive.'

(Focus Group with Care home owners and managers, Birmingham, 24/09/2009)

The Home as an Entity

For most people reading this, the word 'home' has a variety of meanings and conjures a range of images, as well as generating an assortment of feelings. It isn't difficult to acknowledge therefore that the notion of 'home' refers to more than bricks and mortar, but also involves the ambience, the relationships between the particular residents, the values and attitudes of those 'living' and 'visiting' there, the rhythms, the smells, the noises and the activities that routinely take place, to mention but a few. These latter aspects might be referred to as 'homeliness' and give one a sense of whether the home genuinely tried to cultivate an atmosphere of it being the resident's 'home' in the sense alluded to above, or whether it was simply a place in which the residents lived.

In this section, the findings relating to the home as a physical and emotional space are discussed. The care homes visited as part of this study were diverse, as the general descriptions in Appendix 5 show. Some were purpose-built facilities for residents with diverse needs, some were specialist purpose-built units such as Home 2, catering exclusively for people with dementia. Others were conversions from large or medium sized former residences, to homes that are converted town houses.

First Impressions

> The setting was very pleasant in an old rectory that appeared to be not far from the centre of the city... The building is very pleasant and backs onto a bowling green which provides a very nice environment for the residents to sit out in warmer weather. Unlike some other homes I have been in over the years, there does not appear to be one central day room, but rather a number of lounges scattered around and it will be interesting to find out how the different lounges are used. Next to the kitchen there is a small room which is used for the preparation of teas and coffee and then on the other side of the corridor there is a tiny staff room where the staff retire to have a cup of tea or eat their meals.
>
> **(Fieldnotes, Care home 1, Afternoon)**

This positive impression was shared by a relatively new staff member:

> *'I haven't got experiences of lots of homes this is the only home I've ever worked in. The thing that I liked when I first came for the interview, since I walked in the door I wanted the – the position 'cause I loved the feel when I came in, the … it felt like a home not an institution - it felt like a home. One of the things with this, with our home here, the rooms are different sizes, different areas of the home it's not laid out like in straight lines, it's not laid out in a – in a – a very formal … it feels it … yes, it feels like a home, got different areas, different quiet areas, or more social areas or places where people can, little corners that people can sit quietly as in the conservatory, you know, little areas that people have as their own space and that's quite nice just to have little … That's an observation that I – I think makes this feel like a home. It doesn't feel like an institution, you go into some other larger establishments and it's straight lines all the rooms are very much the same sort of size, the same, similar look, whereas our rooms are slightly, hopefully more individual, they're sort of tailored or can be tailored for the, for our residents' own personal care and it feels more – more homely. The idea is it … I like the feel … again, my own personal observation, it feels like a home, it gives the … we've got the fantastic nursing staff and we've got the care in place but predominantly it's a home and the – the nursing side of it, again, my own personal observation, it's like an add-on for their home.'*
>
> **(Interview with an Administrator, Care home 1)**

Contrast the above accounts with the fieldnote below which describes a purpose built home:

> The deputy manager comes to show me around the home. I need security codes to get in and out of the doors. There are two units downstairs and two upstairs they all look very similar. Each has a long corridor with bedrooms, bathrooms and toilets and at the end a lounge and a dining room. The last unit he shows me is Ravesbury and I decide to observe here... I sit in a corner of the dining room as lunch is not quite finished, there are four tables, seating three men and seven women. One woman sits in a large armchair in the dining room. The dining room is decorated in light colours with framed photographs of food on the walls, all the tables have tablecloths and there are fake flowers in vases on

the tables. The chairs are fabric covered and match the curtains which are falling off the rail. There is a wood effect vinyl floor covering. There is a room off the dining room which is a small kitchen and washing up area. The music playing in the lounge can be heard in here. After lunch I go to sit in the lounge. It is a large room with chairs around the edges and one sofa, also at the edge of the room. The walkway from the bedrooms, and to the next unit is between the lounge and dining room, so people pass by fairly frequently. ...A girl pushes a laundry trolley through and waves at the man in the corner who waves back. The CD is playing music, comical stories and comical songs. There is a clock on the wall and some pictures, an organ in the corner with the lid down. There is a rummage box in one corner with a large teddy on top. The manager had mentioned earlier about her frustration when she provided rummage boxes for each unit but discovered them packed neatly away rather than available for residents. I don't see any magazines and there are very few tables.

(Fieldnotes, Care home 7, Afternoon)

Meeting Residents' Needs

For older people living in care homes there are considerations other than the nature of first impressions which are of more importance. A study undertaken in 38 care homes in Sheffield set out to establish how care buildings can make a positive contribution to quality of life (Parker et al., 2004). A buildings assessment tool was developed which identified ten requirements or domains of importance to frail older people living in care settings:

- Four domains cover the universal needs of people living in care settings;
- Three domains cover the physical needs of frail older people;
- Three domains cover the needs of older people with cognitive problems, such as memory loss and confusion.

The domains concerning older people's universal needs include privacy, choice and control, personalisation and community; those addressing physical needs are safety and health, comfort and support; and those concerned with cognitive needs involve normality and authenticity, awareness of the outside world and support for cognitive frailty. As this study concerns best practice surrounding dignity and dignified care, abuse

and neglect, therefore issues of privacy, choice and control, personalization, community; safety and health, comfort, support, normality and authenticity, awareness of the outside world and support for cognitive frailty provide an entirely appropriate focus. Similarly the fact that providers see a facility as the person's home rather than seeing the resident as someone entering their space can impact on the way in which care is delivered.

Meeting Older People's Universal Needs

In relation to privacy, older people need opportunities for privacy, for example, when talking to their visitors, or receiving help with personal care. Buildings with good provision have a number of small seating areas where private conversations can take place, rather than large single lounges. Public areas are separate from residents' bedrooms, bathrooms and toilets and these areas are not visible to people passing in corridors if doors are open. To enable choice and control over one's environment to be exercised, the home should provide older people the opportunity to choose how and where the day is spent. Areas such as a quiet lounge with no TV, a kitchen where drinks and snacks can be prepared, and a room where games or other activities can take place should be provided. A choice of styles of easy chairs, settees, upright chairs and tables enables residents to exercise personal preferences. Residents should be able to choose a bath or shower, and they should be able to control the temperature, lighting and ventilation in their own rooms.

Because the care home is also the older person's home, buildings should provide opportunities for personalisation including space for the person's own furniture and somewhere to display pictures and ornaments. Positioning of emergency call points should allow choice in furniture arrangement. Similarly, the area around each bedroom door should provide opportunities for personalisation. Storage and display space for personal items should be available in lounges and bathrooms and where possible residents' bedrooms should have a small garden area or window box outside to allow people who wish to, to choose their own plants. Because everyone needs a sense of community the home should allow residents to be part of the wider community. The location of the home in relationship to public transport and local services is included in this domain, as well as provision for visitors within the building. Features such as suitable spaces for family gatherings and a room where religious observances can take place should be available. The building should reflect the cultural expectations of the resident group, which may differ between older people

in different ethnic groups.

All of the homes in this study had individual bedrooms except Home 5, which had five shared rooms although plans were underway to alter this situation.

Although this home had a number of separate lounges and areas for private conversations, other aspects of privacy such as separate public and private areas and bedroom furniture arranged so that people in bed cannot be viewed from the corridors, were not well served as the following fieldnotes demonstrates:

> The manager then asked the senior care assistant to show me round - I had to wait for a few minutes and so was looking at the activities board in the hall... Whilst I was waiting residents were walking or being taken through to the dining room for lunch. From the next corridor I could hear someone saying loudly 'Do you want the toilet Violet?' repeatedly – I couldn't hear the reply. She then said 'Now you wash your hands and I'll wash mine' 'That's it – we're washing our hands aren't we?' The senior care assistant Lillian had to accompany a doctor to see a resident and so asked one of the care assistants, Susie, to show me round. (The building is essentially three town houses knocked into one - the majority of the bedrooms are upstairs. Downstairs there are nine bedrooms, a main lounge, quiet lounge and sun lounge, catering kitchen, dining/activity room with conservatory, bathroom, three toilets and the office.) ...Many of the bedroom doors were propped open, but the care assistant opened the closed ones without knocking – perhaps because she knew the residents were at lunch. We came to one propped open door and there was an elderly lady in bed – the care assistant said – 'Oh somebody's supposed to be coming for Helen to give her lunch' She didn't speak to the resident herself. She then opened a door to a room with two bed-bound residents in and pointed at them and told me that they were in hospital beds and needed everything doing for them. Again she didn't speak to them. She pointed to some doors and told me about the residents who were there ... We then passed another open bedroom door with an elderly lady sitting there being served lunch.
>
> **(Fieldnotes, Care home 5, Afternoon)**

In relation to choice and control, the homes again were varied. For instance in Home 5 above, the care assistant walks into the residents' bedrooms without knocking denying resident's control over who enters their own room. In contrast, the approach in Home 6, is very different:

> As Barbara shows me round she knocks on doors before entering and apologises for disturbing residents when we go in at lunchtime. She introduces me to residents who want to know why I'm there. One lady in Ullswater tells me 'they're golden here' another in Windemere tells me that they do a great job. There is a really homely feel about the place and residents chat with each other and the staff. In one unit a relative is eating lunch with her mother and other residents as she lives far away…There is a really good feeling about the place and a lot of laughter.
>
> **(Fieldnotes, Care home 6, Morning)**

One home in particular had made huge efforts to ensure as much choice and control as possible for residents regardless of the extent of their cognitive impairment:

> This specialist facility caters for up to 70 people living with dementia, including those who are still quite active. Care has been taken with every aspect of the environment to make it homely, relaxed and designed in a way to encourage independence amongst the residents. Five adjacent bungalows are each split into two, creating smaller communities of just seven to eight people. Each has a quiet room, communal kitchen where anyone is free to help prepare food, two dining areas and two sitting areas, each with a fireplace. Simple visual cues are an integral part of the decoration. They help residents identify their surroundings and encourage them to explore other places - neighbouring bungalows, the clubhouse or the sensory gardens that lie at the heart of the development. Twenty-four hour care is focused on the needs of each individual resident and is flexible, with few routines, so that residents have the space and choice to live their lives as freely and fully as possible, just as they might choose to do in their own homes. The aim is to provide an environment that reassures, enables freedom and provides an opportunity for residents to move around and find fulfilment in the different environments and daily activities. All the units are arranged around the central garden and what they call the

> clubhouse which is like a central conservatory in the middle of the garden. The other units can also be accessed by a walkway that goes behind the office. These can be restricted to residents by code locked doors, however, during the day these doors are left open so residents have the opportunity and freedom to wander between units and through the garden and club house.
>
> **(Fieldnotes, Care home 2, Morning)**

All homes offered a range of communal rooms which could be used for confidential conversations or different activities; however, as will be shown in Chapters 5 and 6, the limitations of choice and control were less to do with the physical environment than they were to do with staffing numbers or characteristics.

Opportunities for personalisation again varied from home to home, and although most offered the opportunity for smaller personal items to be accommodated in residents' own rooms, in most homes, the opportunity to rearrange furniture and have personal garden space was limited.

Some homes had gone to great lengths to ensure that the home was part of the wider community, while for others, especially those in rural settings, this was more difficult.

> Residents are encouraged to be involved – they tell me that Bob delivers the mail to the other residents and also takes out the bottles for recycling. Ida teaches crochet and knitting to local children (residents' grandchildren, staffs' children, local school groups). They try to encourage children's involvement in the home and have a children's area stocked up with toys and games – for example children will come in and grab a toy or a book and take them to their granddad to read or to play with them or just to keep children from being bored while visiting. They have also donated an area in their sensory garden for local children to be able to come and plant seeds and grow vegetables, as the local school doesn't have a garden...They are also hoping to set up a carers' café in the day centre somewhere carers can drop in for a chat and to support each other – they want to open the day centre on a Sunday for Sunday lunches so that relatives can come and eat with their relatives – they plan to set it up like a restaurant... The walls have photos and posters on showing trips to Llandudno and a canal boat trip – also a fundraising day for an

older person's charity - that the residents took part in. The trips clearly involve staff, residents, relatives, friends and even staffs' relatives.

(Fieldnotes, Care home 5, Morning)

In other care homes life for residents was more restricted and isolating, separate from the world around them:

'And they could – there's very, from what I've seen in the last month, there's very little activities that are planned for them. Erm they're locked within the unit and there's, there's nothing for them to do. They sit in the lounge or just stare at each other or at the walls or at TV. Erm, you know, there's no...There's getting the, the residents actually involved in living. Take them out in the garden it's not going to take you much time, a little bit of fresh air, different scenery. But yeah they - I don't even think they're allowed outside to be honest.'

(Inteview with a Care assistant, Care home 3)

Meeting Older People's Physical Needs

In relation to the domain of safety and health the key focus is on protection from harm. Homes should ensure adequate lighting in all areas, fire protection, non-slip floors, and control of hot-water temperature. Residents with dementia need safeguards against leaving the building and intruders should not be able to enter. Bathrooms and toilets should be designed for easy rescue of residents who have fallen, for example, by having doors that open outwards and bedside lights or nightlights should be used to minimise falls when residents get up at night. Care home environments should take account of the need to support physically frail older people. Residents with muscle weakness, impaired mobility, and or sensory impairments have to be able to trust the environment to make up for these frailties. Fittings such as taps, flushes and door handles should be easy to use. People in wheelchairs require full access to all indoor and outdoor spaces, corridors and doors should be wide enough to accommodate these and ramps should replace steps. Residents who are able to walk independently, should be able to do so safely with handrails and seats breaking the journey between bedroom and communal rooms, while the use of colour to highlight contrasts between fittings and

backgrounds assist people with visual impairments. Door handles, taps and toilet flushes should be easy to grip and turn and consideration should be given to the physical comfort of residents such as the ambient temperature, noise levels, natural light and the absence of unpleasant smells.

One home's solution to the problem of residents falling in the toilet or bathroom was to remove locks from the doors:

Respondent:	'Right, dignity is say for instance somebody's spilt drink all over them, some … instead of going over "Take that top" you need to take her away, and not into a bathroom neither, I think the best is to take them to their own bedroom, let them choose what they want put back on rather than take them to a bathroom, people can walk in and out, they might be undressed, it's not really … because we don't have locks on the bathroom and.'
Interviewer:	Why are there no locks on the bathrooms?
Respondent:	'Because we don't want … we get a lot of wanderers with bad dementia, we don't want them going in and locking them, I know we can actually open them from outside, but it's how long would that take and have they fallen so we tend not to put the locks on in the bathrooms but we do in the bedrooms, they do have locks on their bedroom doors for their own privacy, but we've all got a key to get through to them or some of them it's not even a key, it's just a – a turn um, it's dignity – it's dignity for them as much as us as well, um, that's about it.'

(Interview with a Senior care assistant, Care home 2)

In a number of homes, noise was an issue:

> The TV is on a music video channel and there is still a fault on the set which means that the volume goes up and down and at times is blaring.
>
> **(Fieldnotes, Care home 3, Morning)**

> Later I saw what I thought was one of the first instances of inconsiderate activity that I have seen in all the time that I have been here and that was when the radio was on in the lounge and then, after he had had his cigarette, Rowland came in and switched the television on but nobody put the radio off. It was really getting on my nerves but I don't know if anybody else, staff or resident noticed. I did think, however, that it is already difficult for the staff and residents to understand each other and having two devices blaring like that was not going to help.
>
> **(Fieldnotes, Care home 1, Morning)**

The physical environment impacted on staff as well as residents. In homes that were converted former residences, difficulties in implementing safe lifting techniques were an issue:

> *'Yeah like at the moment we shouldn't be lifting anybody because of the – the law the Manual Handling Act, but we still sometimes we have to because we don't have a choice really. Sometimes the bedrooms are too small for the hoist.'*
>
> **(Interview with a Senior care assistant, Care home 1)**

Illustration 1: Non-purpose built room demonstrating difficulty of accessing the bed via hoist

Meeting Older People's Cognitive Needs

The physical environment can support or inhibit residents' abilities to maintain a degree of independence. In two of the homes (2 and 6) particular attention was paid to ensuring residents could find their rooms with the use of colour and personal effects including photographs outside of the rooms. Free access to an enclosed garden also enabled freedom and the ability to potter and engage in a fulfilling activity. In Home 2 in particular, the circular nature of walkways, between the different units and those in the sensory garden, ensured that residents could walk freely without getting lost or being confronted by locked doors.

Enabling people to retain awareness of the season, the time of day and the weather is also important in maintaining normal rhythms. Safe access to outside space and windows that look out onto the world provide a focus of interest and can assist in orientating residents. Finally, people with dementia function better in an environment that feels familiar to them (Davies, 2000) so the physical environment should give the impression of being on a domestic scale. Materials and decor should be like those found in an ordinary home and smaller seating arrangements with side tables and lamps rather than strip lighting help to maintain a sense of normality.

As well as the specialist dementia homes, one home appeared to have adopted these principles in its small dementia unit:

> The main lounge-diner has two tables with dining chairs, a sofa and three armchairs around a fireplace and television. There are plenty of small tables, paintings on the walls and music playing on a stereo in the corner. The doors open onto a small courtyard with a couple of benches and planters and sweet peas growing in planters. There are games and books in the corner and one of the tables has several painted stones on it.
>
> **(Fieldnotes, Care home 8, Morning)**

The physical environment was also important for staff as the design of certain homes, particularly those with lots of corridors and rooms off the corridors, made it difficult for staff, if they were inside a resident's room to supervise other residents and to communicate with other members of staff, which could impact on care delivery especially safety.

A number of staff recognised the benefits of purpose built accommodation:

Interviewer: Again you've worked in all sorts of different homes, what contribution can the physical aspect of the home…

Respondent: 'Purpose built is much better, much much better.'

Interviewer: In what ways?

Respondent: 'They're usually wider corridors, there's more light, they are fit for purpose. Older places, I've worked in rambling old houses, added bits on, added bits on, added bits on, cold, drafty corridors, just not fit for purpose at all so they have to have building work done, which disrupts the day to day living of the residents. But not fit for purpose is – I think this type of house is the best really'

(Interview with a Dementia unit manager, Care home 4)

As well as the physical environment, the extent to which the home provided a sense of being the person's home also appeared to be important.

Being a Home

All of the homes had philosophies and mission statements about promoting a homely environment, meeting the individual's needs and doing this in a way that demonstrated respect for the person's dignity. In many homes, reception areas displayed these philosophies and value statements. Some of the homes made impressive and genuine efforts in turning their philosophy into action so that the care home was the person's home rather than a place in which they were merely cared for.

> Michael and Maria also come in as well to help with those residents who need some help with feeding. A nice touch I saw today that gets a little away from the institutional feeling to the meal is that residents have the opportunity to have a sherry with their lunch. This was something that Rowland thoroughly enjoyed.
>
> **(Fieldnotes, Care home 1, Lunchtime)**

The domestic knocks on a resident's door "Hello, am I alright to come in?" I hear her chatting to the resident about last night's world cup football match....I decide to go downstairs to see what is happening. Two residents are having morning tea in the hall... There is nobody in the green lounge but there is music playing (Classic FM) and CD's on the shelf. There are newspapers on the table (large print), a newsletter and an activities timetable. There is a jug of juice on the side, a piano and a shelf with books and games. There is a large solitaire game on one of the tables. I go and sit in the blue lounge, a man is sitting by the window and another man comes in on his motorised wheelchair with his wife ...There is music on in here, a large TV, a well-kept fish tank and a radio and TV guide in large print.

(Fieldnotes, Care home 8, Morning)

The staff who don't wear uniform, are encouraged to eat their food with the residents as it is felt it promotes a greater family atmosphere, so after the main course is served to the residents the staff serve themselves. Amy told me how on night-duty the staff wear pyjamas and slippers as this gives a sense of normality and an important cue to residents that it is bedtime.

(Fieldnotes, Care home 2, Afternoon)

I chat to Irene for a while. The TV is on showing 'Flog It' – Irene tells me it's a great programme. Two other women come into the lounge from the bedrooms. One calls over to Irene "We've been playing cards. I nearly fetched you, because you like cards don't you? She calls back "I don't mind cards, except when I lose at gambling." Brenda, a care assistant, comes in and says to one of the women who have just walked in, "Dolly come to the table for me now it's nearly tea time…Are you coming to the table for tea ladies?" Dolly sits in the lounge. Brenda says "Are you having tea there, not at the table? …You can if you like." A visitor comes through from the bedrooms with a large dog. Irene calls over "Let's have a look at your dog then." The visitor brings him over to the lounge for a pet. After this Irene goes to the table and sits with three other ladies (there are no men living on the unit at the moment). One of them pours the tea, another pours the milk. Brenda goes out to get the trolley – she tells the ladies that's what she's doing and that she'll be back in a minute. When nobody is watching TV Brenda switches it off and begins to serve tea.

"Betty do you want cheese sandwiches or ham?" Betty replies, "One of each." Brenda serves each person in turn – sandwiches or toast with a cup of soup. Three ladies stay in the lounge area and Brenda brings their tea to them. I chat to one lady about the dog (gone now) – it is her daughter's. Brenda takes some tea and sandwiches up to the people who have stayed in their rooms.

(Fieldnotes, Care home 5, Afternoon)

In each of the above examples, either by the scale of the rooms and furnishings, the serving of meals to take account of personal preferences, making meals a social occasion, respecting the privacy of resident's rooms as their territory or normalising the home by staff wearing their own clothes and sharing the normal activities with residents, these homes attempt to create an atmosphere of 'homeliness' and assist residents to feel that they are 'at home'.

The physical layout of the home served either as a barrier or facilitator to exchanges and interactions between residents and was an important contributory factor in determining the home's atmosphere. In the example below this staff member's comments demonstrate how flexible some homes are in ensuring residents engage in activities that seek to promote a homely atmosphere:

'On nice days they can have sandwiches in the garden.'

(Interview with Administrator / receptionist, Care home 8)

In other homes the atmosphere was obviously institutional and little thought was given to promoting a sense that the space was the residents' as shown in the following examples:

Frank has finished his breakfast and wants Sheena, the senior care assistant, to get him a cigarette from the office. Sheena says, "Wait in the lounge and I'll bring you one." Frank replies, "I waited and nobody came" to which Sheena responds, "Go and ask Barbara" (the manager). Frank doesn't want to ask Barbara. Sheena crossly, "Frank I'm doing the tablets you'll have to ask somebody else." Then to the other care assistants, "Could somebody sort him out please?" Rachael another care assistant says, "I'll give him one of mine."

(Fieldnotes, Care home 5, Morning)

Other examples from the same home highlight the institutional atmosphere:

> Elsie wants to go to bed but is told she has to stay up until 8pm for her tablets.
>
> **(Fieldnotes, Care home 5, Evening)**
>
> One of the things I hear in passing is that all of the residents have to be in bed before the night shift come on at 21.00 as that is the afternoon shift's responsibility.
>
> **(Fieldnotes, Care home 3, Evening)**

In one home residents were not allowed to retain their personal toiletries in their own rooms:

> Respondent: 'I think the layout's pretty good because you've got your hallway with all the residents rooms and then you've got a cupboard full of all the like personal toiletries and you've got everything you need there and you've got the towels next to it and basically it's a hall and you've got what you need and then you can go and help certain people. I think it's a good layout, but the only thing I would say is it would be better if the toiletries were in their rooms because it's easier to then, you know you've got one lady you can sort out and then you could go straight next to the gentleman who may be next door, that's the only thing I would say, but because – '
>
> Interviewer: Why don't they do that then, do you know?
>
> Respondent: 'Well, I'm not sure but it's something to do with, it's personal, so they want it kept in the cupboard locked away, but to be honest it would be easier if it was in their rooms, but

I think that's something we're trying to sort out as well.'

(Interview with a Care assistant, Care home 7)

In the first example Frank, who is quite capable, isn't allowed to keep his cigarettes and is reduced to asking for one from the office. Even if this is done for the best of reasons, health promotion, safety or whatever, there seems no recognition that he is an adult who if he lived at home would carry his own cigarettes. Even the simple activity of determining what time to go to bed is removed from residents and this simple choice is governed instead by the practices of the home. In the last example, the removal of personal toiletries is difficult to explain as it would seem more convenient to have toiletries to hand in people's bedrooms.

Discussion

The findings described above highlight some salient features of the social care system in some homes in England. Owners and managers of care homes, representatives of the Relatives and Residents Association as well as people working in the sector described changes in regulation; in the nature and dependence of residents; in inspection policies and processes; and changes in training requirements. These changes are well documented in the Wanless review of social care (King's Fund, 2006) which suggests that the constant change and fragmentation is challenging for providers, making it difficult for them to keep up to date, meet changing responsibilities and plan for the future.

As well as change, there are also inconsistencies particularly in the way in which people are assessed for care, in the way services are inspected and in the fees charged so that something of a postcode lottery exists. This may change in future as a result of the Pembrokeshire ruling (Pitt, 2011) which requires that local authorities take account of need and demonstrate transparency in determining the level of fees paid to providers for supported residents. However, some of the greatest inconsistencies are in the area of training. There is no required qualification for entry into social care and, as will be shown in Chapter 7, this is a source of concern for providers with many stating that some training providers and assessors are better than others. Although government targets are that 50 per cent of care staff will have achieved NVQ level 2, there is considerable confusion regarding training providers and about funding for training. The switch to the Qualifications and Credit Framework (QCF) which is currently taking place adds to the general confusion. Within this framework there will be

new Health and Social Care level 2 and 3 diplomas and these will replace the Health and Social Care (HSC) NVQs level 2 and 3. The diplomas are made up of nine mandatory units and a range of optional units. The mandatory units are targeted to meet the Common Induction Standards (CIS) and are common to everyone regardless of the specific sector in which they are working. There are also options to take a generic Health & Social Care Diploma or to follow a specialist dementia or learning disability pathway allowing people to modify their learning to their specific role or area of practice. Overall, many stakeholders, as cited above, want to see more standardisation within the sector.

Consideration should therefore be given to: identifying measures to increase standardisation in terms of required staffing levels, fee structures and training, as this would make a positive impact on providers, service users and their families, as well contributing to improved quality of care. As the postal survey highlights (Appendix 4), the type of training undertaken was highly variable. It also suggests that to promote dignified care, training should address more than task focussed, mandatory training.

Despite the changes and inconsistencies, the care home sector must continue to provide a 'home' and meet the needs of the older people that it serves. As shown above, some facilities are better placed than others to do this, for a variety of reasons. Because many older people residing in care homes spend the majority of their time within the confines of the home (Kellaher, 1986) the physical characteristics of the home can play an important role in ameliorating or increasing the impact of both physical and cognitive impairment (Brawley 2001) and providing an environment where dignified care can be readily delivered.

There is also evidence that the physical environment can impact on the quality of care delivered by staff (Parker et al, 2004; Netten 1993; Keen 1989). Although a number of studies have been undertaken in relation to the design of care homes for people with dementia, (see for example, Cantley and Wilson, 2002), relatively little research has been undertaken within residential and nursing homes more generally, (Parker et al., 2004). Although this study did not set out to explore the built environment of care homes and the impact on residents and/or staff, the differences between the homes was something that made an immediate impression on each of the researchers. The importance of choice and control for the well-being of older people has long been established (e.g. Langer and Rodin 1976) and the findings demonstrate variations in the extent to which the homes were able to meet this need, those in relation to privacy, and a sense of

community. In particular choice about using outside space was most obviously restricted in some of the homes, even when gardens were safely enclosed. Where only one lounge was available there was limited choice for residents to exercise.

Earlier research has shown that meeting the older person's need for privacy is an important consideration in the design of care homes (Morgan and Stewart 1999). Private bedrooms and doors which avoid people passing in the corridors viewing the person were available in most homes, however sometimes these physical characteristics were overridden by staff propping open doors. Locks removed from toilet doors in one home, was another example of privacy being given little regard. The impact of a lack of privacy and sense of control and security on a person's sense of dignity is well established (Tadd et al 2005; Nolan, Davies & Brown, 2006; Tadd et al, 2011)

Closely related to privacy and dignity is a sense of self and identity (Tadd et al 2011, Nolan, Davies & Brown, 2006) and this can be enhanced by the opportunity to have personal objects in close proximity to reinforce feelings of familiarity and comfort (Lee et al., 2007) and a sense of continuity. Again homes varied in the extent to which this was achieved and while some homes worked hard to ensure residents retained a sense of their identity by personalising areas both around and within bedrooms, others removed personal items for no immediately obvious reasons.

The ability of homes to meet residents' physical and cognitive needs also varied as described above, however, for the researchers, what was very evident was the way in which the various homes took account of the need of residents to feel 'at home'. The claim that scale is an important consideration and that a homelike environment offers therapeutic benefits for frail older people has been emphasised in a number of studies (Ulrich, 1995; Brummett, 1997; Regnier & Scott, 2001; Barnes, 2002; Parker et al., 2004). In one home in this study uniforms were not worn and there was free movement and involvement of visitors. Although perhaps large buildings overall, in some homes, the arrangement of facilities were scaled down to domestic proportions. In other homes concerns presumably about safety put residents in the position of having to ask for things like cigarettes, despite the National Service Framework for Older People (Department of Health 2001) endorsing the view that older people should be able to 'determine the level of personal risk they are prepared to take when making decisions about their own health and circumstances.'

Conclusion

This chapter has described and discussed the findings related to the provision of social care at the macro level of the system as a whole and at the micro level of the individual home. Constant change and inconsistencies characterise the system as a whole making it difficult for both providers and service users and their families to steer a path through the complexities of the system.

The physical characteristics of individual homes are important in meeting older people's needs and some homes appear better equipped to adapt and modify practices and surroundings to ensure residents' experiences of care and their life in the home are satisfying, engender wellbeing and fulfilment and promote a sense of dignity. The extent to which a care home made attempts to be the person's home was something that struck each of the researchers and although some limitations were due to the physical characteristics of the buildings, the greatest impacts in relation to this were due to the routines of the home and the attitudes and behaviours of staff. These will be discussed in the following chapters however some conclusions are deserving of further consideration: in particular; training to enable managers to support workers, promote team working, promote quality outcomes and an environment that enables residents to feel at home should be considered.

Because many decisions directly impacting on residents, such as rules regarding personal belongings and freedom to engage in outside activities are taken by senior staff within the home. leadership and modelling of appropriate attitudes and behaviour are key to improving care quality. Also, attention needs to be given to ensuring that a broad perspective on dignity is brought to the fore in the care home sector. This needs to go beyond important issues of privacy and dignity during personal care, to consider the maintenance of personal identity and preferences.

CHAPTER 5

THE WORK

"All labour that uplifts humanity has dignity and importance and should be undertaken with painstaking excellence."

(Martin Luther King, Jr.)

Introduction

This chapter reports on the interview and observational findings relating to the work undertaken in the care homes: who does what; and how it is approached.

These are discussed under three main headings, 'Who Does the Work?', 'Teamwork' and 'Getting the Job Done'. 'Who Does the Work?' explores some of the issues surrounding recruitment and retention of staff, where the staff come from and the issues that this raises. Teamwork considers the importance of working together and highlights tensions within some of the teams we observed. Getting the job done considers being equipped to do the job, the fundamental aspects of the work and how these are approached, and how the rhythm of the home is given priority over the rhythm of the person.

Who Does the Work?

Although many older people live independently, or with domiciliary care provided in their own homes, approximately 460,000 older people are resident in the 18,462 care homes registered with the CQC (SfC, 2010). The estimated number of jobs available in the residential sector in 2009 was 596,000 and the estimated number of staff within these jobs was 563,000, highlighting a shortfall (SfC, 2010).

Like most Western countries, the UK is facing problems in relation to recruitment and retention of sufficient numbers of care workers to care for the growing numbers of dependent older people (Hussein and Manthorpe, 2006). Care work has been described as emotionally and physically challenging and poorly paid (Stone et al., 2003) and this no doubt is part of the reason for difficulties in recruitment.

As indicated in Chapter 1 the shortfall between the number of posts and the number of staff working in care homes means that all of the care homes within the study were concerned about recruitment in one guise or another. For some the fee structure precluded employment of additional staff, while for others there was a shortage of suitable people wishing to work within the care home sector:

Respondent: 'Yes, like the equipment or training or if we need to be more staff on the floor and stuff like that, if we're running short or some places they – they get the agency in, we can't, so it's hard. But we are trying to get some people here but it's not easy to get people here.'

Interviewer: What it's not easy to get staff?

Respondent: 'It's not easy to get staff even though there is high unemployment, but it's not easy because they will come here and they will see maybe the money are not good for them or the work is too hard and, er, maybe the whole process of induction I don't think we are doing it the way how we should be doing it, but it's not up to me really.'

Interviewer: Hmm, why do you think it is so difficult to get people to work in this area?

Respondent: 'Because the work is hard and the money is not so good and, er, not everybody wants to, you know, wipe the bottoms and stuff like that [laugh]. But it's not about that, to wipe the bottoms, it's just, er, you know, it's about to look after the people make them happy, but it's – it's hard to get people, that's why we are trying to get people from abroad or usually the most common staff in here is foreigner staff, not only … er we have like maybe ten per cent of English staff the rest are different, are foreigners, hmm, that's it really.'

(Interview with Senior care assistant, Care home 1)

'Because typically, a senior carer within this home is on £7.02 per hour! And you can go down to Sainsbury's or Morrison's and I'm sure for an hourly rate stacking shelves, it's going to be more than £7.02! It will be seven…eight, nine quid an hour…I don't know, whatever it might be. And local people aren't prepared to do that unless they have this vocational element to them.'

(Interview with Care home manager, Care home 4)

> The RN who is on shift is from South Africa but has been doing agency work in the UK for the past seven years. She tells me that she works in a number of nursing homes around the area. She tells me that all in all she finds them generally pretty good but she does find homes run by charities tend to be better resourced. She tells me that her overall impression of all the homes she has worked in, in the UK she feels that the vast majority of people are trying to do a good job but often they lack resources, particularly staff.
>
> **(Fieldnotes, Care home 2, Night shift)**

One staff member highlights the some of the problems in recruiting and retaining staff within social care:

> Iris says that in South Africa you are rewarded for length of service, all your qualifications etc – she thinks it is terrible that in the UK a brand new carer can be paid the same as someone with 10 years experience. They all talk about how 'anybody can go into care' and the low status of the profession here.
>
> **(Fieldnotes, Care home 7, Afternoon)**

Sometimes the location of the home posed recruitment problems such as those located in isolated, rural areas, or those in wealthy residential areas where the local population were reluctant or did not need to consider such employment:

> *'Recruiting staff can be a problem here as the home is in a rural location and is not on a bus route. Mm, I do tend to find, mm, sometimes the staffing can be a problem, er, particularly if morale's low amongst the staff, the carers and I know that I've got to keep it to a tight ratio, both for CQC regulations and otherwise for the staff as well, and I try really hard - it's - my worst bit.'*
>
> **(Interview with Care home manager, Care home 8)**

> A good proportion of the staff are from overseas with the largest groupings being Filipino and Chinese. The manager and the assistant manager tell me that recruitment is an issue that is compounded by the fact that local accommodation is so expensive. [I heard a report on the radio that the average rental cost in the London area is £20,000 per annum and bearing in mind the basic wage for a carer is £11,500 per annum…] The home has therefore converted some of its space to provide accommodation for overseas workers to help in attracting and retaining staff.
>
> **(Fieldnotes, Care home 4, Afternoon)**

The difficulties in recruiting and retaining staff impact on both staff and residents. In relation to staff, staff shortages result in individuals working long hours and junior staff often being left unsupervised:

> I get the impression that this manager has been brought in to try and improve conditions and from the conversations that I have had with her I very much think that her heart is in the right place. However she is trying to do this in the face of many basic challenges concerning resources and organisational culture. Her most basic challenge is staffing levels. Although I have not seen much use of agency staff a lot of the staff are working long hours and there are 'bare bones' staffing levels. I have seen two 18 or 19 year olds caring for 15 plus residents for a whole shift practically unsupervised.
>
> **(Fieldnotes, Care home 3, Morning)**
>
> The manager tells me that they are having to ask staff to work about 60 hours a week to cover care needs but she is loathe to ask them to work anymore as she feels care suffers. But staffing levels are very much an issue for her as a manager and she particularly feels that she could do with at least one extra member of staff on night duty but is restricted by both resources and the ability to recruit.
>
> **(Fieldnotes, Care home 4, Afternoon)**

Respondent: 'I'm based on this unit but if they're ever short-staffed I either go upstairs or next door.'

Interviewer: Okay. How do they handle it with short staffing? Do they get agency staff in as well or do they tend to work it with the staff that they've already got?

Respondent: 'Yeah. They tend to do that. I haven't really seen many bank or agency staff working here. If you've got say two people on each unit and you've got a floater downstairs, they take the floater for upstairs, so then you are short-staffed again. So it's a big circle.'

(Interview with Care assistant, Care home 7)

As shown in table 2, in all but two care homes a proportion of staff were non-UK born workers. Accurate figures for the number of workers born outside of the UK are difficult to come by, but the most recent figures from the 2008 ONS Labour Force Survey (LFS) shows that 20 per cent of 'care assistants and home carers' were born outside of the UK, although actual percentages vary with location (SfC, 2010). The same source shows that 50 per cent of these workers come from the Philippines, Poland and India, a similar pattern to that observed in this study. Research commissioned for Skills for Care (2009) demonstrated that employers' viewed overseas workers positively as they are perceived as enthusiastic, hard working, generally more qualified, younger and have less time off work than UK-born colleagues. They also provide a high quality of service. Similar views were expressed by the managers in this study:

> She [the home manager] told me that all in all she felt she had a very good team in the home. She said to me "You've probably noticed some of the issues. They are a good team but you get the divisions between the Filipinos, Eastern Europeans and the English, but most of them are good workers. I know I shouldn't say this because maybe it's racist but if I had my way I'd only employ Eastern Europeans and Filipinos as if I ever have any trouble it's nearly always the English staff."
>
> **(Fieldnotes, Care home 1, Lunchtime)**

'You know, I've worked with British carers and a lot of them are fantastic…but on the whole, you do…there's almost a…almost a cultural will to care from, say, Filipinos and Chinese. Sometimes… generally…I know I am generalising and I shouldn't do this, but you don't get that from your typical British carer.'

(Interview with Care home Manager, Care home 4)

The main problem experienced with overseas workers was in relation to communication, especially the effective use of the English language, which was sometimes an issue with other care staff and with interactions with residents especially when delivering care:

Respondent:	'I mean with the foreign staff as well, because what is it now, our last manager used to take them aside, if they didn't understand something, she'll well make a way with them understanding things, but no one seems to have time for them anymore and things like that.'
Interviewer:	I think that's an issue that's coming across, people whose first language isn't English and is there is a separate set of difficulties there?
Respondent:	'Oh definitely. I mean the staff they're good English most of them, it's just like there's some slang or something, like I don't know, it's just some words and it upsets us sometimes when they don't understand and they won't ask and they go and do something totally different. So there is sometimes a language barrier.'

(Interview with a Senior care assistant, Care home 7)

Respondent: 'It is, it can be, not for everybody. But we have got a lady here who's very hard of hearing, with a hearing aid, and she finds it extremely difficult to understand, you know, what some people, like you say, with a different language other than English, are saying. She even finds it difficult what we're saying some of the time so it – the – you know, obviously we know that the battery needs changing. But on the whole she can understand us but, yeah she does find it very difficult. And there are a few others that do as well.'

Interviewer: Hmm and again is there ever an issue with communication between staff as well?

Respondent: 'It can be, yeah it can be. Depending, yeah. I mean, to be honest with you, our own permanent staff that work here it's not too, too much of an issue, but if we have agency, and some of them are local as well as maybe from Africa or wherever, that can be very, very difficult. Yeah, that can.'

Interviewer: And can it lead to sort of problems with communication?

Respondent: 'Yeah because with the RNs as well. I mean we do the tablets, the Seniors do the tablets you see, so if they're trying to say something to me about the tablets I don't always, you know, I'll say "Well you best come and show me just to make sure we get this right". Because it's not as easy, is it, always to understand'

(Interview with a Senior care assistant, Care home 2)

In some homes there were strict rules about the use of language:

> ...on the other side of the corridor there is a tiny staff room where the staff retire to have a cup of tea or coffee and to eat their meals. So far this has proved a good venue to meet and talk with staff. It is not the most welcoming of rooms. It appears quite untidy and a little shambolic with staff notices on the board one of which I notice states quite strongly that staff must remember to speak English at all times in front of both residents and other staff.
>
> **(Fieldnotes, Care home 1, Morning)**

Despite the clear instruction that English had to be spoken at all times, this was not always adhered to as a later fieldnote shows:

> It is now about 18.30 and by now all the senior managers have left for the evening. When I get to the lounge two Filipino care assistants are there speaking Tagalog in front of a resident this is something that I don't think would go on during the day.
>
> **(Fieldnotes, Care home 1, Afternoon/Evening)**

Language competence was also an issue in relation to training:

> *'He told me that language was a key consideration in relation to training. From his point of view in an environment where a considerable percentage of the staff do not speak English as a first language any training that is delivered needs to take that into consideration if it is to be effective.'*
>
> **(Interview with a Senior care assistant, Care home 1)**

In Chapter 1, the influences leading to staff stripping the person of dignity, or showing a lack of respect for the resident's human value and worth were discussed and the under-valuing of care work, low societal status, poor pay, minimal training and poor working conditions (Innes, 2002) were identified as important factors. For care assistants who were not UK born, many would want to add racism to this list, which they experienced from both their colleagues and residents:

They all commented on the common experience of racism both in work and outside. As one of the group stated, "It might be illegal but what can you do about it?" They said as soon as people realise you are a foreigner their behaviour towards you changes. They seemed to feel very much at a disadvantage in this country. They remarked how in the Philippines they could be highly qualified but in the UK they were lucky to get a job as a care assistant. All of them told me that they send money home to their families in the Philippines and that while wages were better in this country they found that they were having to work all the hours that they could just to keep their heads above water in this country. They all seemed to want to return to their own country when they had enough financial security to do so. I also picked up some resentment to the way that they [the care staff] feel that they are exploited because of their work ethic. One of the group said "We Filipinos work really hard. When we wake up in the morning and feel sick we just shrug it off and go to work, but the English people they get up and they feel a bit bad and they go to the Doctors and sign off for two weeks or their cat dies and they take time off work and the employers know that."

(Fieldnotes, Care home 1, Afternoon)

At the end of the shift I get the opportunity to talk to Maria. She has been working in the care industry for the past twenty years in many parts of the UK. One of the topics that we talked about was the amount of Eastern Europeans and Filipinos working in the industry she felt that particularly the Filipinos were hard working and often highly skilled but that they had to endure a lot of racism from the residents and the Eastern Europeans.

(Fieldnotes, Care home 2, Afternoon)

When I first met the manager she told me the story of how she was treated when she first came to this country and how she felt she was exploited and encountered extreme prejudice from care home owners and fellow care home workers. She told me it is just not in Filipino culture to complain when they are exploited, they just tend to do the work and say nothing and this is something that she feels some care home owners and managers exploit and why they are keen to employ Filipino workers.

(Fieldnotes, Care home 3, Afternoon)

As well as colleagues and employers displaying racist attitudes, some residents were either abusive towards or refused to be cared for by foreign care workers:

> *'Because we used to have a gentleman, he would never have a 'coloured' – if we had 'coloured' carers on the unit, he would never let them go into his room. Never on this earth would he let them in his room. So it doesn't make our job any easier, when we start getting loads of these in, it makes it hard, because then they get abusive towards us, because if I have to have a carer with me and she's like Filipino and that, they take it out on me, which is not fair on them. I understand where they're coming from, but they've got to have the care at the end of the day.'*
>
> **(Interview with a Care assistant, Care home 3)**

Recent policy changes with regard to immigration were of concern to some care staff but of greater concern to care home owners and managers who relied heavily on non-UK born staff to deliver services:

> *'So I am really concerned that if the current focus on immigration continues…and on work permits, etcetera…that we will be moving people on, saying we will not renew your VISA or you are not entitled to stay in this country and there won't be the new crop of carers coming through.'*
>
> **(Interview with Care home manager, Care home 1)**

Getting the Job Done

Essential to being able to fulfil any role is being equipped to do so. This involves having appropriate information, resources and training. The subject of training will be discussed in detail in Chapter 7 so this section will mainly focus on information and resources.

Information

Much of the information that care workers require to fulfil their role concerns details of the residents. Many care workers spoke at length about the types of information they were given:

'Well when we come in, in the morning we have a hand over first to see where the residents are up to. All their care plans provide all the information we need, so we know how they're lifted or like what diets they're on, so we then like – I'll tell the carers what they're eating, what needs there are throughout the day, so that's what we do, yeah.'

(Interview with a Senior carer, Care home 7)

In some homes it seemed to the researchers that an inordinate amount of information was recorded. For instance in one interview with a senior carer, she complained about the amount of paperwork and then described the following records that were kept and continually updated:

- Monthly care plans
- List of whose monthly care plan is started
- Weekly weight chart
- Daily record
- Seniors daily record completed twice a day
- Entertainment Activities record
- Medication record
- Bath book
- Getting up and going to bed'
- Seniors' bath list
- Weekly charts
- Repair book
- Nail care
- Wheelchair assessments
- Absence and returns
- Healthcare record (e.g. opticians),
- Contacts record
- Admissions record

(Interview with a Senior care assistant, Care home 5)

It appeared to the researchers that much more effort was put into recording care than considering its quality. This seemed to be a result of the inspection and contract monitoring routines and served to prove what had been done, when and by whom. Many staff complained about a lack of communication especially between managers and floor staff:

'I think there's a lack of communication in lots of different care homes, because it's the care staff, office staff, management. There is just not enough communication, because I can walk in and say somebody is in hospital, nobody has told me that they're in hospital. So then I walk onto the unit, I think where's that person? Come down here and then it's just all, just one big row. The office, the management I don't…it's weird because the management don't tend to interact with the care assistants, it's the seniors, the 'red tops'. It's them that do all the interacting, that's where mistakes are made.'

(Interview with a Care assistant, Care home 6)

In some homes the issue of communication was taken very seriously as it was recognised that staff whose first language was not English need to understand any information they are given:

'Barriers to communication could be a whole host of things. It might be communication in terms of spoken English or written English or what have you. So we have to be pretty circumspect, pretty certain that anything we put out to the community of the home, is going to be understood by Chinese, Filipino, Lithuanians, Latvians, Polish, Russians…the whole host. So that's a mine field in itself. So anything that we put out there really almost has to be put across on a one to one basis to each person…and that's quite tricky.'

(Interview with a Care home manager, Care home 4)

Other staff felt that knowledge was essential to do the job safely and they felt it was wrong that people could walk straight in to care work without any qualification or relevant experience:

'But I think on induction they should either have an NVQ2 or previous experience or something, but they don't. It's like someone can just walk off the street, come and get a job here and they've got responsibility of 18, 17 residents, so it's ridiculous really.'

(Interview with a Care assistant, Care home 7)

She tells me that she feels that one of the biggest barriers for her providing quality care is the amount of inexperienced staff who are employed within the home. She tells me that she feels that due to staff shortages and high staff turn over the home will employ anybody off the street as she says.

(Fieldnotes, Care home 3, Lunchtime)

Resources

Also essential to doing the work are adequate resources. The care assistant below described the difficulties of having only one hoist:

> *'The people who need the hoist…there, there's more people downstairs really that we can do the hoist, but on the odd occasion well a lady fell out…fell the other week while she was seeing the district nurse in her room and we had to take the hoist upstairs and round those thin corridors and it was a nightmare. But we did manage it but really I think there should be one upstairs. We need one upstairs but that's just my opinion so.'*
>
> **(Interview with a Care assistant, Care home 5)**

This home in particular seemed short of basic equipment as the following two fieldnotes demonstrate:

> A lady, Janice, who is the daughter of one of the residents comes to have a regular Sunday evening hymn singing session with the residents. She invites people to join in, helps them over to one end of the lounge with some help from Judy. Whilst this is happening, Hilda gets out of her chair, and takes the Zimmer frame from the lady sitting next to her (who is asleep) and starts to walk out of the room. As she reaches the door Judy spots her and says "Where are you going with that, that's not your Zimmer" and takes the Zimmer frame from her, turns her around and brings her back into the room. [I wonder whether more Zimmer frames would help – several people appear to be able to walk with a little support]
>
> **(Fieldnotes, Care home 5, Evening)**

In the following example the lack of appropriate equipment meant that residents had to rely on staff for help, thereby increasing their dependence:

At lunch there are six people who require feeding and several more who are struggling a little but there doesn't seem to be any adaptive cutlery. Mary says to Sahira (about Tom) "He's very lucky to have you feed him…can you not teach him to do it himself?" Sahira replies, "He can't do it." Mary asks, "Has he tried?" Sahira says, "Yes he just drops it all over the floor."

(Fieldnotes, Care home 5, Afternoon)

In another home, well maintained wheelchairs were a major problem:

> A visitor (the pastor's wife) comes in to see her and asks her if she fancies a cup of tea. Margery says she would so the pastor's wife goes to ask Akinobu for a wheelchair. It takes several minutes to find a suitable one. They eventually get Margery into it and the pastor's wife says. "I hate to tell you this, but this is the one with the flat tires." And then to me, "I nearly had heart failure pushing this last time". It's another five minutes before Akinobu manages to find one with good tyres and he puts foot rests on it, there is no seatbelt on this one, though. They go to Sainsbury's for a cup of tea.
>
> **(Fieldnotes, Care home 7, Afternoon)**

> As a care home owner he expressed the view that this was one of his biggest challenges as he felt that increasingly they were being asked to achieve more and more targets but at the same time their resources, particularly in relation to the amount of fees they received was declining.
>
> **(Fieldnotes, Care home 1, Afternoon)**

Staff Shortages

Apart from facilities and equipment, the biggest resource issue was the shortage of staff which was reported in every home:

> *'It can be quite stressful coming in when there's a lack of staff, the staffing level. You do find in care, staffing is a big problem, isn't it.'*
>
> **(Interview with a Care assistant, Care home 6)**

> Enid fills me in at the end of the shift that the son who was in with the deputy manager earlier on in the day is unhappy with the care that his mother has been getting as he feels that people are not keeping enough of an eye on his mother during the day. Enid agrees that he is probably right but what are they to do when there are only two of them for fifteen residents and as she says the nurses rarely come on to the unit to help out.
>
> **(Fieldnotes, Care home 3, Evening)**

'And about the resources as well, because you can't do a few things if you don't have the resources for that. And it's about money. How can I be expected to release people from the floor to go upstairs with training videos and CDs and tick boxes? ...The thing that would most improve my job is being able to spend more time with the residents.'

(Interview with a Senior care assistant, Care home 1)

Respondent:	'I would say when we're being told you have to do activities, you have to do this, you have to do that and then you're told that you've got to go onto another unit and do something and you're taken away and you think well I can't achieve these goals because there not leaving me here to do it. And that to me is frustrating.'
Interviewer:	So you've got things that you need to do but because of, staff shortages is it, you end up being taken off the unit?
Respondent:	'Yes, yes. Once again having enough staff so that you can sit and listen to them so that you're not rushing when you're doing their personal care – you actually have got time to stay in the room with them and allow them to do as much as they can for themselves. I feel if we've got too much to do we will tend to do it all ourselves because we want to get it done quick because we've got other people to get up. And that's taking away their dignity.'

(Interview with a Senior care assistant, Care home 6)

The carers go off to work and so I talk to the nurses, Undine and Harriet. We talk about needing more staff and the dependency of residents – they have a 1 to 5 ratio – Undine tells me that's fine if the residents are self caring but if they need a lot of care it's not enough. "So people cut corners." Lucy arrives and we continue the conversation.

(Fieldnotes, Care home 8, Morning)

Interviewer:	Is there anything that makes it more difficult to provide dignified care?
Respondent:	'I've never really thought of it that way. It's hard to think things isn't it when you're actually bringing them through. I think it's when there's not enough staff, you know, if they take somebody away when there's not enough still on the floor um, that – that could be another one.'

(Interview with a Senior care assistant, Care home 5)

I say I'm interested in what makes it easier/harder to provide good care – Paul calls out "More staff" - they all agree. They talk for a long time about how frustrating it is not to be able to give the care they'd like to because of not enough time. Pamela talks about it being a 'Cinderella service', she says it's difficult to get the staff because there are some aspects of the job people don't want to do and the pay's not great but if you have a pay rise the residents' fees go up.

(Fieldnotes, Care home 8, Night shift)

Interviewer: What is the main thing that gives you stress would you say?

Respondent: 'Hmm I would say not enough staff. Yeah I think having, you know, personally myself if I know I've got these six jobs to do that is part of my routine, the work, it stresses me out the fact if I can't do them. So I hate to leave work knowing that I haven't done what I was supposed to do. So it tends to stress me out because you run about at the last minute, you know, trying to "Oh I've still got this bit to do" or "I'm supposed to do this, I've still got that bit to do". But because there maybe hasn't been enough staff – well it's Because it – it's difficult because I'm on nights, but because there's only going to be one staff per house, although I've always been mainly here myself, there's always been somebody to come and help me, either the RN or whatever and we get every… everything done but I think it would – that would stress me out the most. Knowing that, that you're expected to do these jobs but how am I supposed to do it when I'm here on my own and all these things have got to get done because the residents come first so hmm.'

(Interview with a Care assistant, Care home 2)

The staff shortages took their toll on some members of the workforce, as in the next example where a deputy manager was also covering for the manager:

I go into the office and find Peter, the deputy manager, he looks exhausted. I ask where would be best for me to go today and he's says I can go anywhere so I choose an area that I've not been to before. I ask if the manager is about and he tells me she is off sick for at least two weeks and probably longer as she has been having chest pains and she already has a heart condition. He is covering her work as well as being 'on the floor' he says some of his trained staff are on pre-arranged annual leave too so he's really short staffed. We have a long talk about this and how they just have to cope. He tells me that he was even doing the laundry yesterday as there was no laundry staff.

(Fieldnotes, Care home 7, Afternoon)

Teamwork

The degree of team working, relationships amongst staff and the management and supervision of staff, emerged as a key theme. We observed instances of individuals being flexible, stepping in to support their colleagues and working as a team. Whilst some affiliations were naturally stronger than others, the excerpts from the fieldnotes and interview transcripts provide examples of co-dependent practices and diffusion of expertise in the face of staff shortages and limited resources. In such circumstances, the ability to work as a team was essential to the smooth running of the home and the quality of life for residents, as this care assistant describes:

'We're a team, almost definitely, anybody who works in here, that's part, we're – we're all part of, er, that's what … we … it's our residents' home and predominantly it's their home and we're just here to – to make sure that they, the way I perceive it to be, we're here just to make sure that they – they can live their lives as comfortably, as safely and as – an as um fully as possible so anybody who works within the care home whether it be our gardener to the manager whatever you … whichever way you think of the hierarchy we're all here just to make the environment… everything is … they – they are our focus so we – we're all here, we're one team and we take one little part of that away and it causes problems within the home.'

(Interview with a Care assistant, Care home 1)

In this home in particular the above comments were borne out by the observations within the home:

> I was talking to Lani and two senior carers. Lani had been a nurse in the Philippines and Nelia was a midwife. Having talked to these two and having now seen them working on the ward it is obvious that they have a close relationship and cover each other in their duties there is a strong element of co-dependence in their practice. The care home workers are allocated certain residents which they are mainly responsible for. Obviously in practice this is difficult for them to adhere to without ignoring other residents. I have particularly seen it in practice with Lani and Nelia that they cover each others patients and look out for each other. I observed at meal time today and to be honest, and I was impressed at their practice in the face of very limited resources. Due to the needs of all the different residents there are various demands on staff as some eat in the dining room, some eat in their rooms and some need to be fed… Obviously I couldn't observe every case but the way that the chef and staff worked together and handled it impressed me and it struck me that a lot more personal care is evident here than is often achieved in a hospital setting at meal times.
>
> **(Fieldnotes, Care home 1, Morning)**

In this instance the observation of the extent of the team work extends beyond staff involved in direct care and also includes ancillary staff such as the chef. In this instance the researcher observes the chef find an alternative meal for a resident who does not want to eat their meal as presented. The researcher remarks that this is different from the situation in many hospitals where the nutritional needs of older people are often unmet (Age Concern 2010) which may be unsurprising as care homes are or ought to be, as identified in Chapter 4, the person's home.

In many homes teamwork was seen as a priority. In the following examples, a great deal of resource went into team building, not just among the care staff but with all administrative and housekeeping staff as well and this was reflected in how the staff worked together:

During the night shift there is one care worker allocated per unit and the care and nursing staff work across units to help each other out as they are required. I have noticed that the staff are very flexible and move in and out and between units and work things out between themselves in order to get the duties done as easily as possible.

(Fieldnotes, Care home 2, Night shift)

In other homes the concept of a 'family' was used to denote the close working arrangements between the staff, and the importance of socialising occasionally outside of work helped to ensure harmonious working:

'But I think if you – if you know your workers, get on well with the manager, get on well with your team, you shouldn't be stressed, I think knowing each other stops that stress. It's like if I didn't know any of the carers and they didn't know me and none of the carers knew each other, I think there'd be a lot of stress because they're not friendly because it's just a job to them but because it's like a family, we all go out every so often for a drink and meet up, er, don't discuss work at all because it's something, we're not out to discuss work, work's in there, not out here, so we just have a drink and have the time. When we come back we'll say, "God, last night were funny" we're like a little family, so that takes a lot of stress off you.'

(Interview with a Senior care assistant, Care home 5)

Some home managers demonstrated a sense of pride when their homes were 'running well' as the following example shows:

'I think what I enjoy is the kind of like…the really close team spirit that there is within the home. I enjoy working with the residents. I think…my previous background was in Health and Fitness and I originally went into Health and Fitness because I felt as though I wanted to help people and help society. I know that sounds a little bit high in the sky but I was quite naive at the time. I have to say that I enjoy being successful and running a successful home so when its full I feel quite proud…and when the team is running well and working together, that makes me feel really good!'

(Interview with a Care home manager, Care home 4)

In other homes there were occasions where lack of teamwork resulted in duplication of effort:

> Carol comes out of the bathroom and asks where she should go – Jenny says 'Either to your room, or downstairs…actually can I weigh you.' She explains it is monthly weight time. Carol follows her to the bathroom despite being weighed by Undine earlier. Once in the bathroom Jenny realises that Carol has already been weighed.
>
> **(Fieldnotes, Care home 8, Morning)**

The lack of team work was often evident to researchers:

> Another issue I feel I have experienced at this home is the lack of teamwork where care and nursing staff to do co-operate enough to contribute to the best care that can possibly be delivered.
>
> **(Fieldnotes, Care home 3, Morning)**

Teamwork was particularly important in reducing the conflicts and tensions that can occur, especially when working in stressful environments where staff feel overstretched. Examples of the types of tensions and conflicts are discussed in the following section.

Tensions in Teamwork

Tensions were observed in some of the care homes and were highlighted by staff during the interviews. These tensions stemmed from a number of sources, including working in teams that comprised: staff from different ethnic backgrounds and cultures; older and younger care staff; and regular staff and agency/relief workers. We also observed tensions between day and night staff and between nursing staff and other care staff. Limited understanding and respect for one another's roles and responsibilities, along with poor communication, underpinned a good many of the tensions that were reported to us or that we observed.

Cultural Tensions

Cultural tensions were evident even in homes where team-working was encouraged and for the most part evident:

Interviewer:	Yes just cultural understanding and cultural awareness, like you said something as simple as a boiled egg or something?
Respondent:	'Exactly and you've got somebody from – and diversity, we've got people from Africa, from Europe, China, Philippines and they all have their own cultures and sometimes they don't get on.'
Interviewer:	Oh yes, no, I've seen this, yeah.
Respondent:	'They don't get on. The Romanians don't get on with the Poles and…'
Interviewer:	For a lot of them there's a long history…
Respondent:	'Yeah it is and you can't just ignore that. But they have to work together and I say to them you have to leave all your differences at the door and you come in and you work together, because if you can't work together, I don't want you here. I said you might as well go and work in Tescos, because you have to work well as a team.'

(Interview with a Unit manager, Care home 4)

In another home where teamwork generally appeared good there remained underlying cultural tensions. This was evidenced in the excerpts below from both an interview transcript and an observational fieldnote:

'Yeah, and changing the culture. At the moment we have I think like eight people from Philippines and it's not easy to, you know, er, change their stereotype, their routines because it has been like that and every movement, every change takes time especially in this place because there is nobody really who can push it through. Then if you try, there is somebody else who will stop you again so you have to push harder and there is, there will always be somebody who will just try to stop you, you know, that's it really.'

(Interview with a Senior care assistant, Care home 1)

In the same home this staff member also discussed some of the issues and strategies adopted to foster good working relationships:

> He told me that over the years he had come close to resigning on a number of occasions but had always been persuaded to stay by the owner. He was quite open about the tensions that he saw within the home between the Filipinos and the rest of the staff. He told me that although he thought they were "lovely people" they had their own way of doing things and that because of that achieving change could be difficult. Politically within the home Zigmund and one of the Filipino staff have been promoted to senior carers to keep things sweet between the different groups. The Eastern Europeans and the Filipino staff are outwardly friendly to each other and do cover for each other and help each other out but the separate cultures certainly keep together and the Filipinos do speak their own language when no one is looking.
>
> **(Fieldnotes, Care home 1, Morning)**

These observations and quotations highlight some of the difficulties encountered in trying to promote teamwork amongst a multi-cultural workforce. Even where on the surface all seems well, some staff (Filipinos) were seen as resistant to change believing that their ways of working and approaching older people were best. In casual discussions with Filipino staff, it was evident that their approach to care was often based on their views of older people and how they should be treated. In Filipino culture older people tend to be revered and they engender feelings of empathy and devotion. This can often result in Filipino staff being reluctant to encourage older people to do things for themselves preferring to do things for them instead. As shown above this could be a source of irritation for other staff.

Wherever the workforce was multi-cultural there appeared to be the potential for conflict:

'I usually, if we come to a disagreement, we'll go to management, but I usually get my way at the end of the day, because their care abroad, they have to retrain here…. and they'll take my side to her side, because their nationalities and what they do in their nursing homes there, are different to what they do here and they try to bring that over here, but we don't want it over here. We want it done how we want it done, yeah……And what does my head in, they talk in their language, I hate it. I said if you've got something to say, say it in English, because we like to know what's going on. I'm very naughty like that, I will tell them off.'

(Interview with a Care assistant, Care home 3)

These tensions stemmed mainly from differences in beliefs about older people, their role in society and the provision of family care, as well as the use of foreign languages in the care home and the perceived effectiveness of training undertaken by staff from overseas.

As described above racist attitudes, by both staff and residents, also resulted in heightened cultural tensions and impaired the ability to work as a team.

Tensions between Day and Night Staff

Some tensions arose when staff felt they were unfairly treated or the work was not evenly distributed:

They tell me about how night shifts are difficult because of all the cleaning and laundry and that "if you don't do your work you get it at the other end" [get into trouble from the day staff]. They feel there is too much responsibility on nights as there is no senior carer on duty and although the manager is on call it's not the same. …They tell me that nights are very busy – people getting up, falling. "The day staff only have one job to do – caring, they can concentrate on that, on nights we have the kitchen, laundry, cleaning."

(Fieldnotes, Care home 5, Night shift)

She goes out and comes back with the cleaning trolley. She tells me with some irritation, that they have to do chores at night and that on the other units they can start straight away as the residents are all in bed but here they stay up later…'

(Fieldnotes, Care home 6, Night shift)

Tensions between Staff Groups

Tensions between different grades of staff were also observed, in particular between nursing staff and care workers. Often, these tensions arose due to poor channels of communication, a lack of respect and mutual regard for individuals' skills and limited insights into the contribution particular staff made to the overall delivery of resident care:

'I don't feel that I'm respected when nurses look down at you. At the end of the day you're a carer, you're a nurse, no different. You're still looking after residents and the carers are more involved with the residents because you know, you're helping them with breakfast and all those kind of things, but with the nurses it's like, give them medication, write reports, it's things like that and it's two different roles but some nurses do look down at you and think, oh, you know, do this, do that and I don't like it when I'm told what to do, because you know sometimes you feel like, well why don't you do it, because you know I'm busy with someone else. Yeah, they do look down at you.'

(Interview with a Care assistant, Care home 5)

'Yeah and I think another thing that, erm, niggles me a little bit is people don't sort of respect other people's job roles. I know people just think of me "Oh it's [Name], she just sits in the office all day shuffling papers". And it's not that at all, I don't think they realise the depth that it actually does involve and people don't and I am, you know.'

(Interview with an Administrator, Care home 3)

> Later Laura was telling me about the tensions that exist in the home between the nursing and care staff…The tension between the nurses and the carers is because the nurses have been complaining to the management that the carers are not responding quickly enough when the call buttons are pressed but as Laura says, "Well, what do they think we are doing, if we are busy what are we supposed to do?"Laura believes that it is a hierarchy and race issue as she believes that the Indians [the nurses] look down on the Filipinos [care assistants]. Again as she says: "It is on the screen in front of them and they just look at it. If we are not responding we have reason. Why can't they help us out? We are all here to help each other but it seems to me that those in the dark blue [nurses] see it below them to do what they see as carers' duties."
>
> **(Fieldnotes, Care home 1, Afternoon)**

A strategy adopted in one home to emphasise teamwork and bring an air of normality for the residents, all of whom had dementia, was disposing of uniforms:

> *'Well, it's nice to just feel part of the team. We work with the residents and the residents being as they are. I mean, none of us wear uniforms. The care staff don't have uniforms so they all treat us the same.'*
>
> **(Interview with a Catering assistant, Care home 2)**

Tensions between Older and Younger Staff

Older staff were sometimes critical of younger members of staff; they raised concerns about their level of competence and their ability to provide high quality care as well as their level of motivation and commitment to looking after older people:

> *'I think the staff they're not trained enough and I think because they're young and they're old, oh, it don't matter, let's just get her done, do you know what I mean?.... with the new staff, they're not having enough training to get them old people friendly…. I mean they are coming in, they're doing their makeup, sod the makeup, you're here for these at the end of the day you know.'*
>
> **(Interview with a Care assistant, Care home 3)**

'I mean we've got one on the unit, who will never make a carer, not in a million years, she'll make a carer. She's more worried about her makeup…. And her hair extensions, false nails, you don't care with false nails for a start. Oh I can't do that, because my nail might come off. Waste of time, waste them employing her, just a waste of time.'

(Interview with an Administrator, Care home 3)

This was highlighted as a particular issue in the context of dementia care, with the unique set of challenges this can bring:

'I think it's because it takes a certain type of person to work on there and the team that we've got on there are all very laid back and you know, hmm, are just – it's just a lot of the staff on there are the older staff that have worked here. And I just feel that we've probably got that bit more experience than the younger girls. We've had quite a lot of training on there. I've just done my Level 2 in Dementia Awareness. Hmm, so that was quite intense.'

(Interview with a Care assistant, Care home 6)

The importance of mentoring younger, less experienced members of staff in the provision of dignified care was recognised by some, however, the mentoring role appeared to have developed by default rather than by design. This, of course, is no substitute for formal training. Some of the staff we spoke to and observed raised concerns about the level of training provided to new staff, believing it to be insufficient:

'I've come in and so I don't know whether perhaps I would have liked a bit more support.'

(Interview with a Senior care assistant, Care home 6)

Staff were also cautious of relief workers brought in from agencies to cover periods of staff sickness and annual leave; their lack of familiarity with the home environment, limited understanding of home routines as well as limited engagement with those working there, was thought to compromise the delivery of effective care and increase the risk of poor practice.

Leadership and Supervision of Staff

Effective leadership and ongoing supervision of staff was considered critical to the delivery of high quality, dignified care, especially acting as a positive role model:

> *'On an individual basis, I'd like to think that the staffs in the home see me and hold me as an example of how to behave. If they see me interact with the residents and with the relatives then they'll hopefully hold that up as some kind of a beacon, some kind of an example of how they should behave.'*
>
> **(Interview with a Care home manager, Care home 4)**

> *'I think you need to – if you're in a home where say there's not a lot of staff and them staff are left on their own, well they've – you're really giving them licence to do what they like if – but here, like [Name], the boss, she works with everybody, she goes round everybody so she gets to know them, she works with them and gets to know the staff and she knows people's hmm, you know, plus points and maybe their negatives points and tries to help them in their negative poi… you know, points, where they're may be not be. She is a clinical, clinical manager.'*
>
> **(Interview with a Care assistant, Care home 2)**

> *'I think this laissez faire management style is – you can have all this good start – it can be undone by that very relaxed management style. You've got to have strong leadership and go back. The review process is critical, as critical as the starting week.'*
>
> **(Interview with a Home trainer, Care home 4)**

Lack of effective channels of communication between managers, team leaders and frontline staff were identified as a particular problem in two of the homes we observed:

'Um, management [laughs] can be a big problem….Lack of communication, big lack of communication here. There's a lot of cliques here. Cliques who – with the management, who get away with a lot. There's people who work really, really hard and they're no better thought of for it and also get away with nothing, which to me is unfair.'

(Interview with a Senior care assistant, Care home 6)

'I think the communication with the management sometimes, because when we are asking for things it's not many times it's happening and you know most of the time the answer is 'no', so I mean and that – that is the, I think the most frustrating thing really, if we want to get something and we can't.'

(Interview with a Senior care assistant, Care home 1)

The failure of management or those in leadership positions to recognise and or understand the challenges faced by frontline staff in delivering care and how this could lead to feelings of anger and disillusionment, as well as being stressful and demoralising was recognised by some managers:

Respondent:	'Well, it's not important about being friends, it's important about - I want the staff to know that I could be the first rung on the ladder to get them to - if they've got a problem that needs taking further up the ladder to management, I'm happy to be that person, do you know what I mean, because I don't like it when things do brew among the staff. I try and be approachable anyway, so.'
Interviewer:	Yeah, okay. So it's a people management thing?
Respondent:	'Yeah, you've got to be a people person, you can't just sit there and shut the door and say 'not today thank you, I'm not interested.' It really wouldn't get me anywhere, if people think I was a bit of a miserable person, I wouldn't get anywhere with my jobs.'

(Interview with an Administrator, Care home 8)

'My biggest concerns I think are sometimes it's not the people we bring in to care for people, it's people like me where the problem is you know, the problem lies with the way we want to run these places and structure it and organise it and our own anxiety at looking as if we're not good at our job or failing or whatever, that's where – where things I think go wrong.'

(Interview with Care home manager, Care home 2)

The availability and continuity of managers or those perceived by the staff as leaders, also emerged as an important issue. Frontline staff raised concerns about turnover of senior staff and how the perceived lack of leadership in managing change in some homes gave rise to feelings of ambiguity and uncertainty:

'No, well we had like a deputy manager called Katherine, she did everything like if the staff had problems we'd speak to her, even family problems she'll understand and we'd go and talk to her in a room, but the manager at the time just left it all to Katherine, but she's left now and everyone has just gone downhill since then. I mean Gloria came in, she had her own plans but she got half way through them and she decided to leave, so that didn't – that's wobbled us a bit again so we don't know where we're up to kind of thing……. I mean now I'm senior I've got my team now and I've picked them up a bit and we're having little team meetings and things, but not all the units are doing it, that's just because I'm senior. I think, oh, I need to pick everyone back up. So we are trying things to pick it back up, but there's no one to listen to us if – say if one of the carers had an opinion which they bought to me, because we've got no manager we can't talk to anyone about it, apart from the nurse in charge ….I think there should be more support from people higher as well. I mean they should come in and ask us how we feel about – like what this is about now, I think more people should come in and do it…. But they just don't seem to listen.'

(Interview with a Senior care assistant, Care home 7)

At times this lack of continuity was confusing for residents and relatives too:

'We still have family saying that they feel unsure about who to go to and so on.'

(Interview with a Care home manager, Care home 2)

The lack of positive feedback in some care homes also did little for staff morale:

'I know we get paid for what we do and that should be enough but we do get criticised quite a lot in our general meetings and it would be nice sometimes to have a bit of praise.'

(Interview with a Home trainer, Care home 4)

Fundamental Care

Care work is hard work and as seen from the above, it is often poorly paid and stressful due to a shortage of resources, including staff. The next section considers what the work consists of and how it is undertaken. Before that however it is worth making some general observations on our findings in relation to direct care. The focus of care, certainly in seven of the homes was task based rather than individualised, often done according to time rather than residents' need. Likewise, the postal survey (Appendix 4) indicated that the most common type of training was task focussed. This is not simply a reflection on the care staff lacking interest in the residents as individuals, but rather it may also reflect the low level of staffing within the sector. In interviews with care workers, when asked about their role in caring for older people all spoke in great detail about the list of tasks they complete (sometimes with the timings). They often referred to the residents according to the task in hand, such as 'feeders'; 'doubles' referring to residents who require two people to get them up or provide intimate care; similarly 'singles' for those residents who need only one person to assist; and 'walkers' who require minimal help with mobility.

When staff were caring for residents in their own rooms, those residents who were mobile and in the lounges, for example, were often left for long periods of time without supervision, resulting in calls for assistance going unanswered. On many occasions researchers had to intervene to try and find someone to help. The majority of staff were aware that these situations were not ideal and many spoke about how having time to spend with residents and getting to know them as people, would bring them real job

satisfaction as well as contribute to the delivery of more individualised, person-centred care. On very few occasions did researchers observe residents being taken outside into the gardens or into town for a coffee and the majority of residents spent their days within the confines of the care homes. Creating a work environment which creates job satisfaction is an important aim, as chapter 3 demonstrates that higher levels of job satisfaction are associated with positive approaches to dementia care, fewer negative attitudes, less emotional exhaustion or depersonalisation and greater mastery.

Eating and Drinking

One of the most important aspects of fundamental care is the provision of nutrition for residents. As well as providing nutrition, eating and drinking has important social aspects. In many homes, bibs or plastic aprons were used to protect residents' clothes, but in others, napkins were used and were deemed more appropriate for adults. In most homes the residents were offered a choice of appropriate food and those needing help were for the most part assisted sensitively and calmly using the opportunity to engage:

> From 11am the smell of bread baking permeates the air from the bread machines in the kitchen area. This is done to stimulate resident's appetites and provide a sense of time. The male care assistant announces to the whole unit: "Ladies and Gentlemen it is now lunchtime." I notice that glasses are used to serve water rather than plastic beakers and there is no squash served and that residents are not given bibs but serviettes are placed under their chins. On the menu today there are chicken nuggets, savoury pastry and sandwiches. A care assistant sits by the side of Alan and helps to feed him. She talks to him saying, "Thick soup isn't it? You can eat it quicker than I can spoon it in. It's nice having the music on in the background isn't it? You're enjoying it aren't you?" After he has finished the soup, she encourages the resident to try the finger food, "Take this Alan in your hand it a savoury pastry I will put it in your hand." Another care assistant comes over and asks, "Alan do you want a cheese sandwich or ham and cheese, you choose, is that what you want?"
>
> **(Fieldnotes, Care home 2, Lunchtime)**

In other homes great efforts were made to ensure that eating was seen as a social occasion:

> The home has started having monthly restaurant evenings – the residents were asked what they missed most about being here and one of the things that came up was going to a nice restaurant so they have set up a system where every so often the dining room is turned into a candlelit restaurant and six residents (when it's their turn) plus two guests each are invited for an exceptional meal – invited into the blue lounge first for aperitifs and canapés and then they go through to the dining room for their four course meal. The resident's guests pay a small fee for their meals. Lillian [the manager] has given up her own time to come and waitress at one of these events and they are very popular.
>
> **(Fieldnotes, Care home 8, Morning)**

In one home, however, feeding residents was reduced to a perfunctory task to be completed as quickly as possible:

> About half of the residents were wearing plastic aprons. The lady at the table next to me begins complaining very loudly, 'Cold tea, bloody awful, supposed to be your dinner. If that's your dinner it's a disgrace, wants reporting' to which a carer, Sahira, comes over and asks, 'Do you want a fresh cup of tea Betty?' The lady replied that yes she does and the carer brings her one saying 'Alright lovey?' A male carer, Jim comes in and asks one lady 'Do you want sweet?' to which another carer, Judy, replies 'She's had cheese.' One lady requires help with feeding and three different carers help her at different times 'Are you eating this Elsie? Take your time, do you want a drink? Take your time.' Cheryl comes to help a lady near me to drink her tea 'It's cooled down a bit now would you like a bit?' Table 1 have had their main course and are now having yoghurt for pudding. Jean spoons the yoghurt into Amy's mouth – there are no words spoken and she spoons mouthful after mouthful. I time it and note that it she presents a spoonful every 3 seconds. Amy barely has time to swallow before the next spoonful is there. There is no opportunity for her to savour or enjoy the food. This continues until the pot is empty – the last spoonful is preceded with 'One more' but that is the only conversation. I can see that when there are several people

> who need help with eating some staff want to do it as quickly as possible. At other meals I've noticed carers give a spoonful to one person, then a spoonful to the next and the next then back to the first – and at the time I thought it was a bit like a conveyor belt, but I have to say it's got to be preferable to this 'speed feeding'.
>
> **(Fieldnotes, Care home 5, Lunchtime)**

In this home in particular there was a tendency to use 'elderspeak' especially at mealtimes which patronised and reduced the resident to a child like status:

> It is midday in the dining room. Karen to Ruth, Bill and Amy, "Food is here, cottage pie – Yum. Mmm, yummy yummy." She then proceeds to feed Ruth: "Right Ruth open your mouth. Eat it. Well done...good girl…open your mouth.. don't talk while you eat… open wide… Ahhh…it's lovely…..nice?" Elsie is brought in and Sarah tries to put a plastic pinny on her Elsie says "I don't want it on I'm just going out." Sarah: "Everybody is putting theirs on now." Elsie doesn't want it and takes it off then starts to remove her underwear. Sarah calls for help and she and Sheila take her out of the room. She is brought back five minutes later and a pinny is put on her. Sahira is now feeding Ruth "Ahh she's lovely" – she gives Ruth a hug. "Ruth – open wide. Ooh that's nice."
>
> **(Fieldnotes, Care home 5, Lunchtime)**

Rather than being a pleasurable activity, some staff approached feeding as a task to complete as quickly as possible, ignoring the residents that they were feeding and instead chatted to other care staff:

> Raam brings Sheila her rice pudding, Sheila is trying to say something but he just spoons in the pudding. I notice him waiting, spoon raised with the next spoonful before she's swallowed the first. All the staff are now having a discussion about how the floating member of staff should come over to this unit in the afternoon. Gloria: "They have more to get up in the morning but not in the afternoon …and here with all the feeding." This is discussed across the room so everyone can hear. When the senior comes back in she asks Tom again if he wants some help, he says he does but then won't take the food – she offers to warm it up for him but Tom's not sure if he wants it.
>
> **(Fieldnotes, Care home 7, Lunchtime / Afternoon)**

Despite being very busy and having a number of residents who needed help with feeding, some care assistants managed to feed more than one resident simultaneously whilst maintaining an air of calm:

> The female carer doesn't rush as she feeds people but she gives a spoon to Deirdre and then one to Ernest. Given how few staff there are, this is probably one of the few ways to give people their meals whilst the food is warm. To do it one at a time would mean either rushing or some people having to wait longer to eat. The female carer is feeding Ray and Nigel at different tables so she gives Nigel a couple of spoonfuls and then goes over to Ray. Another carer is taking food to the bedrooms to feed other residents.
>
> **(Fieldnotes, Care home 7, Evening)**

Elimination Needs

Although no observation of intimate care was undertaken, on a number of occasions residents within the public areas needed to use the toilet. There was considerable variability as to how this was dealt with within the care homes. In the following example a woman needs the toilet but the first reaction of the carer is to scold her:

> Pat comes back in and sits down. She says to Michael "Can you help me love?" he says he won't be a minute. She calls out for attention several times. "Excuse me" and "Somebody's wet everything here." I don't see what she's doing but Michael says "Come on don't do that here, you've got more sense than that – I'll take you to the bathroom" and leads her out of the room. As they walk, Pat is distressed. "They're all talking about me." "No they're not, they're all just talking." "They are because of all the wetting." "Don't worry we'll sort you out."
>
> **(Fieldnotes, Care home 5, Morning)**

For some residents who were incontinent the policies concerning incontinence pads impacted both on the residents' comfort and quality of life and the way care staff felt about their work:

> Residents are assessed and issued with a specific amount of various strength incontinence pads which are supposed to last them a specific length of time. Even though the resident may feel uncomfortable the staff are encouraged not to change the pad until the indicators display that the pad is full. One care assistant tells me that this makes her feel cruel as she feels she is not responding to the residents' needs but is rather responding to the directions of the pad people.
>
> **(Fieldnotes, Care home 1, Night shift)**

In the following scenario, the staff failed to recognise the signs that a resident needed the toilet and ignored his repeated requests:

> Steve is pushing back in his wheelchair. The brakes are on. I hear him mutter "Where's the toilet?" He taps the arm of the man sitting next to him "Where's the toilet please?" He gets no reply. Steve tries to get up again, Brian stops him. Steve is trying to say something but Brian talks over him. "Steve, please sit down. I'm making some toast for you, Steve." There is no effort made to find out why Steve is getting up. This happens three times, Brian has to run as Steve is very unsteady. Someone calls from the kitchen. "Bring him something to eat quick." Brian brings Steve some toast he doesn't eat it, he mutters again "Where's the toilet?" But nobody hears. Steve asks Marion where the toilet is, she tells him it is just round the corner. Steve gets up to walk, Marion says "But you can't go on your own." Another care assistant says, "Come on, Steve, eat your toast." I tell her Steve has been asking for the toilet, and she says. "He's only just got up" and then to Steve. "Steve, eat some more breakfast and I'll take you to your room." Steve eats some toast. Irene is doing the tablets. She comes over and says to the care assistant "Steve Wilson?" The care assistant points him out. He says to Irene that he wants the toilet. She doesn't hear properly, and asks him if he's all right. He says "I want a wee." She replies "Will you just take your tablets for me and then we'll take you quickly." Steve agrees and takes his tablets. Irene says, "Okay, there's your toast." And she places the toast in front of him again. Nobody takes him to the toilet. Ironically I hear a care assistant in the kitchen, saying "Ooh I'm bursting for the loo!" Brian takes Steve out of the dining room in his wheelchair: "Hello Steve." He takes him through to the lounge and sits him in an armchair. I go

> through and sit next to him. He turns to me. "Hello love", and then he mutters something about the toilet again. I tell him I'll ask someone, she overhears and mouths across the room, to me, "I'll take him." She comes over and helps him into any wheelchair (she doesn't use the footrests) and takes him to the toilet. It's been approximately 50 minutes since I heard him first ask the man next to him. She brings him back and says loudly. "There you go Steve, you needed that, didn't you. I nearly weed whilst he was doing it."
>
> **(Fieldnotes, Care home 7, Morning)**

Another example in the same home was rather more distressing as a resident who had been incontinent had to wait because a student on a work placement was eating a chocolate biscuit and this was viewed as acceptable by the nurse in charge:

> The nurse in charge of the next unit today comes in – he goes to see Peggy who is standing up again: "How's my sweetheart?" – he signals to Michaela that there is a smell (of faeces) and say's "That's why she's up." Michaela, who is sitting eating a Wagon Wheel says "I can't do anything at the moment". Sarah comes in and the nurse asks them both to change her as soon as possible. Michaela says "I don't fancy changing her while I've got a mouthful of chocolate." Sarah says "Who are we talking about?" The nurse replies "Margaret, she's pooed [sic] love."
>
> **(Fieldnotes, Care home 7, Lunchtime)**

In some homes there was a tendency to take people to the toilet at predetermined times as the following shows:

> Staff tend to check people's pads and take them to the toilet etc after lunch at the start of the afternoon shift.
>
> **(Fieldnotes, Care home 8, Afternoon)**

In one home, experiential learning was used to impress on staff what it is like to be dependent on someone else to fulfil basic human needs such as going to the toilet:

'I make them feel what it's like for somebody to take somebody to the toilet. Like they get to the door here and they are just dying, because I say right, I have the pads and everything, the gloves, I say come on, toilet, come on I haven't got long, quite serious about it and they're thinking oh my God and they come back and I say look, that's exactly what your residents are feeling every time you take them to the toilet.'

(Interview with a Unit manager, Care home 4)

Washing and Dressing

Washing and dressing affords the opportunity for residents to maintain their identity and for staff to demonstrate that they understand the need for residents to maintain their individuality and their bodily modesty. This can be very challenging for staff as a number of residents, especially those with cognitive impairment, appeared to have lost their inhibitions:

Pat is pulling her skirt up again. The care assistant jumps up again and goes over to her "Don't Pat, there's gentlemen in here – you don't want to go flashing your legs." A few minutes later Pat is pulling at her skirt again. Linda notices that her underskirt is hanging lower than her skirt and takes her off to sort it out. Her underskirt has slipped down again. Linda spots this and says "Come with me to sort it out" but Jean comes over and sorts it out there and then in the lounge.

(Fieldnotes, Care home 5, Evening)

In the lounge Dorothy has stripped to the waist getting herself ready for bed. Ann runs in with a blanket to cover hr up Ann: "You can't do that there are men about in the lounge." Dorothy replies, "Oh get away with you, it's no bother, they are not that sort." Ann manages to get her to cover up.

(Fieldnotes, Care home 4, Evening)

Peter wanders into the lounge without his trousers. Judith escorts him back into his room.

(Fieldnotes, Care home 2, Lunchtime)

At times staff found it difficult to dress residents neatly and felt guilty about taking residents out in a dishevelled state:

> Brenda comes in with her stockings round her shins, she's not sure what is happening "They say I'm going to the hairdresser's" I tell her Renee will be back in a minute to explain. Elsie tells me "She gets very confused – she forgets what flat is hers every night." Brenda says "I thought the hairdressers was in this building but they say I've got to go outside." I say that I thought the hairdresser's was here too Renee says "So did I but I've been told to get her shoes and coat on." Renee goes out again and comes back with Jim in a wheelchair. She then brings Brenda's shoes but they are very tight – Brenda wants her slippers. Renee tells her she can't wear her slippers outside and Brenda replies "Then I need to have my hair done inside." Renee gets another pair of shoes and puts Brenda's cardigan on. One stocking is still below her knee. Sarah comes to collect Brenda "Are you ready? Lets pull your bits up [stockings] …are these going to come down again?" Renee says, "Yes she could do with some with the hold ups" and Brenda says, "They keep falling down." Sarah says, "We should ask her family to bring some in." Brenda asks, "How many times do I have to have my hair done?" Sarah replies "Just once." Brenda "I seem to be having it all the time." Sarah explains, "You've not had it done for a while because there's not one here." Brenda asks "Where am I going then?" Sarah tells her that they are going on a minibus into town and that she will stay with her and bring her back. She tells her there are quite a few people going. Brenda seems happy with this and Sarah and Renee help her out to the minibus. Renee tells me "I feel awful taking Brenda out with her stockings like that. All the clasps have gone but she won't take them off and she won't wear tights. What can you do – she needs hold ups really."
>
> **(Fieldnotes, Care home 6, Afternoon)**

Because intimate care was not observed it was not possible for researchers to gain any sense of personal hygiene practices, although in some homes residents appeared to be washed according to when their name appeared on a list or in the bath book rather than when they needed or requested to do so:

Andrea and the carers all come to the nurses' station to discuss who else needs a bath, they check in a book. "Mrs Green, I don't think she's had a bath this week...I'll do her."

(Fieldnotes, Care home 8, Morning)

Moving and Handling

Another aspect of personal care was moving residents from communal rooms such as the lounge to the dining room, the toilet or their bedrooms. On the whole this was done sensitively as many residents were dependent on assistance, with some requiring hoists. The majority of staff were concerned about ensuring residents' safely. Sometimes however this concern with safety could lead to poor practice as the detailed extract below shows.

One lady, Jean is lying on a sofa, she keeps almost rolling off and needs to be helped back. Jim tells me she is an ex nurse and has a daughter in Australia who calls her dad every day. He says she should really have one to one but it's 'this' and he rubs his fingers together to indicate money. He and another carer put a padded footstool and a table in front of the sofa as a barrier… Simon comes in from the next unit to give Bob his medication (as the two units are connected, residents tend to use both) He asks me how things are going and spots Jean about to fall off the sofa. He helps her back. This happens several times over the next few minutes so he asks Sarah to fetch the floater to come and sit with her. Sarah says she'll sit with Jean for a bit. Sarah talks to her "Jean, are you comfortable? Where are we going?" She speaks very politely and seems genuinely warm. …I have a long chat with Sarah, she says she feels terrible keeping Jean on the sofa like this but that she falls a lot, or will crawl around but then Jack will trip over her. I ask if she will walk with somebody helping but Sarah says she really needs two people. She talks about working in care – this is her first care job, she says they need more staff, but ones who are genuinely caring and not just in it to earn money. Sarah needs to start helping other carers with some of the residents but as soon as she gets up to go, Jean tries to get up, Sarah runs back and puts Jean back on the sofa. She's really worried about leaving her and says so to Simon. They put two tables as barriers and Sarah goes to tell the deputy manager and Jim. Jim comes in

and tells me how difficult it is, he hates blocking her way but she keeps falling and they don't have enough staff to have someone there all the time. He notices a smell of faeces and says to Sarah that this may be the reason that she wants to get up and that she won't settle until she's changed. Sarah says they've just started changing someone but that they'll come to Jean next. Jim stays for a while until the floater comes. He says he hates it that she has to wait to be changed. The floater sits with Jean. She is a young Asian woman. After a while Sarah returns with a lady in a wheelchair and asks another care assistant to help her put the lady in her chair. The care assistant gets up and Jean tries to get up so Sarah says "Oh don't worry about it, you stay……oh maybe just really quickly." The care assistant quickly helps Sarah and then runs back to Jean. Sarah says that Jean is next. Once she's changed the staff bring Jean back in her nightie, they put her back on the sofa and give her a blanket. They put two tables and a footstool in front as barriers. Jean tries to get up. The tables make it more dangerous I'm sure as she could trip over them. Jean is getting up – [I can't watch her fall so I go to sit with her]. She's determined to get up so I make sure she doesn't fall. Jim comes over, we sit her in the next chair and he goes to get her medication – co-codamol. He hopes the codeine phosphate will "Settle her a bit". While he's out she gets up again to walk so I give her my arm and walk down the corridor and back. Jim comes back with a chocolate mousse (with her liquid meds in it) to feed to her. He lies her back on the sofa to feed it to her. She is quite out of breath after the walk down the corridor. She keeps trying to get up and hits him. He says "C'mon Jeanie, c'mon sweetheart…that's nice isn't it…we're nearly done…come on sweetheart. Lie down let's put your blanket on...I don't want my girl getting cold."

(Fieldnotes, Care home 7, Afternoon)

In the above example the staff were genuinely concerned for Jean's safety and their actions, including hiding medication in food and barricading the woman, although appalling, were done with the best of intentions. It was also unlikely that any assessment of risk had been undertaken, as if it had, it is doubtful that such crude measures would have been taken to restrain Jean (Clarke and Bright, 2002). Yet if anyone had suggested that their actions could be viewed as abusive, the carers would have been shocked and distressed, and with so few staff, and little guidance on determining

whether their actions would be viewed as legal or illegal under the Mental Capacity Act (MCA. 2005), it is difficult to see what other actions could be taken with staffing levels and facilities as they were. Other staff in the same home were less concerned about how they dealt with residents who were unsafe on their feet:

> Claire brings cups of tea in for people. Harry tries to stand and she shouts out "Sit down Harry." Then whilst carrying three cups of tea, she sort of reverses into him and 'pushes' him to get him to sit down. She gives a cup of tea to Maureen and Steve and then feeds Harry his – he won't hold it properly and keeps spilling it so she stands there and feeds him.
>
> **(Fieldnotes, Care home 7, Night shift)**

Medication

Some practices in relation to medication such as putting medication in food are inappropriate unless there is a clear justification based on careful assessment and consideration of issues of mental capacity. Overall, however, the administration of medication was taken very seriously, although at times it raised dilemmas with which staff had to wrestle:

> There is a tension between providing care i.e. what is best for the resident while at the same time respecting their wishes. I saw an example of this in the conservatory today as one of the residents was due to take some medication which Sindu brought in to her. However, the resident, who I get the impression has dementia, did not want to take the medication and was quite adamant that she did not have to. There then followed a fifteen to twenty minute process where the care assistant at first and then the senior carers cajoled and encouraged the woman to take her medication. They were successful in the end but maybe if they had 'respected her wishes' she would not have taken the medication.
>
> **(Fieldnotes, Care home 2, Afternoon/Evening)**

This classic dilemma of autonomy versus beneficence is no less common within the care home setting than it is within a hospital, the difference being that the staff are less well-equipped to deal with it, as often support in determining the best course of action is unavailable.

Managing Pain

In every home staff were very proactive in ensuring that residents did not suffer unnecessary pain from whatever cause. There were many examples when staff would notice a limp, a bump or a bruise and take whatever steps were necessary to ensure residents were comfortable. When residents were distressed at the end of life, staff were visibly distressed as the following example shows:

> Andrea tells me that Eddie is in a bad way and has been in bed for the past four days. She tells me that she thinks that he may be close to death and all that they can do is make him comfortable but it is not easy as he is very distressed which she finds upsetting. At 23.35 Ceri and Emily go in to turn Eddie in order to avoid bed sores, from outside in the lounge the sound of his moans and whimpers as they turn him are quite distressing. Ceri goes into check on him as he is certainly getting more agitated. At 00.30 she comes out and starts to clean the floors, but Eddie is getting even more agitated. At 00.40 she goes back in to check on him. Eddie starts shouting out and screaming. At one point he is shouting out "I'm dying, I'm dying." After a while Ceri comes out looking quite concerned and goes to find Emily. At 01.05 Emily and Ceri go into Eddie's room to see if they can make him comfortable and to give him additional medication. After 20 minutes they come out and although he is not quite so manic but is still whimpering. However as time goes on Eddie is obviously getting more and more agitated and by 02.45 his shouting appears to be bothering other residents. At 02.50 the care assistant, the RN and the RMN seem very concerned about his condition and meet up to discuss what can be done to make Eddie more comfortable. They review what procedures have been followed and what medication he has been given. After they have discussed it for sometime the RMN says: "Well I think that we have done everything we can do for the time being. We'll just have to live with it for now and hope that he becomes less agitated later." At 03.15 they go back in to see if there is anything they can do for Eddie as he is still shouting. They

> stay in there for 15 minutes while they turn him and give him some additional pain medication. When they come out he does seem a little more settled. Ceri seems very concerned about him and says to me: "Maybe he can get a little more rest now."
>
> **(Fieldnotes, Care home 2, Night shift)**

Social Interaction and Activities

Many staff in the care homes appeared to develop genuine and enduring relationships with some of the residents as the following observation shows:

> Marion comes in and kneels down next to June. She tells her she's been feeding and washing the people upstairs. They have a lovely chat about what she has been up to on her days off. Marion laughs and jokes with June, Linda and Emily.
>
> **(Fieldnotes, Care home 5, Evening)**

In many homes, regular social activities were provided at least on a weekly basis and often more regularly:

> This afternoon from 14.00 there is a clothes show on in the dining room and a music therapy session on in the TV lounge. The music therapy session in particular is very popular with a number of residents coming from upstairs. The session consists of an outside provider coming in and playing music to which the residents do gentle exercises. Even some of the least able residents are able to take part in some of the simpler exercises so it is a good way for them to maintain some activity. [As these sessions are very popular it is difficult for me to conduct observation as space in the room is limited and it is difficult for me not to get in the way. All I can really do in these sessions is pop my head round the door and peer in] From what I see it is a very popular session and many of the residents seem to take great joy from it. During the session those residents that want to are taken into the clothes show which provides the residents with the opportunity to purchase new clothes independently. This is also an opportunity for many relatives to visit as they come in and choose the clothes with their relatives.
>
> **(Fieldnotes, Care home 2, Afternoon)**

In some homes as well as organised activities, staff ensured residents were given every opportunity to engage:

> Jim is brought down in a wheelchair by his wife and they go into the courtyard and chat to the gardener. I can't hear what they talk about but there is a lot of laughter. Glenda (RN) comes in with a carer from an agency. Patricia goes into the courtyard and talks to Jim and his wife. "Did you have a nice time? Where did you go?" Janet is setting up the bar billiards at one of the dining tables. Patricia is concerned that it will need putting away if there are no staff in the room, in case somebody hits somebody else with the ball on a string. Janet says "I don't like toys being put away...I mean games." She takes the badminton out to Jim and his wife – apparently they met playing badminton. They chat for a bit then she leaves them to have a go which they do. Jim misses most of his wife's serves but they have a good laugh. Janet gets Emily playing bar billiards, Andrea comes over and sits down to join in. Janet tells her "Andrea this is called bar billiards, you only have to hold the ball ...yeah well done...well done you've got three more to do." They play this for a while then a catering assistant comes in with tea. Jim's wife has a go at bar billiards.
>
> **(Fieldnotes, Care home 8, Afternoon)**

Visitors also were encouraged to join in the social atmosphere of the home:

> A couple come in to visit the male visitor's mother, but they chat to Emma and the other ladies – The female visitor gets out pictures of her granddaughter "See I told you I'd bring them for you" – to Emma. By now the news has finished and the visitors say "I don't think anyone is watching this." "No you can turn it off I think," says Jan. The activities coordinator, Pam comes to do Be-active (Chair based exercises to music) The visitor says she can't join in because she has a bad back – Pam jokes that it's a feeble excuse and says to another lady, "Your frozen shoulder doesn't stop you joining in does it?" There is a lot of chat and laughter so it's hard to follow what everyone is saying. It is a pleasant, warm atmosphere.
>
> **(Fieldnotes, Care home 6, Morning)**

Only in one home did a staff member openly suggest that social integration or activities left something to be desired, although this is not to suggest that social integration could not be improved in other homes, for as identified in Chapter 4, residents were for example often prevented from even going into the garden. On the whole staff were so concerned about completing essential tasks such as personal care and feeding, that many of them had time to think about meeting residents' needs for social engagement and activity :

> *'I suppose it's like any organisation, they don't want to spend money. And they could – there's very, from what I've seen in the last month, there's very little activities that are planned for them. Erm they're locked within the unit and there's, there's nothing for them to do. They sit in the lounge or just stare at each other or at the walls or at TV. Erm, you know, there's no...There's getting the, the residents actually involved in living. Take them out in the garden, it's not going to take you much time, a little bit of fresh air, different scenery. But yeah they - I don't even think they're allowed outside to be honest.'*
>
> **(Interview with a Care Assistant, care home 3)**

Rhythm of the Home Given Priority over the Rhythm of the Person

From the foregoing it is clear that the 'work' is often organised for the convenience of the home rather than for the residents. The following detailed report of an evening observing in a lounge demonstrates this clearly and gives a flavour of what is referred to above:

> Lounge 6pm. I sit in one corner of the lounge, there are seven chairs around the wall in this part. June, Elsie, Pat, Emma, Annie and Linda are here. Pat, Emma, Annie and Linda are asleep. The news is on the television in another part of the lounge but it can be heard and seen from this corner. Pat wakes up, gets up and walks to the toilet. A care assistant calls over "Pat where are you going?" June and Elsie say she's going to the toilet. The care assistant comes and holds Pat's hand to help her out. The care assistant brings Pat back from the toilet and helps her to sit in the chair. Emma, Annie, Linda and June keep nodding off and then waking up. A second care assistant comes in and kneels down next to June. She tells her she's been feeding and washing the

people upstairs. They have a lovely chat about what she has been up to on her days off. The assistant laughs and jokes with the residents. She tells me this is the best care home she's worked in – the staff are very friendly. She tells me she's doing her NVQ2 and she enjoys it – it keeps her busy. June asks to go to bed, the care assistant says she'll take her after supper saying, "I want you to eat something because you've not had much." There is a genuine warmth between them…Emma is asking to go to bed. The care assistant asks if she'd like some supper first. Pat is pulling her skirt up again and the assistant jumps up again and goes over to her "Don't Pat, there's gentlemen in here – you don't want to go flashing your legs." Ellen wants to go to bed but is told she has to stay up until 8pm for her tablets. Another care assistant says "She'll be better when she gets her hearing aid in three weeks. So will she (pointing to Annie) she's so quiet." Annie asks where her mother is and is told "She's not here." Annie keeps saying she doesn't know where her parents are. Betty comes to join us. At 7.30 the staff begin to hand out supper (tea cake and horlicks) and Louise begins some of the tablets. Pat is walking about and is told, 'Pat sit down while I've got hot drinks...sit down sweetheart...sit down love before you fall.'

A senior care assistant Gordon asks another if she can take Jill to the toilet because she's squirming in her seat. The assistant says that she can't but will get one of the other girls. Then he says: 'Pat, you're in my way you're going to get hurt. Emma sit down you've got to wait for your tablets.' The care assistant tells me, 'This is the worst time of night because they're all agitated and want to go to bed.' Emmerdale is on very loudly. The carers seem to be interested but I don't see any of the residents watching it. Gordon is talking to June he is concerned about Jill because he thinks she needs to go to the toilet. The friendly care assistant asks June if she wants to go to bed and brings a wheelchair for her.

The care assistant (Maureen) returns from putting June to bed and her colleague says that Emma is shattered and needs to go to bed, Maureen says "I'll take her first then" and wakes her up saying, "Emma do you want to go to bed?" Emma doesn't hear this properly and says "Eh?" Linda shouts out "I do" so Maureen takes her instead. Pat is walking about clutching her pants – I think perhaps she needs the toilet – Another care assistant takes

> her by the hand. She begins yelling and the care assistant tries to calm her down. Emma begins to take her jumper off (it is very warm in the lounge). There are no staff around. She now just has a vest on so I go to find somebody. I find Maureen who puts her jumper back on and says, "Come on Emma I'll take you to bed... Ahh look at her smiling…It's lovely when they smile. C'mon sweetheart…that's it sweetheart…ahhh, she's a little smiler." It is now 8.15.
>
> **(Fieldnotes, Care home 5, Evening)**

This long extract gives a flavour of a typical lounge at that time of day. The focus is on giving residents their supper, their medications and then taking them to bed. However, as staff are not supported (or prepared to focus on the individual) there seems no prioritisation of 'need' so that the most tired individuals are taken to bed first. Emma who wanted to go at 6pm waited over two hours to be taken.

In the following example, the staff's wishes are physically imposed on the resident:

> Peter and Gemma go to 'sort' Agnes out. By 10.56 Peter is back in the lounge then Gemma comes in and says "Agnes just doesn't want to get up. She's dressed but won't get up." The nurse hears this and says "No, just come with me." The nurse and Gemma go off and a little later I hear screams coming down the corridor. Toria walks past and whispers "That's Agnes that is." The nurse brings Agnes into the lounge looking really tired and drawn and they sit her in a chair in the lounge where she goes back to sleep.
>
> **(Fieldnotes, Care home 3, Morning)**

This example of how the rhythm of the home supersedes the rhythm of the person demonstrates the way that in some homes little account is taken of the resident's individual needs and personal preferences. The example above highlights how because it was late morning and residents should be up, so Agnes will get up appeared to be the attitude of the nurse. She did not appear to consider why Agnes might wish to stay in bed, or what she would do when she does get up, other than sit in the chair and fall asleep.

Discussion

This chapter has described the findings in relation to 'the work' of the care home. 'Who Does the Work?' described some of the issues surrounding recruitment and retention of staff, where the staff come from and the issues that this raises. The findings in relation to 'Teamwork' considered the importance of teamwork together with the tensions within the team. 'Getting the Job Done' considered being equipped to do the job, the fundamental aspects of the work and how these were approached, and finally how the rhythm of the home was frequently given priority over the rhythm of the person.

In Chapter 3 the results of the standardised questionnaires completed by staff in relation to attitudes to ageing, mastery, approaches to dementia, job satisfaction and burnout demonstrated that a noteworthy minority (21 per cent) of the respondents had high scores on depersonalisation; just over one quarter reported low levels of personal accomplishment; and 31 per cent reported moderate to high levels of emotional exhaustion, whilst almost one third of the respondents were experiencing some level of burnout which in turn could negatively influence the level of care provided. There is a substantial amount of research exploring work satisfaction and stress of care workers and the impact on quality of care and outcomes such as wellbeing (Hannan, Norman and Redfern; 2001), although most studies focus on hospitals and nurses, rather than care home settings and social care workers. Whilst some findings are contradictory, the use of different measures and methods means that it is difficult to draw robust conclusions.

Powers et al. (1994) found that staff reporting the most distress maintained the most positive interactions with residents, while Shepherd et al. (1995) found that staff reporting the least distress had the most negative interactions with residents. Hannan, Norman and Redfern (2001) suggest that a possible explanation is that staff displaying little empathy towards residents are less likely to become distressed, whilst those demonstrating high levels of empathy are more likely to become distressed if they feel unable to deliver high quality care. In another study, Astrom et al., (1991) found that the risk of burnout was higher in staff of lower grades. These findings appear to be supported by those in this study.

Other important aspects include the work environment and the staff outcomes, which were discussed in detail in Chapter 1. Work organisation and workload are also important contributors to staff stress and burnout and hence, the quality of care. Higher staffing levels are also related to

better resident outcomes (Spector and Takada, 1991). Bearing in mind the multi-cultural nature of the care workforce in many geographic locations, barriers including language, acceptance and the experience of racism may all add to staff stressors and impact not only on the quality of care, but also on staff retention.

Promoting teamwork can be effective in empowering care workers and providing them with the ability to make work-related decisions and work more flexibly to meet residents' needs, rather than adhering to strict routines (Yeatts and Cready, 2007). Improved team working is also associated with higher job satisfaction and lower staff turnover (Riggs and Rantz, 2001). Teamwork is complex, however, and rather than being 'imposed' by managers, it requires all of the staff to embrace the value of it and work to maintain it (Tyler and Parker, 2010). Essential for effective team-working is a supportive management culture (Lopez, 2006) where staff are mentored and supervised and managers model the behaviours and dispositions they wish staff to display (Tyler and Parker, 2010).

In this study, it was rare to observe managers 'out on the floor' in four of the homes (1, 3, 5, and 7) and, apart from Home 5, these were the homes where there was more evidence of tensions and conflicts amongst the staff. Most of the homes were hierarchical, with nurses separate from care workers and again rarely seen 'on the floor'. The work, in the form of instructions as to who was to do what, when and so forth tended to be passed down from senior care assistants to care assistants, who appeared to have little say in planning the care residents required. This is unlikely to foster collaborative team working.

The levels of 'care' in the different homes were variable as described above, but appeared to be of a higher standard where staffing levels were better (Home 2). Although there is a growing body of literature examining the links between nurse staffing levels and quality of care in US long-term care facilities, (Stevenson 2005, 2006), there is little research evidence focused on the UK or on the care home sector (Szczepura et al., 2008). 'Quality' is notoriously difficult to define and often resident outcomes are used as a proxy, such as residents' quality of life (Bowling, 2001; Tester et al., 2004). Other factors also impact on the residents' satisfaction with care, including choice and control (Boyle, 2004) satisfaction with the mealtime experience (Amelia, 2004), and homeliness, (Titman, 2003).

For people with dementia, a survey of what is important for their quality of life (Alzheimer's Society, 2010) showed that 'relationships or someone to

talk to' was ranked as the most important factor with a peaceful, safe and secure environment ranked second, as key quality of life indicators. Bearing in mind that many of the staff interviewed bemoaned the fact that they had little time to sit and talk to residents and build relationships, this has implications for the quality of life for residents, particularly those with dementia.

In the majority of homes participating in this study, discussions with managers revealed few of them had considered quality improvement initiatives, although in one home, (Care home 6) the Eden Alternative, a whole organisation approach to life in residential care, had been adopted. The CQC is currently developing a voluntary Excellence Award due to launch in April 2012, which will be subject to a consultation exercise commencing in May 2011. This may promote interest in quality improvement initiatives such as the recently developed 360 Standard Framework (Hurtley and Duff, personal communication, 2010), and the My Home Life initiative (Help the Aged, 2006) which although not a quality Improvement programme has had a significant impact on the quality of the residents' experience. The introduction of an accreditation system in Australia has provided the basis for both policy and practice developments in quality improvement within the care home sector (Barlett and Boldy, 2001) and the Wellspring model in the US also claims to have improved quality (Reinhard and Stone, 2001).

Conclusion

The findings from this study in relation to the work within care homes, who does it, the role of team work and how it is done appear to be borne out by the literature. However, it is important to acknowledge that we did not approach residents to ascertain their views directly. The care home workforce appears to be at risk of significant stress and burnout, due to workload and tensions and conflicts in the workplace, which do not appear to be well managed. This impacts on the quality of care delivered to residents, which while far from abusive could in some instances be seen as neglectful and lacking dignity, and does not yet measure up to excellence.

CHAPTER 6

THE PEOPLE

"Wherever there is a human being, there is an opportunity for a kindness."

(Seneca)

Introduction

This chapter explores the personal and interpersonal aspects of the care home for the three main players: the residents; the relatives; and the staff working there. Although interviews with residents or relatives were not a formal part of this study, researchers often engaged in conversation with both relatives and residents in the course of the fieldwork. The interactions and the way in which the various actors related to each other were studied during the periods of observation.

The Residents

Within the eight homes participating in the study, the dependency level of the residents varied as shown in Table 1. In relation to help with eating and drinking, approximately 40 per cent of residents required this type of assistance with the range varying from no-one in one home to 75 per cent in two homes. Assistance with movement varied from 16 per cent in one home to approximately 65 per cent in two homes giving a mean of 39 per cent. In every home there were residents with dementia, from 100 per cent in three homes to 25 per cent in one home giving a mean of 66 per cent. The profile of the residents impacted on many aspects of life and work in the care home.

Resident Attitudes and Behaviour

Many of the residents were very happy in the homes and expressed gratitude for the care they received:

> He seems very open and very chatty and wants to know why I am there and what I will be doing. When I tell him about the study he is very keen to tell me what a good home this is and how happy he is here. Ernest comes in on his electric wheelchair and says to the care assistant: 'How you doing?' She replies: 'I'm doing ok you know, bearing up.' Ernest asks: 'You on holiday next week?' 'Yes I'm off for two weeks.' Ernest remarks: 'Oh we'll miss you.' 'Oh thank you Ernest.' Ernest says: 'No, I mean it you and Jennie are two of the best.'
>
> **(Fieldnotes, Care home 3, Morning)**

The manager introduces me to the residents who want to know why I'm there. One lady tells me 'They're golden here' another tells me that they do a great job. There is a really homely feel about the place and the residents chat with each other and the staff. Another resident gestures to me to come over so I go to talk to her – I tell her why I'm there, she tells me that the staff are lovely and that she trusts them – she tells me she even trusts the young man (male care assistant) to help get her dressed, 'To put my knickers on and everything –so that goes to show how I trust them'.

(Fieldnotes, Care home 6, Morning)

One lady tells me 'it's lovely here…we sometimes moan but doesn't everyone.'

(Fieldnotes, Care home 8, Evening)

Jane: 'It's not very nice, miserable, it's cold and wet.' Pamela: 'It's lucky that we have a nice place to be in. Not a dreary place. You know we don't have to shop for our own food. We are very fortunate'...Peter tells Julie that he is so thankful for all the time that she has spent with him and then Julie tells me that this is what she thinks the job is all about.

(Fieldnotes, Care home 2, Morning)

Respondent:	'She was chatter, chatter all breakfast talking about how wonderful it was and I thought Wow…you know, to get a response like that, I've obviously done something right, you know, I've pleased 'em … because you get the residents, the other residents and they all enjoy it, they sing along and just, I don't know, but they're harder to, definitely. But I – I got it right Thursday'. Well thank you very much'
Interviewer:	[Laughs] And you found that very rewarding?

Respondent: 'I did, Friday morning when I went round to say "Good morning" to them, I thought, oh, that's alright, you know. It's unusual, 'cause usually they'll have a little moan at me, "Well, why didn't we have this, and why don't we do this?" Cause you might notice something what they don't, you know, 'cause you're like, you're out … you know you've got your care team, then you get – because I notice that the residents look at you different as well in Activities… 'cause from the team leader … they sort of like – I've walked into one of the units this morning and they've just nothing but smiled at me, giving me little waves.'

Interviewer: Yeah, it's unreal and you know.

Respondent: 'They think, oh what's she going to get us up to today? That's what they're thinking, they must be. They must look at me and think, oh, you know, the last time they, what we done together. But, um, one of the residents actually commented this morning that they had a lovely time the other night … the children were wonderful.'

(Interview with an Activities coordinator, Care home 3)

Respondent: 'I just like being with…talking…and being a social person… and…'

Interviewer: Like you were saying before, you're a people person?

Respondent: 'Yeah. And I think it does give them a bit of a lift because you see that they are pleased and they don't' …some of ..I mean I go upstairs and I am … I can go upstairs this morning and I will get mobbed by about five – can you do my nails? Hair today? Oh can you do my hair then? It's something for them, and you can see it just… they get a bit … although having said that they've got a new activities coordinator up there, Sonia, and she is brilliant. And there is so much more to do.'

Interviewer: She is very proactive isn't she?

Respondent: 'Yeah yeah. But, they still would have their nails and hair done, because they love it. And they will come running up to me and they sling their arms round me and Oh hello", and they are pleased…'

(Interview with Hairdresser, Care home 4)

Despite this positive behaviour, some residents challenged each other, as well as the staff. For example, there were often arguments between residents especially those with cognitive impairment. Some residents become annoyed with the behaviour of people with cognitive impairment, perhaps because they did not understand it. Often repetitive behaviour was seen as difficult as the following example showed:

A woman comes in who is one of the residents who normally doesn't come out of her room very much and she comes along to the group in the music lounge asking people who they are and where they have come from. It carries on without much incident with most people ignoring her but she starts to shake everybody's hands and touch people on the head and face. Again this carries on without much incident until she gets to Andrew. Andrew who is listening to his music puts up with it for a while but then tells her to f*** off. It really doesn't seem to register with the woman who carries on touching his head and face two residents, Viv and Barry are annoyed at her bothering Andrew and Viv shouts at her to leave him alone and Barry shouts quite loudly at her to b***** off. Another resident, Chris finds this very amusing and starts laughing. The woman finally registers, I think that she is annoying people and wanders off back to her room.

(Fieldnotes, Care home 2, Evening)

Some residents were also forthright about their preferences and were not afraid to assert themselves when changes that they did not like were imposed:

As well as the activities that the coordinator organises during the day they also have a monthly quiz, domino and card competitions where each unit has a team. They also have Bingo (they did cancel it because 'people from outside' disapproved), but the residents demanded that it was reinstated'

(Fieldnotes, Care home 6, Morning)

Aggression

No aggression from staff towards the residents was observed, however staff interviews revealed stories of aggression towards residents in previous jobs or different homes which often involved residents with dementia displaying "difficult" behaviour:

'I think they do here [treat residents with dignity] while I've been here, I mean, I have worked in another home where we had one really bad dementia … and this girl had been there for some years and I'd walked into a room and this woman wouldn't let her get her dressed, she was taking everything off while she were putting it back on and instead of calming her down, she was shouting at her, which made this other lady worse, made her agitated and I just walked in at the right time because she had her fist up to hit this old lady. And I said, "I'm sorry" I said, "I didn't like what I saw…" I said "…I want you in the office." And she said, "Yeah well she's stressing me." I said, "She's not here for that, she's got dementia, she don't know what she's doing and you do" and we gave her the opportunity to either give notice or to be fired and she gave her notice in.'

(Interview with a Senior care assistant, Care home 5)

Aggression towards staff was both observed and reported in interviews as a daily occurrence. It often occurred during personal care, when staff were trying to wash, dress or move someone or get them out of bed. Aggression towards the staff was viewed as a part of the job, something that they simply have to endure:

> Jan looks tired, she tells me she is only just back from long term sick – her shoulder was badly dislocated and she had a lot of nerve damage – I ask if it was from a fall and she tells me, 'No, a resident pulled my shoulder out of its socket.'
>
> **(Fieldnotes, Care home 5, Evening)**

Most often, aggression towards staff was associated with residents with dementia:

> At 15.20 Greg starts to get very agitated. His wife isn't here at the moment as she has popped out to get something for him. Mei goes and sits with him to try to get him to calm down. It doesn't seem to work very well and he tries to get up out of his chair. Mei goes to assist him but he is very unsteady on his feet and Mei is tiny. As he gets up he lashes out with his arms and strikes Mei across the chest. The blow knocks the wind out of her and she falls backwards and the other carers run from across the lounge to assist her. Mei is quite obviously shaken up but after she has composed herself she comes back and takes over settling Greg down.
>
> **(Fieldnotes, Care home 4, Afternoon)**

Aggression between residents was observed on a number of occasions – usually, but not exclusively, between residents with dementia:

> As one of the care assistants is preparing breakfast one of the residents kicks another quite hard in the shins at the table and quite a nasty argument breaks out. The care assistant steps in between them and says: 'Calm down ladies, take it easy'. She takes one away from the table to another table. The resident says: 'She's really hurt me, she's bruised my shin. There are some horrible people here'. The care assistant replies: 'Oh don't worry about it, it is such a nice day and it's my birthday as well'. Then she gives the resident a big hug.
>
> **(Fieldnotes, Care home 4, Morning)**

> Pat sees Frank in the corridor and begins to shout at him "Oi you, get out…get out". Frank comes up to her and tells her to shut up - his face in her face. Jan comes in pushing a resident in a wheelchair and calls to Frank to calm down. He moves his head as if to head-butt her but doesn't make contact. Pat raises her hands to push Frank away – he pushes back and Pat falls backwards, hitting the chair and the floor. Frank ends up on top of her – I don't know if he fell or jumped on top.
>
> **(Fieldnotes, Care home 5, Morning)**

Sometimes the aggression appeared random and for no obvious reason as in the following example:

> Jim walks along behind the sofa that Bill is sitting on and smacks Bill on the head before disappearing into the corridor. Nobody but me sees this, Bill sits up suddenly "Who just hit me on the head?" – he looks around puzzled but there's nobody to be seen so he sits back again.
>
> **(Fieldnotes, Care home 7, Night shift)**

The organisational perspective on aggression often included the perception that aggressive residents 'shouldn't be there' as they were seen as needing more specialised care:

> 'As long as we can manage them and they don't get violent we're happy to have them. If they can't manage them then they are moved to EMI care.'
>
> **(Fieldnotes, Care home 5, Afternoon)**

Training in dementia and challenging behaviour was seen as important in dealing with aggression:

> *'Yeah, well like obviously like dementia, um, residents we'll go on dementia course, for EMI there must be some courses that we could go on to get us trained up and to make us more aware of what they're thinking.'*
>
> **(Interview with a Senior carer, Care home 5)**

There were also indications of routines and tasks exacerbating aggressive or disruptive behaviour:

> Tara tells me about the routine for getting residents ready for bed. She tells me that ….Aggie can get quite aggressive if they try to put her to bed before she wants to, but the night staff expect the afternoon staff to get the residents in bed'
>
> **(Fieldnotes, Care home 3, Evening)**

Some relatives were clearly concerned regarding resident aggression. One daughter talked about her mother having been involved in an incident with another resident:

> Talking about her mother again she refers to there being 'No more punch ups'. The daughter tells me that she had a call to say that her mother was in A&E needing two stitches in her head and how they talk about it being 'six of one and half a dozen of the other'. She says things are better now with the Promazine.
>
> **(Fieldnotes, Care home 5, Morning and afternoon)**

Despite there being many examples of aggressive or challenging behaviour on behalf of residents, there were also many examples of resident's behaving in an empathetic manner towards other residents and staff.

Empathy and Understanding

Many residents responded to the suffering of others, showing concern for those perceived to be less fortunate and attempting to act as their advocate. Phrases such as " I'll ask for you" were frequently overheard. Other examples of residents' concern for others are below:

> George asks Julie if she can take Jane to the toilet because she's squirming in her seat. Julie says that she can't but will get one of the other girls. After a few minutes George is talking to Mary saying he is concerned about Jane because he thinks she needs to go to the toilet.
>
> **(Fieldnotes, Care home 5, Evening)**

Leah asks, 'David, are you ready?' Christine interrupts saying 'Can you help this man?' Leah says 'What's the problem?' to which the resident replies, 'I need the toilet.' Leah says she will need to get someone to help and thanks Christine. After seven or so minutes Christine says to the man, 'No one seems to be coming I will press the buzzer again for you.'

(Fieldnotes, Care home 2, Evening)

Ruth is in her recliner chair and Amy is stroking her hand. Ruth looks much younger than everyone else. A visitor arrives with her mum in a wheelchair and they sit next to me – the visitor introduces herself and we have a long chat – she and her sister help out a lot with the activities as Jane was off for a long while with breast cancer. She tells me about Ruth – she's only 60 something but has Pick's disease. Amy wants to sit Ruth up, but the visitor says she doesn't think they are allowed and had better wait for the staff – Amy says she cares about her so much.

(Fieldnotes, Care home 8, Afternoon)

The sun is shining in Kate's eyes – Bob another resident asks her if it is annoying her and asks me to close the curtains, which I do – Kate says 'Thank you very much…don't know where the carer is supposed to have gone.'

(Fieldnotes, Care home 6, Morning)

The behaviour and attitudes of staff, as well as those of the residents, also impacted on the quality of life in the care home.

Staff Behaviour

Empowerment and Disempowerment

Empowering residents involves recognising, promoting, and enhancing their abilities to meet their own needs, so that they have a sense of control over what happens to them. This can be difficult to achieve within a care home setting, as any institutionalisation frequently exposes people to circumstances that disempower them (Faulkner, 2001; Grau et al., 1995). Empowering residents can also enhance their experience and sense of dignity just as actions which result in disempowerment can deny dignity as the examples in this section demonstrate.

Many examples of staff empowering residents were observed throughout the study. The most common examples involved eating and drinking when residents were given a choice of what to eat; the opportunity to feed oneself; appropriate assistance or utensils to promote self-care, such as plate guards or modified cutlery; providing alcohol if desired; giving a choice about wearing protective clothing and having food and drinks available on a self-service basis.

> Ernest shouts across the dining room to me to tell me how good the food is here. He asks the care assistant: "Can I have a glass of that Lambrusco?" She replies: "Of course, do you want a glass as well Eddie." Eddie says: "Yes please."
>
> **(Fieldnotes, Care home 3, Morning)**

Staff:	Isobel do you want mashed potatoes or roast or both?
Isobel:	I don't care.
Staff:	Shall I cut it for you?
Isobel:	Yes please
Staff:	Jane are you ok?
Jane:	No not really
Staff:	Do you want a hand cutting your food?
Jane:	Oh yes please
Staff:	There you are that should be easier for you.
Jane:	Oh yes thank you very much

> **(Fieldnotes, Care home 2, Lunchtime)**
>
> Chris comes back in and starts to do the menus: "Doris, what would you like for your dinner tomorrow? Saturday…For breakfast you can have … for lunch you can have …" She goes through each option. Next Chris asks Jennie what she wants to eat – there's a choice of soup or salad - Jennie doesn't know what to have. Chris explains that salad is cold and Jennie says that she doesn't like cold food so Chris suggests perhaps soup would be better. Jennie agrees. Chris goes round each person in turn asking what they would like and then goes to ask the people who are in their bedrooms. She says to Neville "Shall I send them down for a cup of tea?" He replies "Yes or they can have it in their rooms." Another care assistant comes in. Betty wants another cup of tea. Chris says "She's had two but she's moaned about each" and

looks to me for corroboration. The care assistant smiles and says she'll make another. She does and takes it to Betty saying "That feels lovely and hot to me – taste that and see what you think." Betty tastes it and says "Yes, that's lovely thank you."

(Fieldnotes, Care home 6, Afternoon)

Other ways in which staff tried to empower people included explaining things and offering information, promoting independence, promoting confidence, asking the person for their opinion, accepting refusals and offering choice in what to wear, when to get up and go to bed and in what they would like to do:

'We had this lady who came and she was on the wheelchair, and now she's walking, so that means that we – someone, like, our head of unit, she said, "Let's try if she can stand" she can stand… so for the next couple or three days, we tried to stand her up, she managed, later on she said, "Maybe, let's try to, er, do a few steps". We did, she can walk now.'

(Interview with a Lifestyle leader, Care home 4)

Staff:	Hello how are you I have some tablets for you- for the pain – for your stomach.
Resident:	I've got no pain in my stomach.
Staff:	That's because you are taking these tablets four times a day.
Resident:	Well why must I take these tablets?
Staff:	Your doctor prescribed them for you.
Resident:	But I haven't seen a doctor.
Staff:	It was sometime ago but the doctor did prescribe them.
Resident:	Well I don't care. I don't want to take them.
Staff:	Well OK but what about your other tablets.
Resident:	I'll take the normal ones yes.
Staff:	OK I can't change your mind can I?
Resident:	No.

(Fieldnotes, Care home 1, Afternoon)

'Yeah, the night staff stay till eight o'clock so there's plenty of us in on a morning so you don't have to rush. And obviously if somebody doesn't want to get up out of bed we don't force them. Sometimes … there's a couple of … there's two ladies who s ometimes don't get up all day till the day after. But we, we go up and check, you know, take them a cup of tea up or some toast, just to make sure they've had something. But like I say you just … you can't force people to just sit there all day can you? You know, if they don't want to get up then that's their choice really so I think that's about it really for that.'

(Interview with a Care assistant, Care home 5)

Jen comes in from the bedroom corridor and says "Doris has got back in bed, she's asking for tea and toast in bed" and goes to make it.

(Fieldnotes, Care home 6, Morning)

The care assistant asks Katie 'Do you want me to take you down?' [to bed] "No, not just yet" says Katie. "Well just let me know when you want to go."

(Fieldnotes, Care home 6, Night shift)

Residents are encouraged to be involved too – they tell me that Bob delivers the mail to the other residents and also takes out the bottles etc for recycling. Ida teaches crochet and knitting to local children. The TV is on in the lounge (news) and a care assistant is showing a magazine to one of the residents. She points out the pictures and reads the explanations "These are called the calendar girls – they've posed nude for a calendar with strategically placed objects – look." The resident laughs, "Are they plates?", as she points out one of the calendar poses. A lady from another unit comes to the door, and the care assistant jumps up to answer it and says "Hello". "I'm just having a look" says the lady. "That's okay – this unit's called Rose" She then goes back and talks to another resident, who is there for a fortnight's respite. "Can you see the magazine?" "Do you want to see those triplets I was showing Nora, the three little babies – aren't they beautiful?" The tone of voice used is polite and adult – there is no baby talk or elderspeak.

(Fieldnotes, Care home 6, Morning)

Disempowerment was also evident in a variety of ways in each of the care homes. The ways in which residents were disempowered included: contradicting what residents were saying, patronising them in a number of ways and not listening to them or their wishes, however some residents challenged this:

> Betty asks for some hot tea. The care assistant feels the cup and says it is hot and she can't give it to her any hotter. Betty says 'It might feel hot to your hands but it's not hot to my mouth.' The assistant tries to explain that she might burn herself. Betty says that if she thought the tea was too hot she'd wait until it cooled down a bit she says "I'm not barmy, I might be in here but I'm not barmy. Why is she so stupid?" Betty asks the care assistant to try the tea to see how tepid it is but the care assistant refuses. Betty asks: "Why not?" To which the care assistant replies, "Because that's your cup of tea." Betty says "It's because you don't want to be proved wrong."
>
> **(Fieldnotes, Care home 6, Afternoon)**

> June is feeding Pam her soup, Pam says 'I don't like it' to which June replies, 'One more.' Pam says 'I don't like it.' June says 'Mushrooms.' Pam again says, 'I don't like it. I'm sorry I can't do it.' Finally June says, 'Alright' Peter comes in and says 'Come on Pam, sit down and finish your dinner' Pam: 'I don't want it.' Peter: Come on'. Pam: 'I've just said I don't want it.' Peter: 'Pam you've got to eat your dinner now, stop making a fuss in the dining room people are trying to eat.' [Pam wasn't making a fuss she was just trying to leave.] The senior care assistant says "Peter, take her through, see if she'll eat it in there.' Peter tells Pam that it's fish and says 'Your daughter says you like fish.' He gives her a drink which she accepts and says 'Why don't you sit down to finish it?' Pam sits down. Meanwhile, Mary says to Arthur 'I did ask for a baked potato because it was on the list this morning.' Arthur says something I don't hear and Mary replies 'There's no point in bringing that list round really is there?' Arthur says 'No not really.'
>
> **(Fieldnotes, Care home 5, Morning and afternoon)**

Lack of staff resources led to a lack of time, which in turn led to disempowerment. Staff felt it was quicker to do things for residents rather than promote their independence:

> David can manage his drink himself, although slowly. He takes a few sips from the cup himself, but the work placement student takes it off him and feeds him.
>
> **(Fieldnotes, Care home 7, Morning)**
>
> Elsie's yoghurt pot is still in front of her with a little bit left in it – she is very slowly and carefully getting it out with her fingers and tongue. Jen comes over and says to her – "I'll get the rest out for you", and gives her a spoonful. "There that's all gone" and takes the pot. June takes Bill's hand from his cup 'Bill let go' and feeds him his drink.
>
> **(Fieldnotes, Care home 5, Evening)**
>
> Residents are encouraged to be involved too – they tell me that Bob delivers the mail to the other residents and also takes out the bottles etc for recycling. Ida teaches crochet and knitting to local children. The TV is on in the lounge (news) and a care assistant is showing a magazine to one of the residents. She points out the pictures and reads the explanations "These are called the calendar girls – they've posed nude for a calendar with strategically placed objects – look." The resident laughs, "Are they plates?", as she points out one of the calendar poses. A lady from another unit comes to the door, and the care assistant jumps up to answer it and says "Hello". "I'm just having a look" says the lady. "That's okay – this unit's called Rose" She then goes back and talks to another resident, who is there for a fortnight's respite. "Can you see the magazine?" "Do you want to see those triplets I was showing Nora, the three little babies – aren't they beautiful?" The tone of voice used is polite and adult – there is no baby talk or elderspeak.

Another way in which staff disempowered residents was in the use of 'elderspeak' or disrespectful communication. This may be by using patronising language such as pet names, scolding, outpacing or speaking to residents as though they were children.

The domestic comes in "Good morning darling" she says to one of the residents.

(Fieldnotes, Care home 6, Morning)

'D'you mind moving to the table with the ladies? …That's it, move in a bit sweetie…everyone's in different places.' Sara brings Enid back in 'Shall we go in here...get some nice lunch for you?' Sara is serving up some meals 'Excuse me Mrs H…there you go Enid, mind the plate sweet pea because it's hot.' She asks Amelia if she's finished or if she wants some help – outpacing her a little as Amelia struggles to find her words. 'Oh Marion don't wipe your nose on your..' She goes out and returns with a tissue 'Here you are darling that's a tissue, keep it up your sleeve.'

(Fieldnotes, Care home 8, Lunchtime)

Sheena is now feeding Rosemary 'Ahh she's lovely' – she gives her a hug 'Rosemary – open wide. Ooh that's nice.' I hear Sheena saying to Tim 'Naughty, naughty Tim, naughty naughty boy' and later 'Well done, good boy' but I don't hear why. Back in the lounge shortly afterwards, Rosemary is saying 'I don't know where I am.' Jean says 'You're alright, you're with me.' To which Rosemary replies, 'Oh thank goodness.' Jean tickles her under the chin and then turns to me and says 'You'd never think she used to be a ballerina would you?'

(Fieldnotes, Care home 5, Afternoon)

Some staff, however, were very aware of the impact of this type communication:

'Well, obviously because they're the older generation, and I respect my elders because you know, they are your elders and you talk to them like you know, Mr or Mrs or you say their name and you'll talk to them in a way which, they're adults, we're younger, you can talk to them as an adult, because I know with dementia it's kind of like going backwards, so you feel like you kind of look at – some carers look at them different and may talk to them like a child, but if you still maintain that, you know "How are you Mr so and so" and that, just keeping their dignity so they're not being like oh, why are you talking to me like that, because you

don't know what's going on in their brain.'

(Interview with a Care assistant, Care home 7)

Other types of disempowerment involved making jokes at the residents' expense:

> Carole says to Kath, "What's up with you Kath?" Sue who is giving her her tablets says "She's got her sexy legs out – wooing the men." All three laugh. Carole asks "What's the matter with your leg ..I've told you about swinging from the wardrobe." I don't hear Kath's reply but later realise this is because she has difficulty speaking).
>
> **(Fieldnotes, Care home 6, Lunchtime)**

Talking about people as if they weren't there and asking questions about them rather than to them was another way in which residents were disempowered:

> At tea time Karen comes round handing out biscuits from a box to some residents while another brings tea. At one point she shouts over to the other care assistant 'Does Pam have sugar?' A male carer, John comes in and asks one lady 'Do you want sweet?' to which another care assistant replies 'She's had cheese.'
>
> **(Fieldnotes, Care home 5, Afternoon)**

Sometimes staff failed to ascertain what residents were trying to do, and instead made assumptions without checking these:

> Stan stands up, Vernon says "Sit down Stan", Olive says "I think he wants to -go to bed, you can put him in the wheelchair." Vernon helps Stan into the chair and takes him out.
>
> **(Fieldnotes, Care home 7, Night shift)**

Another way of frustrating residents' wishes and disempowering them was by withholding information:

> Julie is trying to placate one of the residents who is trying to get through the keypad locked door and says "No I'm sorry I don't

don't know the codes, they change them all the time."

(Fieldnotes, Care home 2, Afternoon)

Frank comes back in and asks Sheena "When am I going to the dentist?" Sheena replies that "It's not today." Frank says, "But when is it can you have a look?" Sheena responds, "I've looked in the diary already and it's not today."

(Fieldnotes, Care home 5, Morning)

Routines could also be a major influence, and where these were rigid they also served to disempower residents:

Jenny decides to leave the table. A care assistant calls "Jenny you've not had your toast yet, you've not had your tablets either. Wait there." Tim tries to leave the table in his wheelchair. Another care assistant says "Where are you going? You'll have to wait for your tablets." and pushes him back to the table. Tim tries to leave again Sheena comes in "Where are you off to? Have you had your tablets?" she then goes and asks the senior carer, "Has Tim had his tablets?" "No." "Shall I bring him over then?" She starts to put Tim's feet on the wheelchair foot rests.

(Fieldnotes, Care home 5, Morning)

Other disempowering aspects that were observed were restrictions on residents' movement inside the home and going outside. Sometimes a rationale was given such as it being too cold, too hot, or it being the wrong time, or as seen in Chapter 5, 'barricades' were used to restrict movement:

After she finished shaving him he wanted to go outside for a cigarette but she told him it was too cold and that she would have to get his pullover first which was back in his room. As she went off to get his pullover he wasn't going to wait and scooted himself to the door to the conservatory and was trying to open it to let himself out. She had to come running back and said to him 'You can wait five minutes while I get you pullover' and wheeled him to the centre of the room away from the door putting the brakes on the wheelchair. Richard still wasn't having it and although quite badly paralysed he managed to get the brakes off and get

back to the door by the time she returned.

(Fieldnotes, Care home 1, Morning)

Rachel says 'Hello Mrs Cline' Mrs Cline asks, 'When will I be able to go out?' Rachel replies, 'You want to go out? It might be a bit hot yet- maybe this afternoon. You've got rosy cheeks.'

(Fieldnotes, Care home 8, Morning)

On some occasions the wishes of the staff were imposed on residents reducing them to objects to have things done to:

At 10.35 Philip comes back into the lounge and sits down with Eric and has a chat about some of the articles in the magazine. Then Tara comes down the corridor and she calls in to Philip, 'Philip can you go up there and sort Alice out. She's up there with the curtains open and everybody can see in, it's just not on'. Philip and Janet go to sort Alice out. By 10.56 Philip is back in the lounge then Janet comes in and says Alice just doesn't want to get up. She's dressed but won't get up. The nurse says, 'No, just come with me.' The nurse and Janet go off and a little later I hear screams coming down the corridor. Tara walks past and whispers "That's Alice that is." The nurse brings Alice into the lounge and she is looking really tired and drawn and they sit her in a chair in the lounge where she goes back to sleep. The TV is on a music video channel and there is still a fault on the set which means that the volume goes up and down and at times is blearing. Tara comes up to me and says "Alice is always falling asleep and it's mad getting her up all the time and putting her through that just so she can fall asleep in the lounge again."

(Fieldnotes, Care home 3, Morning)

One of the most disempowering and humiliating actions observed was when residents were left to soil themselves rather than being taken to the toilet:

Everyone apart from John is now sleeping, a young female carer *comes in and writes notes. I go to find Peter the deputy manager. I talked to him about what Moira told me last week about being told 'That's what the pad is for' when she wanted to go to the*

toilet in the night. I tried to make it sound like a naive enquiry rather than an accusation and asked whether it was a night time toilet policy or anything like that. He seemed shocked and said 'If an incontinence nurse heard that she would go up the wall.' He says Moira should be able to get out of bed to go to the toilet in the night and I tell him about the cot sides being up. He says he'll look into it and have a word with the staff but that he will talk about it generally and not single out Moira.

(Fieldnotes, Care home 7, Evening)

As well as residents being disempowered, there were also examples of staff being disempowered by management:

A staff member tells me that they get very little support from their area manager and a lot of criticism. She talks about how they get told off if they don't put table cloths on the tables, even when residents pull them off or stuff them in their shirts etc. She tells me it should be based around the residents not what management likes. She tells me about Doris being grumpy and not wanting to get up so Isobel left her in bed – she got 'told off' for doing that.

(Fieldnotes, Care home 7, Afternoon)

It's now five to three and Sandra is still busy. She says she's not going to have time to do an interview, she's disappointed – we discuss that this is a story in itself – the fact that there is no spare time. She quickly asks me if we're looking at 'dom' care – tells me about the back to back visits they used to have to do she says that had it been her first experience of care she'd never have stayed as she knew it wasn't right. She says that even here they don't get full support and that there are some 'horrendous practices' 'not just with residents' but things like heavy hot drinks having to be lifted down from above head height – she's tried to get it changed but feels she has no voice/impact – she says she'll write some things down to give to me when she returns the questionnaire, then she has to leave.

(Fieldnotes, Care home 8, Lunchtime)

Just as the disempowering actions of staff impacted on residents' dignity, management actions, which belittled staff impacted negatively on their sense of dignity:

> *'Well for many a times, managers can shout, er things that go wrong, what the carers do, but I am the head senior 'cause I'm responsible for whatever they do if nothing's done right by them and it's reported, it's me what gets it and get a "Come here!" you know they can get that sometimes because they're in a mood themselves and I can get the shouting at no matter where I am, I could be stood in the lounge with all the staff, which belittles you, my dignity's gone – gone right down. I'd rather be pulled in, in the office. It happened to me not long ago, actually, some staff had brought somebody down and they'd not put … they'd put them in a wheelchair but they'd not put the strap on, so they could've slipped out. Got a telling off, come back on, "Sort your staff out". I'm like "Wow, what's the matter?" and I won't even know a way round it, I said, "What's wrong?" she said, "Come here and down …" I said, "Right I will sort it" I said "In future seatbelts …"'*
>
> **(Interview with a Senior care assistant, Care home 5)**

Some managers however were very appreciative of their staff and the efforts that they made:

> *'I hope you put in your report how fantastic these girls are and how we couldn't do it without them. The politicians are all going on about how we have to reduce immigration but they are not living in the real world. If they are going to send these girls home they are going to have to come up with another plan as to how we are going to run care homes.'*
>
> **(Interview with a Care home manager, Care home 4)**

Empathy and Understanding

Despite the difficulties sometimes faced by staff many displayed great empathy in the way in which they treated residents:

One of the residents was sat crying – an Asian care assistant came over to her and said 'What's wrong lovely?' she stroked her face and gave her a hug. 'Don't cry.' She wiped her tears away and the resident said 'I love you' to which the care assistant replied 'I love you too.'

(Fieldnotes, Care home 5, Afternoon)

I say hello to the manager and the head of catering who are just finishing a meeting. The manager comes out of the room to return a chair to the dining room and sees that a lady is upset. She goes to comfort her and see if she can help. The head of catering also comes, they help her over to sit with her husband and remind her where she is (as she asks). They talk about what she likes about the home. The resident says 'Yes people always say hello and how are you...that's all you want, someone to ask if you're okay.'

(Fieldnotes, Care home 8, Evening)

A care assistant brings in Claire and sits her opposite Maureen at the table. Another care assistant is sitting at the table feeding Maureen, She says, 'Claire just a moment darling, I'm just going to finish feeding Maureen and then I will be with you.' I am quite touched to see her talking to these residents in this way as both have significant cognitive impairment and I think a less understanding carer would not take the trouble. After she has finished with Maureen she starts to feed Claire. "I have the same shirt as your Aunty. 'Your daughter came to see you yesterday, do you remember?' As she is feeding her she sings quietly to her.

(Fieldnotes, Care home 4, Morning)

Relatives

Drawing on the observational, focus group and interview data collected over the course of this study, the role and contribution relatives made to the continued care of the older person, their role as arbiter of standards and the actions of some relatives in abuse or disempowerment are discussed below.

Involvement of Relatives in the Continuing Care of the Older Person

Many relatives continued to feel a strong sense of responsibility for the older person following their admission to the care home and this was reflected in their continued involvement in caring activities. In particular, relatives often made a purposeful contribution to:

- care planning and the delivery of care;
- provision of personal and practical care;
- companionship and socio-emotional support.

Relatives have unique insights and expertise about the older person's needs, vulnerabilities and personal preferences, as well as a wealth of biographical information. Such insights and expertise are critical to individualised care plans and the delivery of person-centred, dignified care. These insights are especially important when the older person has a cognitive impairment as they can help care home staff understand and respond to the person as an individual:

> *'If the people have got dementia and Alzheimer's then I've asked the families to bring pictures in of when they were younger or just say 'Anything that you know can you write down?' because I do it like nice on a – a big sheet of paper and it's in the care plan, so when people come in on like settlements they can have – they can have a read and they sort of get to know what – what they're – they're about.'*
>
> **(Interview with a Senior care assistant, Care home 5)**

Visiting at mealtimes and helping their relative with feeding was a regular feature in some of the care homes:

> Also today Nina's daughter and Joe's wife all come in to help feed their relatives.
>
> **(Fieldnotes, Care home 4, Afternoon)**

Whilst for some relatives this activity was important in terms of maintaining previous roles and responsibilities, for others support to feed the older person was provided because of perceived gaps in care home provision and to help their relative maintain a sense of dignity and

self-esteem during mealtimes. Staff receptiveness to the involvement of relatives in the provision of routine practical care, such as feeding, varied and whilst some welcomed this type of participation seeing it as complementary to the practical and technical support provided by staff, others were cautious about it encroaching on established routines and ways of working.

A less contentious example of relative involvement in care home life was the provision of socio-emotional support and companionship:

> Ernie's relatives come in and take him for a Sunday afternoon ride in the car.
>
> **(Fieldnotes, Care home 3, Afternoon)**
>
> Gwendolyn comes in after being out on a visit with her family all day and she sits with Mrs Santos.
>
> **(Fieldnotes, Care home 4, Evening)**

Numerous examples of family members seeking to help their relative maintain family and community contacts were observed, including taking regular trips out, as well as taking time to look through photograph albums and personalise rooms with pictures of their family and friends. However, declining physical and cognitive functioning made this challenging for some.

Relatives were observed taking part in activities organised by the homes; sometimes this occurred serendipitously, whilst at other times their involvement was agreed in advance:

> Later in the day the highlight for the residents was a bingo session that was run by one of the care assistants. It seemed like a lot of friends and relatives came in during this session.
>
> **(Fieldnotes, Care home 1, Afternoon)**
>
> At 14.00 in the club house there is a "Singing for the brain session." Apparently this happens every Monday at this time and seems very popular with the residents as they are all getting ready to go over with the exception of Violet. I go over to the session which runs from 14.00 to 15.30. It is obviously very popular with the residents as the session is quite full and some

> of the residents are accompanied by family members and friends and quite a few volunteers have come in to help as well.
>
> **(Fieldnotes, Care home 2, Morning)**

In some homes great efforts were made to encourage the involvement of relatives:

> They are also hoping to set up a relatives café in the day centre somewhere they can drop in for a chat and to support each other – they want to open the day centre on a Sunday for Sunday lunches so that relatives can come and eat with their relatives – they plan to set it up like a restaurant.
>
> **(Fieldnotes, Care home 6, Morning)**

Instances where relatives also helped to support other residents who either did not have relatives or whose relatives lived a considerable distance from the care home and were not able to visit regularly were also identified. This usually took the form of social support:

> A couple come in to visit the male visitor's mother, but they chat to Ella and the other ladies – The female visitor gets out pictures of her granddaughter.
>
> **(Fieldnotes, Care home 1, Afternoon)**
>
> One of the visitors chats to me. She tells me her mother has been here nine years so she knows everybody. She talks with the residents and says to me, 'They like a little talk.'
>
> **(Fieldnotes, Care home 7, Morning and lunchtime)**

On some occasions relatives were also observed watching over residents because of limited staff availability and competing pressures on staff time:

> The staff go out of the room to do something but before they do Maria asks the relative if she's alright to keep an eye on things while she's not there. The relative says yes she'll be 'on standby.'
>
> **(Fieldnotes, Care home 7, Morning)**

> Hilda stands up and begins to walk unsteadily – the visitor (who is not her visitor) helps her across the room to sit in another chair [….] Hilda gets up unsteadily again, and again the visitor helps her to walk to another chair.
>
> **(Fieldnotes, Care home 5, Afternoon)**

It was clear sometimes that relatives had little understanding of cognitive impairment and displayed their annoyance with their relative when they could not understand their explanations:

> Valerie asks Alice if she'd like to do some knitting or look at a magazine or watch TV but she doesn't want to. Just then Alice's daughter arrives; she asks how she is and what's the matter. Alice says she's upset because Jane won't talk to her. "I'm Jane" says the daughter in a cross tone. Alice says something I don't hear and Jane replies "You think that lady is Auntie Jane? Well it's not Mum, Auntie Jane died 20 years ago" This conversation continues for a few minutes with Alice insisting that Mary is auntie Jane and wondering why she won't talk to her and the daughter getting increasingly annoyed and exasperated. The daughter wants to talk to Rita about her mother so Rita takes her into a private room.
>
> **(Fieldnotes, Care home 6, Morning)**

Some homes went to great lengths to help relatives understand that the changes brought about by dementia need not be seen as entirely negative and that the important thing was that the older person was allowed to live their life, albeit with dementia:

> *'Now I know families don't accept this easily, but I've heard families talking about this because … and I understand why families don't accept it easily because they – they see the loss of a person that's different, but there can be some closure and some healing in the process and um, and if people have more of a positive approach, then the person living with dementia will live with it, they won't suffer with it, because the people around them will enable them to live with it and – and not constantly grieve the changes that have happened to them and that needs a lot of – of er a totally different way of thinking and approaching and marketing, the way we think about dementia, the way they've changed the way we think about cancer very much the same*

thing, but there has to be more knowledge out in the general population.'

(Interview with a Care home manager, Care home 2)

Relatives as the Arbiter of Standards

Relatives appeared to play a key role in monitoring the quality of care provided in the homes, many acting as the arbiter of standards. Observational and interview data suggest that relatives often continued to feel responsible for the comfort and happiness of the older person. When issues relating to the provision of appropriate care were raised, relatives usually advocated on behalf of the older person by for example, raising concerns about appearance and cleanliness, highlighting deficits in the provision of basic personal, practical and nursing care, discussing the level of stimulation in the home and questioning the sensitivity and responsiveness of individual staff members:

'I mean I had two girls on the unit the other day, I wasn't on the shift, but I got told, that neither one of them knew how to do a catheter bag, so the family was appalled, understandably.'

(Interview with a Care assistant, Care home 3)

One of the resident's daughters comes to the kitchen area to talk to the nurse as she is concerned about the amount of pain her mother is experiencing. The nurse tells her she will discuss it with the Macmillan nurses next time that they visit.

(Fieldnotes, Care home 3, Morning)

'Yes, I think, I think perhaps people are – families are more aware of what they should expect for care now. I think you know, I think gone are the days where – oh Mum will be in a home and she'll be alright. I think families are more aware and I think they're now – especially when they have to put quite a lot of money to, they want - well – they want what they're paying for and they are concerned that Mum is getting the right, the right care.'

(Interview with a Care assistant, Care home 2)

Some family members were more confident in relating to and negotiating with staff than others. The potential for relative involvement to be interpreted as interference by care home staff or as undermining staff competencies was raised and occasionally there were tensions between care staff and relatives. Staff were aware of relatives who had previously lodged complaints relating to the standards of care provision or resident comfort and well-being:

> Sunni a male care assistant comes in and tells Natalie that someone's relative says that his father wants the toilet. Isobel says he's only just been and Natalie says that the relative has made a complaint before so she'd rather just do it. Isobel says that she complains about something every day.
>
> **(Fieldnotes, Care home 7, Afternoon)**

> At the end of the shift she tells me that the son who was in with nurse earlier in the day is unhappy with the care that his mother has been getting as he feels that people are not keeping enough of an eye on his mother during the day. She agrees that he is probably right but what are they to do when there are only two of them for fifteen residents and as she says the nurses rarely come on to the unit to help out.
>
> **(Fieldnotes, Care home 4, Afternoon)**

> George's wife comes and talks to me about the experiences that she and others she knows have had with care homes. She tells me that she thinks sometimes people are too quiet and frightened to speak up when they are not happy with the level of care that their relative is getting. She tells me that she thinks it is difficult to know when to speak out as the care home providers are the experts and relatives don't always understand. She tells me that she didn't realise how poorly George was being treated at his last care home and put his decrease in weight and worsening condition down to the fact that he was just getting more elderly and frail it was only the hospital that picked up on it and told her to change care homes and referred the case back to social services.
>
> **(Fieldnotes, Care home 4, Evening)**

> The handyman comes in asking if anybody knows anything about any radiators not working. A long conversation ensues, apparently someone has sent an anonymous letter to the regional manager about their mother's radiator not working, and apparently, they complained to the manager four times, but he did nothing about it.
>
> **(Fieldnotes, Care home 7, Morning and lunchtime)**

In one home a Dignity in Care Champion was working closely with relatives to address matters of concern:

> I ask about dignity in care and she tells me that she is the dignity in care champion for the home and that they are also doing 'Behind closed doors'. The relatives also have a checklist and go round the home checking bathrooms and toilets to make sure they are clean and provide privacy.
>
> **(Fieldnotes, Care home 6, Morning)**

Abuse Perpetrated by Relatives

Concerns were raised by some staff that relatives did not always act in the best interests of residents. Staff highlighted power struggles and tensions between relatives and residents that could potentially lead to abuse. Staff also described situations where relatives themselves were involved in aggressive or abusive relationships with residents and the action that had been taken when this occurred:

> *'We've had that upstairs and we've had to have the management in to have a talk with the relatives and then we've had to stop the relative actually coming in, yeah because the client actually told us at the particular time that her son was actually knocking her about in here and we had to tell him first and then I had to go to management and we had to get head office down and that was actually stopped him coming into the home all together, yeah.'*
>
> **(Interview with a Care assistant, Care home 3)**

Abuse can take many forms not just physical you know. We've seen plenty of that here within the families. Sometimes it's emotional, sometimes it is very subtle.

(Fieldnotes, Care home 1, Morning)

She [care assistant] mentions that she was talking to one of the relatives last week and he seemed very money orientated. He wants his mother to have a good end but he wants the money from her house as well.

(Fieldnotes, Care home 4, Afternoon)

Erm, mother is obviously here, daughter comes in to visit, she is quite dominating towards her mother, if I can use that word. We've got a menu system and for those that don't read very well, we've got a large print one in the rooms and daughter said little while ago 'Well I'm going to go through this and I'm going to tick everything that I know mum would like, put a cross by things that mum doesn't like and I'd like her to have that'. But mum likes certain things that daughter says she doesn't. For example she likes soup, when the daughter's not there, she will eat the soup. But when daughter is there she is not allowed it. You know so it's, it's, that's taking her choice away, so that's a degree of abuse…. we have actually had to say to the daughter two or three times more recently, you know 'Please don't talk to mum like that' or you know 'I don't think you should be doing that, those sorts of things, because you know that's not nice at all'

(Interview with a Care home manager, Care home 1)

It was beyond the remit of this study to complete in-depth interviews with residents and or relatives to explore these issues further.

Discussion

This chapter has explored the personal and interpersonal aspects of the care home for the three main players, the residents, the relatives and the staff working there. Residents and their behaviour both positive and negative, were seen to have a major impact on the work of the staff, particularly in the challenges they presented. Resident behaviour impacted

on staff, especially when they were uncertain how to handle difficult or aggressive episodes which included:

- Questioning staff such as why they are doing something/when is something going to happen.
- Complaining – about boredom, waiting, staff, the food, temperature, music/noise, routines and the system.
- Teasing staff and making disparaging remarks.
- Refusing things such as food, medication, activities, getting up, and going to bed. Not accepting care, not taking part and not doing as they are told.
- Wanting to leave the home.
- Accusing staff of stealing from them or hitting them.
- Hitting staff and screaming.
- Not tolerating patronising talk from staff.

As well as challenging staff, residents also challenged each other resulting in:

- Arguments between residents with cognitive impairment.
- Residents getting annoyed with or not understanding the behaviour of people with cognitive impairment.

This highlights the difficulties of group living especially where many residents have dementia and are seen as difficult or display repetitive behaviour for instance. Aggression among nursing home residents is extremely common, and often triggered by territorial issues, according to one of only a handful of studies exploring these issues (Rosen et al., 2008). Rosen et al's findings suggest that giving residents more control and choice in their daily lives, as well as not having individuals with and without cognitive impairments sharing the same living space, might help relieve the problem. Most research on nursing home violence has looked at resident abuse by staff or assaults on staff by residents and assaults on staff were observed during the PEACH study. However, resident-to-resident aggression appeared to be a much more prevalent and problematic phenomenon.

Rosen et al's study suggests that aggressive episodes occur around the clock but appeared to take place most frequently in the afternoon, and that the dining room and residents' rooms were the most common sites for aggressive episodes. Although observation was not undertaken in residents' rooms in this study, a number of episodes did occur in the dining room and were often due to someone being in 'someone else's seat' or taking

someone else's property such as Zimmer frames. Rosen et al suggest that this may stem from feelings of loss of control and choice in daily life, and that it is important to educate staff to personalise care and customise routines to suit individual residents in order to reduce such behaviours. The findings from the postal survey (Appendix 4) indicate that training in challenging behaviour was an uncommon occurrence in the staff induction training. In light of these observations, it could be a highly beneficial addition.

In relation to staff, there was a recognition that 'not everyone is cut out for caring'. Staff talked about their work mainly in terms of a series of tasks to be carried out and in general, they saw their job as difficult, but with many rewarding aspects. Staff attitudes appeared to be influenced by a number of organisational factors. These included:

- Pressure from management to get the tasks and 'measurable' stuff done
- Lack of communication.
- Tensions between different groups of staff (different cultures, night staff, day staff, younger and older staff).
- Lack of time and low levels of staffing.
- A desire for more training – particularly in relation to dementia and challenging behaviour.
- Low pay.

There were more examples of 'responsiveness to individuals' and of staff being polite and pleasant observed, than any other behaviour. Caring and empathic responses were also observed frequently. However, examples of 'patronising & condescending' behaviour included:

- Speaking to residents like children (elderspeak) which might involve inappropriate words used, tone of voice and the use of diminutives.
- Talking about residents not to them.
- Not allowing decision making or risk taking.
- Disregarding residents' opinions.

Staff behaviour, like their attitudes, showed a response to pressure, for example in relation to staff shortages and responses to pressure was a major driver for staff including:

- Feeling rushed, feeling 'torn'.

- Trying to get the job done (e.g. speed feeding).
- Balancing the differing needs of several residents at once by juggling their actions.
- Communicating priorities and constraints to residents such as 'I've got to do Hilda first'.
- Cutting corners.
- Taking away independence as it is quicker to do 'to' someone than do 'with' someone.
- Multi-tasking.

Often staff spoke of such pressures as being a reason for abuse or neglect happening and it was such factors which impacted most on whether staff tended to empower or disempower residents. These staff pressures are likely to link in with the level of burnout reported in chapter 3.

Rodwell (1996) suggests that empowerment, involves people having the power and freedom to make choices and to take responsibility for their choices and actions. Care intended to empower should assist people to maintain or regain self-control of their lives (Anderson et al., 2000; Paterson, 2001) and in doing so increases the sense of independence and autonomy, as well as physical health and overall quality of life (Faulkner, 2001; Gibson, 1991). The importance of on-going positive communication between care staff, residents and relatives cannot be overestimated (Deutschman, 2001) and creating tolerance and acceptance of all residents adds to a climate and care that increases empowerment (Campbell, 2003). Care practices that are likely to disempower range from negative interactions, such as scolding, invading privacy, disturbing people when they are resting, or using physical restraint. Such care results in individuals feeling that their lives are beyond their own control (Conwill, 1993). Both empowering and disempowering care are important when considering resident's quality of life (Scourfield, 2007).

One of the most common ways in which staff disempowered residents was in the use of elderspeak. Elderspeak (Williams and Kemper 2004; Williams, 2009) occurs when speech is accommodated or adjusted when speaking to an older person. Typically, these adjustments include using a sing-song tone, exaggerating and prolonging words or syllables, speaking more slowly than is necessary, limiting vocabulary, repeating statements over and over again, making statements sound like questions, and using diminutives like 'dear' and 'sweetie'.

The studies cited above have shown that such patterns of communication, as well as having an impact on dignity and damaging self-esteem, may also be harmful to outcomes of care. Elderspeak can cause older listeners to see themselves as cognitively impaired or incompetent. It can lead to more negative images of ageing and older people who have more negative images of ageing have worse functional health over time, including lower rates of survival (Langer, 2009). When used with people with dementia, elderspeak results in the person being less cooperative and receptive to care and more aggressive (Williams, 2009).

Research on relatives' experiences of a family members admission to a care home suggests that being able to work in partnership with care staff is of great importance to many relatives (Bauer and Nay, 2003; Davies and Nolan, 2004). Staff need to understand that for many relatives a sense of continuing responsibility remains with family members after an older person moves into a care home (Bright and Clarke, 2006; Hertzberg and Ekman, 2000; Keefe and Fancey, 2000). Family members possess information about residents' preferences, habits and can assist staff to devise care plans that effectively meet residents' needs and promote their well-being (Rowles & High, 2003). However, staff-family interactions can result in conflict (Gladstone & Wexler, 2002; Hertzberg, Ekman, & Axelsson, 2003). Bauer (2006) found that some care home staff tried to foster positive partnerships, while others adopted antagonistic relationships with residents' family members. In addition the task-based approach to care can limit interaction and communication with families and in many homes, routines that are most convenient to the organisation are given priority over those that focus on interaction. This has the potential for developing poor communication practices where important information is not passed on and this can adversely affect residents' care. Ensuring staff are skilled in communicating with relatives and that they understand the need for partnership working appears to be essential.

Conclusion

Given the workload, tensions and conflicts experienced by care staff, which do not appear to be well managed, it is perhaps surprising that stress and burnout are not more common. These aspects impact on the quality of care delivered to residents, which while not necessarily abusive and neglectful as such, does not yet measure up to excellence. The interpersonal interactions between residents, staff and relatives impact greatly on both the quality of life and the quality of care of residents. Although it was beyond the remit of this study to complete in-depth interviews with residents or relatives to

explore such issues the general conclusion is that improved training for staff would be an important part of improving care home life especially in terms of:

- reducing resident on resident aggression.
- dealing effectively with challenging behaviour.
- reducing disempowering practice.
- promoting respectful communication and reducing elderspeak.
- engaging with relatives as experts and being ready to learn from them.
- supporting relatives who wish to make a purposeful contribution to the continued care of the resident and staff acceptance of relatives' involvement in resident care.
- working in partnership with relatives and having a clear understanding of and respect for one another's roles and responsibilities.

CHAPTER 7

DEVELOPMENT OF STAFF TRAINING PACKAGE

"Excellence is an art won by training and habituation. We do not act rightly because we have virtue or excellence, but we rather have those because we have acted rightly. We are what we repeatedly do. Excellence, then, is not an act but a habit."

(Aristotle)

Introduction

This research identified a number of factors that need to be addressed in the development of evidence based recommendations pertaining to training. The evidence gathered in this study has been used to inform the development of a training package aimed at satisfying some of the most pertinent needs of the care home workforce and promoting best practice. The study found a number of key macro and micro issues that can directly impact on the usefulness of any training initiative. For example, how can the wider policy considerations of compliance with both CQC and Department of Health guidelines and requirements effectively be achieved considering the skills, needs and the day to day pragmatic reality of those who work in and manage care homes. This requirement to marry the macro with the micro to improve the quality of care has been highlighted by other studies, and as Deutshman stated: 'Any significant change in the direction of individual care for residents will require training, better understanding of residents and collaboration with the larger system' (2001, p 40).

Particularly in the past ten years a number of studies such as Henwood (2001), Nolan et al. (2006) have indicated a renewed interest within the academic research community in the need for ongoing education, training and support for the social care workforce, possibly in response to the growing importance of the care home sector as the U.K. age demographic changes. Generally within this body of research there is an increasing realisation that training has a key role to play in improving the quality of care experienced by those who live in care homes. As Watson and West (2001) state:

> 'There will be little difference for those we have the responsibility for caring for unless staff have clear specific goals and theoretical understanding of their approach to practice. As is so often argued, in order to provide care we require a suitably qualified workforce who are supported by a knowledgeable and informed management structure. To do otherwise is merely to tinker at the margins of quality care' (2001, p.101).

Policy Guidelines on the Training of Care Home Workers

Although the value of training and support for staff in the care home sector is a well-established idea (Gutheil, 1985; Helper, 1987), a starting point for the modern context of policy-driven training came in May 1998 with the introduction of the National Vocational Qualification (NVQ) for

those who work in the care industries. Since then, policy shifts in the sector have arrived with notable frequency.

At the time this research commenced National Minimum Standards (DH, 2001a) were in force in England, originally established under the Care Standards Act 2000,which also established the National Care Standards Commission (DH, 2000a). These standards stated that managers of care homes must ensure safe working practices for their staff and service users. These safe working practices include but were not limited to:

- Safe moving and handling of people and objects.
- Fire safety, understanding and implementation of fire procedures.
- First aid: The provision of a qualified first aider and an understanding of how to deal with accident and health emergencies.
- Food hygiene, procedures for preparing, storing and labelling food.
- Infection control, the understanding and practice of measures to stop the spread of infection and communicable diseases.

These minimum standards also required that 50 per cent of staff should have or be undertaking the NVQ level 2 or equivalent qualification and that staff members receive a minimum of three paid days training per year. All employees had to receive a structured induction training programme within six weeks of appointment.

In April 2004, the work previously carried out by the Social Services Inspectorate (SSI), the SSI and Audit Commission Joint Reviews Team, and the National Care Standards Commission was subsumed into the Commission for Social Care Inspection (CSCI) (King's Fund, 2006). This shift in the auditing and inspection landscape was then followed by Skills for Care, which is the sector skill council for the industry, launching the Common Induction Standards in September 2005. These standards were a revised version of their 'Induction and Foundation Standards' that had previously been in place but were withdrawn at the end of September 2006. The expectation was that employers would now use the Common Induction Standards, though in practice their introduction did not alter the pre-existing requirements for statutory National Minimum Standards training in first aid, moving and handling, food hygiene and health and safety. The new standards required that within their first twelve weeks of employment every employee should:

- Understand the principles of care.
- Understand the organisation and role of the worker.

- Maintain safety at work.
- Communicate effectively.
- Recognise and respond to abuse and neglect.
- Develop as a worker.

(Skills for Care, 2005)

From February 2005 an NVQ in Health and Social Care was developed which at level 2 required that learners complete four mandatory units and two optional units. The mandatory units included:

- Communicate with and complete records for individuals.
- Support the health and safety of yourself and individuals.
- Develop your knowledge and practice.
- Ensure your own actions support the care, protection and well-being of individuals.

Further changes to the regulatory bodies followed on 1 April 2009 when CSCI and the Healthcare Commission (CHAI) were replaced by the Care Quality Commission (CQC) which became exclusively responsible for the inspection, monitoring and regulation of all health and social care in England. Consequently, since 1 October 2010, new standards were introduced, again underpinned by the Health and Social Care Act 2008 (DH, 2008). These are the CQC 'Guidance about Compliance: Essential standards of quality and safety' which cover 28 regulations and outcomes, three of which (outcomes 12, 13 and 14) relate to the recruitment and training of staff. Outcome 14 directly refers to section 23 of the Health and Social Care Act 2008 which requires that registered care homes must have suitable arrangements in place to ensure that persons employed for the purposes of carrying out the regulated activity are appropriately supported by:

a) receiving appropriate training, professional development, supervision and appraisal; and
b) being enabled, from time to time, to obtain further qualifications appropriate to the work they perform.

(CQC, 2010)

In addition to these changes regarding the regulatory body, as of the 10th June 2011 Skills for Care introduced new Common Induction Standards. These standards now map across to the mandatory units of the new Health and Social Care Diploma which will replace the NVQ qualification and seeks to ensure there is consistency in training approaches for the workforce. There are now eight standards which should be met within the first twelve weeks of employment:

Standard 1	Role of the health and social care worker
Standard 2	Personal development
Standard 3	Communicate effectively
Standard 4	Equality and Inclusion
Standard 5	Principles for implementing duty of care
Standard 6	Principles of safeguarding in health and social care
Standard 7	Person-centred support
Standard 8	Health and safety in an adult social care setting

The diplomas are made up of nine mandatory units and a range of optional units. The mandatory units are very closely aligned to the learning covered by new workers in the Common Induction Standards (CIS) and the aim is for learners from any part of the sector to complete these standards and contextualise their learning to their service/job role.

Training Policy in Practice: Research Evidence

In the postal survey (Appendix 4), the managers noted a wide range of topics covered in the mandatory training. However, the most frequently reported were task focused e.g. manual handling, food hygiene, health and safety. Only a small number delivered mandatory training that would facilitate dignified, person centred care. Varying proportions of these respondents noted the provision of additional, area specific training in themes that would facilitate dignified, person centred care (dementia care training, physical dependency, communication, abuse, dignified care) although less reported specific training in challenging behaviour. Costs of specific training varied, however responses from both managers and care workers indicate that even a short amount of training can have positive effects on care. Common themes running through the positive effects of training include developing a deeper understanding and insight of the situation of the care recipient and facilitating confidence and competence in the care workers, both of which have the potential to improve the quality of life for those living in care homes.

In the observational study, although the NVQ level 2 was in place in many homes, we found that not all care homes adopted it as an industry standard and some home owners reported that they had no NVQ trained staff as they found the qualification did not satisfy their needs. Additionally some home owners and training managers reported that they felt that their limited training resources could be better used on alternative programmes.

Owner 1 'So as a manager trying to put together a funding package of knowing how to fund an NVQ2, you will never see the hassle that they get and it's not the same next month as it is this month. So I would, if you ask the fundamental question, do we pay fees, do we pay for training out of the fees that we receive or does the Government actually, because it's 50% of the market, does it give us any, the money direct and it's a total mish-mash, because we have to steal the price (from) the private patient, to cross subsidise the state funded patient and part of that is therefore, that private patient is paying for the training…..And we never get a straight answer from anybody in…'

Owner 2 'There is never a clear precise answer, there's al ways money made and either you'll hear it one from Government voice as but we've given all the money to the local authorities,… who will operate a training fund, but they serve a number of managers and a number of trainers and then they find they don't pay them what they want, so they pay somebody else to come in and consult and train. By the time the money gets down to us, instead of being that part as allocated by the Government, right? It's down to this sized pot and it's not very precise on the needs of the individual home. It's not orientated towards, it's generalised for a class of care, which encompasses residential, domiciliary, all sorts and not specified for a specific purpose of the type of care that nursing homes give, or hospices give. You know, a lot of it is siphoned off and at the same time, it's irrelevant to our absolute needs.'

Owner 3: 'Underlying this in real terms is the fact that it ought to be the responsibility of the provider of a goods or service, to train his or her workforce and that training should be part and parcel of that goods or services. And therefore, and that training therefore will be attributable to the needs of the workforce of that service and the person, the owner of that company would be in the best position to know what it is he requires. Unfortunately because the overall funding of residential and nursing home care is so low, we don't have that luxury. So what happens is that whenever we make representation to the Government about this issue, the result is that they provide funding for training. That funding for training is often then driven by a driver and so, if I want to actually run a course in my nursing home for example, on taking blood, which is an issue which we would take in a nursing home, I can't get funding for this anywhere, because it's not part of the pre-determined funding issues. What I can do, is I can get funding for Level 2 NVQ's, because somebody has determined that we should have Level 2 NVQ's. That also effects my business, because I don't necessarily want Level 2 NVQ's, because I don't necessarily believe that they are right for, for my business. But I get no choice in that, I can't, I can't secure funding elsewhere for, so what we end up with …, as XXX said, we end up with a dogs dinner in relation to this…. I don't think I have anybody with NVQ 2 in my home.'

(Focus Group with Care home owners, Birmingham, 24/09/2009)

The restrictiveness associated with the provision of mandatory training was a theme echoed by other owners who felt that at times it could be a drain on home resources and that its contribution to increased quality of care was questionable:

'What training is effective? Well our energies that you heard, are channelled into the mandatories and we can struggle time wise, financially and having to buy in, because it's all a bit of a mish mash and you have, to do the absolute essentials. You know manual handling, health and safety, infection control, fire safety, continence, safeguarding and on it goes and there's more and every time you speak to somebody they say this area of training should be your number one priority. I thought that's funny, I've got 10 people who have said that in the last week. That's what they say to me, you know continence, safeguarding etc, etc, it depends who you talk to.

So that sucked us dry in terms of time and that's what lead me on to thinking God, I think actually some of the best work that we do, really makes a difference, I do it in my own time, I do it asking the employees to give up their own time and I do it either on the hoof, or on the drip and that's actually where we make our difference, because we're trying to shovel in what's really important, round what we've got to do or else and so that's the sort of, that's my view of where we've got to. So what do we needed in addition, what's more important what we have to do, we have to do these things. You know, you can't have people who aren't trained to manually handle, don't understand health and safety issues and infection control, fire, what happens if a fire comes, you've got to have all these things in place, that's right.

But to me I've made the list of what do I think is important, and to me, I mean we don't have enough time for all the resources, in a perfect world we'd have, all of our staff would be experienced, they'd be compassionate, and would be very conscious in a caring mentality and unfortunately recruiting in the shallow pool that we do, we don't tend to find that very often. Would that be true?

So we're sucked dry with the mandatories and then some people do NVQ 2 and I've actually yet to see, I mean we have to have that, I've actually yet to see, well I don't feel personally that there's a big sea of difference between those who have done that and those who haven't. Does that reflect in the quality of work?'

(Focus Group with Care home owners, Birmingham, 24/09/2009)

Often the statutory requirements are interpreted differently throughout the sector and the experiences and knowledge of someone who has undergone training in one care home could be very different to those of someone in another. Training managers told us that although there is a plethora of training packages available, the content is often variable. Many recounted varied experiences of the usefulness of training and how important it is, in light of very limited resources, that delivery of training is both pragmatic and perceived to be useful for both staff and managers:

> *'As a manager I need to know what the training packages are for to make sure that it is good because all the training agencies out there are not good. There's a lot of bad ones. And there's a lot of money being wasted.'*
>
> **(Focus Group with Care home managers, London 29/09/2009)**

> *'Recently somebody started a training company and they were crooks and they took everybody's money and then went and closed it …Closed it, yeah…. and ran off with the money. I think there's some of them still around.'*
>
> **(Focus Group with Care home managers, London, 29/09/2009)**

While lifting and handling instruction is compulsory in all homes, content and delivery varies considerably. On occasions staff intimated that the training is of little use to their day to day practice and is provided more to cover the homes so that they satisfy their statutory requirements. Additionally, due to staff shortages and the high turnover of staff, new employees could be working on the floor providing hands on care, with minimal supervision, having received little or no training.

Interviewer:	What training or preparation have you had for doing the role that you've got?
Respondent:	'I had three days induction.'
Interviewer:	Three days induction when you started?
Respondent:	'Yeah I was erm supposed to have shadowed some one.'
Interviewer:	But in reality did that happen?
Respondent:	'No. Only on my first day.'
Interviewer:	Then it's just get out there and get on with it is it, like?

Respondent:	'Yeah, yeah.'
Interviewer:	But did you have, you know, a formal induction training course when, you know, you were in a classroom or something for a day or what?
Respondent:	'Urrh no I did have two hours handling and movement training.'
Interviewer:	So that's all pretty much the formal training that you had and then it was out onto the unit was it?
Respondent:	'Yeah.'

(Interview with Care assistant, Care home 3)

Development of the PEACH Training Package: Potential Barriers

The PEACH training package was developed with awareness of both the policy context in which it would need to exist and the perceived issues with current training policy described by the study participants. Beyond this, though, the research enabled an enlightened view of other barriers, which would need to be overcome. These will be outlined in this section.

Language, Basic Skills and the Nature of the Care Home Workforce

As highlighted in Chapters 1 and 5 the care home workforce in many areas of England is multi cultural with many workers having English as a second language, but even in areas where the workforce are mainly indigenous, there are issues around literacy and particularly textual communication:

> *'Definitely, if I may just say one thing; literacy, when they started the NVQs originally – they came and actually had assessors assessing for literacy… and they found that lots of the staff, which we knew anyway, were dyslexic. Well, if they can't get over the first literacy bit, and then they started putting training in to actually try and make them more literate so they could then actually go onto their NVQ2… and a lot of them couldn't, so they had special programmes made… they had the programmes where they didn't have to write anything, it was all done verbally.'*

(Focus Group with Care home managers, London, 29/09/2009)

The levels of basic skills such as literacy and fluency in English are a particular concern for the training agendas of many care homes. The following extract from a focus group transcript recounts a common experience for those involved in the recruiting and training of staff:

> *'I had a specific incidence of a lady, a mature lady who had worked in care for a number of years, came to us about three years ago and she was a typical lady with very poor literacy, good communication skills, but poor literacy and numeracy. The sort of classic scenario, very disjointed education and came out of school with no formal qualifications and she was supported to do her NVQ2, she did her basic literacy, numeracy, did fantastically well, achieved her Level 1, achieved her Level 2 in health and social care, went on and did dementia training and she blossomed. ….. She had never been given the support or encouragement to experiment and explore those avenues and I think there's lots and lots of different areas, but there's still an awful lot of those people who have, you know, have never been given the opportunity. So, it can be that somebody has, you know, that's coming in with other challenges on communication, but if you know, it's looking at everybody individually. Very, very much so, isn't it, but I don't know, it's such a minefield isn't it. Such a minefield.'*
>
> **(Focus Group with Care home managers, London, 07/07/2010)**

The issues highlighted above suggest that text based approaches to training delivery may not be the most efficacious. Additionally, the different learning styles of individual staff members may need to be taken into account in the development of any training package.

These issues are further compounded by the very different needs of different sections of the workforce such as care workers, nursing, domestic, catering and ancillary staff. As outlined in Chapter 5, effective team working is central to achieving high quality care within limited resources. This importance of a holistic team based approach, both to practice and training has been highlighted by a number of studies (Froggatt, 2000; Gallagher-Thompson et al., 2000; Aoki and Davies, 2002; and Bates Jensen, 2005). As a study by Froggatt (2000) found, if all staff are not involved then it is unlikely that sustainable change can be achieved. The diversity of the workforce in many care homes, where nurses, care assistants, senior carers, administrators, domestic, catering, maintenance and gardening staff have a direct impact on the care experience of residents, poses particular challenges for developing robust and effective team working approaches.

The Impact of Sector Resources on Training

For nearly 20 years numerous studies have identified a major and pervasive barrier for providing comprehensive training for the care home workforce as being insufficient resources (Wieland et al., 1992; Ross et al., 2001; Simmons et al., 2000; Clelland et al., 2005; Heatcote, 2005; Tolson et al., 2007). For home managers resources are a key systemic issue that needs to be addressed for training to be effective. For example, the difficulty of releasing staff from their duties on the floor to take part in dedicated training sessions is a commonly reported problem. Additionally, many managers stated that there are significant problems in recruiting and then retaining members of staff:

> *'The problems with the home, yeah....Well that seems to be... that is the key principle isn't it I think – that ever, is maintaining occupancy levels....And, as you say, that then take – and recruitment of staff. I think those are the two key areas where some homes that have you know, turnover – a high turnover of staff, is the time spent on recruitment and the time spent on maintaining occupancy.....You know, there's less time to actually support the care, and that's the wrong way round isn't it.'*
>
> **(Focus Group with Care home managers, London, 07/07/2010)**

Again, when developing the PEACH training package, it was essential this was carried out with a broad awareness of resource issues such as staff turnover and retention.

Development of the PEACH Training Package: Staff Feedback on Existent Training

Discussions with staff, together with the observations undertaken in the eight care homes, indicated that the factors that impacted most on providing quality care were the lack of resources, knowledge, experience and training. The areas where excellent care could be compromised particularly occurred in the fields of:

- Respectful communication.
- Limited understanding of what constitutes dignified care.
- A tendency of homes to operate task based approaches to care delivery.

- Dealing with challenging behaviour and dementia.
- The impact that risk management has on resident choice and experience.
- End of life care.

Although the research team did not observe any abusive care that warranted immediate intervention, on a number of occasions experienced staff described how in other homes where they had worked they had witnessed abusive care. It was interesting that when staff recounted their experience of abusive practice it was always somewhere other than their current place of employment:

> *'But I mean I've worked in nursing homes where they all have to be up at eight o'clock in the morning, nobody gets toileted until they go back to bed after tea. They're force fed, they're dragged out of bed, if they want to go back to bed, and they've actually dragged them out of bed to get them back downstairs. I had to leave, I was three months and I reported her, but I wanted to take it further, but apparently the home has to know when you get an investigation, because that's the way I went to have it investigated, the home, because the management was the same. She didn't – as long as they were paying, the family were paying, they didn't care I went in at six o'clock to help the night staff one morning and we went into this bedroom – because one's got a bed like say this way and one's got one that way, so her bottom hit her headboard and she'd gone over the top and they said she was only there 10 minutes. The whole floor was covered in blood, so no, they hadn't been to that woman all night and when they did get to her, because I pressed the emergency bell, they shoved her in the car. Instead of getting an ambulance, they shoved her in a car. That's disgusting and if they die at that particular place, they used to put them in the beds and lock the door, so me and one of the night carers used to go in early hours of the morning, to give her some care.'*
>
> **(Interview with a Care assistant, Care home 3)**

> *When I first get to the unit I am introduced to Leanne and when I explain the research to her she is very interested and tells me she has been working in the field of elderly care for over 30 years and how she had both of her parents in care. She has had experience of both good and bad care from both sides, worker and relative.*

She told me that on one occasion she had to take her mother out of one home as the standard of care was so poor. She tells me that one of the things she feels they have right at this home, and that she feels she has not seen done as well elsewhere, is the selection of staff which she feels is very clever and that other homes should adopt.

(Fieldnotes, Care home 2, Lunchtime)

Encouragingly many staff reported that they were aware of how to respond to abuse should they become aware of it. This was reported from not just care and nursing staff but others from the care home team.

Interviewer:	You know even if you feel the abuse is coming from the family or something like that whatsort of ations would that entail then?
Respondent:	'From my level, if I mean if there's anything I'd not be sure if … which I have used in the past, with as you were saying about relatives [laugh] yes what I … straightaway reported to the next level, and then it goes through from – from Jenny (The Home Manager) because she's had … as my manager, she's had years of experience obviously in the nursing sector and in care homes, I haven't got the experience, but sometimes what I can see is one thing could be something completely different as well and then she takes the steps on that. But there are other levels if again if you're not happy we've got the complaints procedures around the home, but on things like that there are different ways of reporting whether to my next person in line who would be our care home manager, then obviously the CQC, it can be raised higher to – to get things resolved but there are levels of report most definitely in place.'

(Interview with an Administrator, Care home 1)

Interviewer:	I'm interested again in how you see your own role. If you saw a case here of what you con sider bad care or abuse or something like that, what would you do?
Respondent 1:	'I'd report it!'
Interviewer:	Who would you report it to?
Respondent 2:	'The line manager.'
Interviewer:	But is there a procedure you've been made aware of?
Respondent 2:	'Yes.'
Respondent 1:	'The Whistle Blower in the region.'
Interviewer:	So that was something in the training again, The Whistle Blowing line?
Respondent 2:	'Yes.'
Respondent 1:	'Yes, that was in the course.'
Interviewer:	So you've had some formal training about that, right?
Respondent 2:	'Yes.'

(Interview with two Catering assistants, Care home 2)

Staff stated that their experience of training had not been particularly positive. A number of themes emerged most notably that training content and delivery methods did not address daily practice and experience, i.e. the actual challenges that staff face on a daily basis.

Interviewer:	What training needs would, you know, what about things like - would you, would training in dementia be useful to you or can you think of any training that you would particularly want?
Respondent:	'I did do a lot of computer training.'
Interviewer:	What do you mean, online training like?
Respondent:	'Yes. Where they tell you, for dementia for example they give you the different de mentias, like there's five different types of dementia and it goes into little a bit of in depth on that. But I, I personally think that you need a little bit more than that computer training. Because there's a lot of questions that I would have liked to ask but nobody was there to answer them for me.'

Interviewer: Yeah well actually jumping to the next question I was going to ask you really, because what do you think is the best way of delivering that training? 'Cause again you're not telling me anything I haven't – other people haven't told me where you know, particularly people have said to me where maybe their first language isn't English they found that, you know, that online sort of training can be quite difficult really.

Respondent: 'Yeah, even for me who speaks English, it is.'

Interviewer: So what would you say would be the best way of delivering such training, face to face, sort of mentoring?

Respondent: 'I would say hands on training, do you know like…'

Interviewer: On the unit?

Respondent: 'Yes, yes. I would think so.'

Interviewer: And then having somebody maybe who could - you can go to and sort of say "well this happened, what's the best?

Respondent: 'Yes is it part of their illness or isn't it? You know like there's a lot of aggression in some of the wards.'

Interviewer: Yeah, would that be sort of something that could be useful for you to deal with, you know, this challenging behaviour, because that's another sort of thing, training that they do?

Respondent: 'I'm not a violent person so I get very upset when they get violent with me. You know, "I've done nothing to deserve it why are you coming up so aggressive", kind of thing.'

Interviewer: So deal… so dealing with all sort of situations could be quite useful maybe?

Respondent: 'It could definitely be useful yes.'

Interviewer: And maybe how to diffuse such situations and sort of stuff like that like.

Respondent: 'Yeah…'

(Interview with a Care assistant, Care home 3)

As the above extract illustrates, and as mentioned previously, training materials were also an area of concern to staff as language or literacy problems meant that text-based materials were difficult to understand and follow. Often staff stated that they were expected to undergo training by sitting in front of a computer or "L=box" following an e-learning package. The prevalent view was that this was done to save the home money, while at the same time being able to claim that staff had undergone training. Although staff felt that e-learning probably did have a place particularly in refresher training and for self-study, generally there was a negative attitude towards it. Instead, staff expressed the wish for more face to face and group based training activity that would provide the opportunity to discuss the situations that they face in practice:

> She tells me that she feels that the NVQ in care is useless. She told me that the best training that she has had during her career was provided by the Red Cross and was the basics of nursing. She feels that the NVQ leads to bad practice as somebody teaches bad procedure to somebody else.
>
> 'What you want is proper nursing training. People think that as carers we don't need proper training but if you want quality care you need quality training. For instance they never teach people as to why things are done. If you don't know why you are doing something you shouldn't be doing it. NVQ doesn't do that. It doesn't teach anything.'
>
> She tells me that she feels that the low wages are one of the biggest barriers to recruitment and that the induction is very basic and only done to cover the home on health and safety grounds. Training is provided by the L Box which is an online resource. They used to have face to face lectures within the home but nobody used to turn up but she believes that face to face instruction and mentoring on the job is a lot more powerful way of training.
>
> **(Fieldnotes, Care home 3, Lunchtime)**

Staff in general indicated that the most useful and enjoyable training and an approach with which they connected most was that relating to their day to day practice. The method of delivery was also an important consideration:

Interviewer: Okay, so moving on to training then, you've mentioned a bit of training that you've had. If you think back to some of the training that you really enjoyed, what was it about that, you enjoyed particularly?

Respondent: 'I enjoyed it when I could bring it back in here and use it basically and especially activities and seeing how that training come across and how better it was for me, like I enjoyed that.'

Interviewer: So stuff that you can apply practically?

Respondent: 'Yeah and like first aid training, it depends on the trainer as well. I mean some can – you just don't want to listen to them, but like the last first aid trainer I had, he was superb and got everyone laughing, everyone wanted to do it and everything yeah.'

Interviewer: So it's got to be a good trainer, what do you think of DVD's and things like that?

Respondent: 'Well at the moment we've got a thing called LBOX here, which we do our training on, which is basically there's about 20 questions on each unit and you get a choice of four to pick from. But to me you don't learn anything from it, it needs to be more practical. Or someone coming in asking us a question and we all in a team come up with the answer. Something like that so it sticks in our head, but this computer thing to me, it's just you guess it and if you get it wrong, you write the answer down and the next time you see it, you know which the answer is. That's how I've seen people do it, so I know they're not learning from it or anything. So I just think it would be more practical and better for them.'

(Interview with a Senior care assistant, Care home 7)

'I mean, what we've all said is that it's – it's 'crap' basically. Sitting somebody in front of a computer for eight hours for an induction session, maybe this would encourage people to take a different approach than the DVD approach.'

(Focus Group with Training managers, Birmingham, 02/07/2010)

Representatives from the Residents and Relatives Association also highlighted the importance of delivering training that was context appropriate. Their feedback highlighted the importance of training that enabled staff to comprehensively examine issues rather than being provided with pat answers. As one relative stated:

'This is the kind of thing that actually matters, rather than kind of sort of books of technical data on how to be a good carer. It's about confronting dilemmas …. about space to reflect, rather than to have answers, and that kind of then begs the question about, how do you create – well you build it into the sort of supervisory relationships that you establish in a home. This is one of the ways round saying, you don't want to take more time. You know, time's precious, you don't want to take people off the floor, but actually if the regulations require that I as a carer am supervised by my next line manager, that's where it's dealt with. Supervision is one of the standards that's still actually problematic, along with care planning.'

(Focus Group with Relatives and Residents, London, 08/07/2010)

A number of topics emerged that were thought to be inadequately covered by current training, including:

- Dignity.
- Respectful Communication.
- Dealing with people with dementia.
- End of life care issues.

In relation to dignified care, although staff told us that they recognised its importance, most appeared to have a naive understanding of what constitutes dignified care. On occasion, some staff displayed quite blatant examples of undignified care:

The TV is on loudly then Hena comes and puts the CD on so that they can dance. Hena and Sharon pull some of the residents to their feet (Elaine, Gaynor and Paula all three clearly have some degree of cognitive impairment/dementia), hold hands, with them and sway to the music. It was hard to say whether or not the residents enjoyed it, but the carers seemed to. At one point Hena said to Elaine – 'C'mon shake your bum.' Sharon then says the same to Gaynor. Elaine goes to sit down. Linda, back from her blood test says 'That's not bloody dancing, they're staying in one place.' Sheena brings the hoist into the lounge to move Janice from her wheelchair into an armchair. Two visitors walk through. Hena runs out of the lounge and then comes back with a straw hat with a ribbon round it and puts it on Elaine's head. Elaine says 'no I can't' but is then led by the hand to dance in the hat. Hena and Sharon cheer her on, laughing. The carers attempt several times to persuade Eva to join in but Eva doesn't want to and walks off. Hena then dances in the hat, putting on a show for the residents. She then tries to put the hat on Linda who says 'Geroff [sic] with you I'm not a bloody teddy bear.' The hat is apparently from another resident's teddy.

[I've made a comment on my field notes 'This is my kind of nightmare' which is because the whole dancing episode made me very uncomfortable – it was clear that the carers thought that they were being entertaining and having a bit of fun with the residents but from where I was sitting , the only people who took part appeared to be those who were unable to say 'no'. Edna dancing in the hat appeared very undignified. It seemed more like the carers were laughing at her rather than with her because she wasn't laughing. That said, it didn't appear to be done with any harmful intent whatsoever – the carers simply didn't appear to realise how undignified this might appear]

(Fieldnotes, Care home 5, Morning)

The concept of dignity seemed to be understood in a manner that was very formulaic and often when asked staff responded with answers similar to this one:

Interviewer: So dignified care, how do you personally provide dignified care? What do you do to maintain a person's dignity when you're caring for them?

Respondent: 'Making sure the curtains are closed in the bedroom, doors closed obviously, making sure that that person is comfortable with me being in that room. Going through step by step what I'm actu lly going to do, while we're in there. Explaining to them that I'm going to wash them, but I want them to wash their front half, I will wash their back. Asking them what clothes they'd like to wear and stuff like that, just so they're making every choice in that room and I'm just there to be in that room with them while they're making the choices, but making sure that they feel comfortable with the surroundings.'

Interview with a Care assistant, Care home 6

The repetition of this interpretation of dignified care suggested a systemic training issue in regard to dignity. That staff made continued reference to acts such as closing doors or clear communication and explanations, but little about the broader understandings of dignity which would need to be incorporated into the PEACH training package.

The importance of respectful communication discussed in Chapter 6, has also been raised in a number of studies (Caris-Verhallen 2000, Bryan et al 2002, Davies et al 2005) and it is recognised as an important component of care which impacts on other areas such as abuse and dignity. In relation to respectful communication staff were rarely cognisant that there was any problem in the way they spoke to residents. To some extent aspects of respectful communication is context dependent such as the use of colloquialsims, and what constitutes respectful/disrespectful communication in one context may be very different in another. On a number of occasions communication that appeared both patronising and demeaning was evident in some homes:

A male care assistant is feeding Denise her pudding. He makes noises to her as he spoons it in "Oooooh, Oooooh" He talks to the female carer about what shifts she is working. He gives Denise very large spoonfuls. She says "No" he says "Oh yeah, Come on… Come on. Good girl"…..He then says "Come on sweetheart, just one more…last one" She doesn't want it but he gets it into her mouth. He wants to wipe her mouth with her pinny. She doesn't want him to. He says "Come on you can't walk about with that on

your mouth…what's his name will be here in a minute and he'll shout at me"

(Fieldnotes, Care home 7, Lunchtime)

Staff reported that although they may have had training about dementia this was often related to the various types of dementia which although interesting offered little help in dealing with the challenging behaviour sometimes displayed by people with this condition. Below is an example of the sort of situation that staff frequently had to deal with:

Linda comes out of her room and just shouts "Nurse, nurse." With this, the tall Filipino nurse comes out of the lounge down the hall. "Oh dear what is wrong can I help you."

Linda: "Where am I, what am I doing here?"
Nurse: "You are in a new place, you came here yesterday."
Linda: "But why? What happened? Did I collapse? Was I ill? Do my family know?"
Nurse: "No you were not ill or any thing you just came her yesterday."
Linda: "Well do you know why?"
Nurse: "Well no not really, but I am sure it is for the best. Don't worry everything will be fine I'm sure. Do you want a cup of tea?"

Linda just sits in the chair sobbing

Nurse: "Do you want to come with me and meet the rest of the group?"

Linda goes with the nurse down to the lounge.

(Fieldnotes, Care home 4, Evening)

As described in Chapter 6, staff regularly had to deal with residents' challenging behaviour which again is not always covered in the training they receive and can prove quite stressful for them:

Respondent: 'I mean, there was an incident where I stared and they said this lady gets up at hmm 5 o'clock in the morning. If you take her into the bathroom, lock the door because she'll wander and that but what they failed to tell me was she was frightened of water. So as I ran the water she attacked me in the bathroom. She just hit me basically and I couldn't get out the bathroom so – that's why I left it because of the violence towards you, that was a frequent occurrence – was that. Because to be honest they were like people who were at the end of their lives and the end and it was their dementia that had.'

Interviewer: They're very confused?

Respondent: 'Yes.'

Interviewer: So how do you handle that, how do - that must be very difficult?

Respondent: 'To be honest you're not trained to handle that sort of – because you're not allowed to restrain or anything like that and basically you walk away and go back and hope that they've calmed down.'

(Interview with a Care assistant, Care home 6)

Staff also reported having little training on end of life issues:

'End of life care, because in care homes we don't get that, we're not taught how to deal with end of life care. It's not just looking after the residents, looking after the families as well. We've got palliative care training coming up, which is long distance, but that's just paperwork. We need more hands on, we don't deal a lot with nurses either when they're coming in to deal with the resident, when they're on their last few hours. That's the only thing really is looking after them when they're dying.'

(Interview with a Care assistant, Care home 6)

Development of the PEACH Training Package: Ideal Characteristics & Aims

The research team formulated a model of what an ideal training package might look like in terms of satisfying both the needs of care workers and those of their managers, while aiming to improve the quality of care. It was also important that the training package could be delivered within the operational constraints of the care homes.

Therefore, any package would need to:

- Contribute to excellent care.
- Promote reflective practice.
- Be low cost.
- Be capable of being delivered "in house".
- Possibly be delivered "in peer groups".
- Build group dynamics and develop team working.
- Reflect care workers' day to day realities.
- Comply with and promote the new CQC Essential Standards and Skills for Care Common Induction Standards.

Contributing to excellent care is obviously one of the key aims of any training package aimed at care home staff. The majority of care staff that took part in this research were trying to provide the best possible care, sometimes in very difficult circumstances. They reported that any assistance or advice that would help them provide better care would be most welcome:

'I mean training as well, like some of them haven't got the training, some – they know how to care, but not communicate with the residents, I mean training did me good with like Dementia Awareness, so I know how to respond to whatever they say, but some people are just – I mean they just don't know how to respond basically and just come off their communication and just sit down somewhere or something.'

(Interview with a Care assistant, Care home 7)

The survey (see Appendix 4) demonstrates that effective training strategies can build staff confidence and staff morale contributing to a more positive care experience for residents. Providing guidance and support in a reflexive practice model can offer a structural framework particularly useful to staff as reflection helps highlight positive and negative aspects of care adding to the group's learning experience. Reflective practice highlights the importance of learning from experience, offering opportunities to explore and relate practical experiences to theoretical learning approaches. Often due to the high demands on staff time it is difficult for care teams to engage in reflective practice as their work tends to be overly task orientated (see Chapter 5).

Providing training at low cost is an important consideration for contributing to the development of excellent care as care homes are working within tight margins and with limited resources. If care home owners and managers cannot afford training it will simply not be provided especially in the current economic environment within which they operate:

> 'There's a direct correlation between costs of training and the payment for care by the commissioners of care, which is the Government, the local authority. If they can't and you'll find in, like what we said, all of the reports, they say we don't have the funds, we can only pay this £1 this year, £2 next year whatever, but they say but you have to have training. They set the quality standards, but the correlation between quality and survival is about running a cost effective business, monitoring your costs in order to survive, which means that it has to correlate closely to your level of training, but you have to meet the regulators so you overfund on training in some areas, because of this year, HCSI, next year it's something else.
>
> Every year you have to suddenly think God, that's the thing they're going to add on. Nutrition one last year wasn't it, they'd been train! Train! Train!, but you've got a big ball in which there are overheads costs and a very little profit and you have to look at that and that's why so many homes went bankrupt and do you realise that at this precise moment, there's just under 91,000 beds bankrupt? You know, that's the figure. The Government is supporting Southern Cross, the Government is supporting

Four Seasons and others, but that's the situation. They're in administration virtually, you know because they can't pay their bills.'

(Focus Group with Care Home Owners, Birmingham, 24/09/2009)

In house training was identified as a useful means of developing the overall knowledge capacity of the home as well as promoting best practice:

Respondent 1: 'I think it shaped some of your practice in house, hasn't it? And leading to greater im provement isn't it?'

Respondent 2: 'And it does sort of influence your external audits as well we found. In the audit we had prior to starting the programme, the audit we had half way through, there's a big difference in sort of staff practice and staff knowledge as well. It's been really helpful.'

(Focus Group with Care Home Managers, Telford, 22/09/2009)

'I like in-house training myself….. Because you can get quite a few staff there at one go … whereas if you're using outside like we do with our partnership with social services, you can't afford to send more than one or two at a time. If it's mandatory training, then you could take quite a long time for all your staff to finish that mandatory training … whereas if you did it in-house in two goes, you're done. Your moving and handling, you've done your basic food hygiene, but you have to pay for that.'

(Focus Group with Care Home Managers, London 29/09/2009)

This provision of in-house training was seen as a useful way to build group dynamics and secondly as a useful way to foster peer group education where one member of staff could pass on best practice to another. However, it was recognised that it was important to monitor this process so as to ensure that bad practice was not cascaded through the workforce. This is supported by much of the literature in relation to this topic (Frenkel et al., 2002; Jones, 2006).

Training that is directly relevant to care workers' experience is also identified as particularly powerful. Where staff do not see training as directly relevant to their daily practice any learning is quickly forgotten but when it is seen as relevant, staff find it engaging:

Interviewer:	Okay. We've talked about what qualities and attitudes to have with working with older people, you don't think they can be taught, we've talked a bit about the training as well. If you think back to some training that you enjoyed, what was it about that training that you enjoyed particularly?
Respondent:	'It was the scenarios and the material that they were using, because it was the POVA that I really enjoyed, because they'd gone into a care home, somebody had gone into a care home and filmed the way that the care staff were treating the residents. And they were using that material to look back and let us know that it does happen and sometimes places will be filmed and I thought that that was really, really good.'

(Interview with a Care assistant, Care home 6)

The desirability of a case studies / vignette based approach was a clear message that emerged from the discussions with participants. Although such an approach is not unique in training, during the evaluation phase when early versions of the training package were piloted, participants stated it was a very powerful approach:

'That's what I see…scenarios as and that's what we use at the moment....Because you give people the knowledge of what you're putting over in the training…you give them the tools and then to see if they've taken it all in, you give them a scenario and see what – you know, their answers are going to be, what their thoughts are. If you're teaching, person-centred care away from task-orientated care… you can say everything, but then at the end of the day if you're given a scenario and they say, "Well, no, breakfast is at nine" …they go to the toilet at three, you know, you haven't got anywhere…with them, but if they're thinking outside of the box by answering a scenario at the end of the training…

and I think it's right, I think scenarios are brilliant as assessment tools…they can provoke discussions.'

(Focus Group with Training Managers, Birmingham, 02/07/2010)

One aim of the package is to get away from the idea that there is only one correct answer for each dilemma given the multitude of challenges faced by care home staff during their working day. Opportunities that assist staff to work through various options for appropriate action helps them develop critical abilities and build confidence. As respondents stated:

'Because like in many things, sometimes things are more right than others, or more wrong than others, but not necessarily black and white, and you've got to help people to cope and accept that, because often – and especially the people, and I say this without meaning to be derogatory at all, often these people like black and white. The people working the sector, they want to know what the right thing to do is, and sometimes helping them to accept uncertainty, and possibility is very important for their personal development.'

(Focus Group with Care Home Managers, London, 07/07/2010)

'I meant more of like a learning – in like a learning environment. Do you know – it would be something, like if they've just started in care, they've never done care before, they've probably never, ever, ever come across any of these situations in their lives, so if they took it with them, and a bit of time, even it was given an hour out of the day or something, to go and sit have a read, and then get back afterwards and then they can ask the questions of like how they would handle it, what would be the best way to do it. Do you know, things that are a lot – so it was more like a learning and put it within their induction package. You don't need to do it all, they could just be given one scenario to go away, have a look at, write a list of questions, like a bit like what we did then, take some notes off it and then you could direct them into the right way, how you would deal with these things.'

(Focus Group with Care Home Managers, London, 07/07/2010)

Based on the ideal model of what a training package could provide, the PEACH package has been developed with the aim of helping staff understand who the residents are and what their individual care needs might be. It has been formulated specifically to help people explore the experiences of ageing and living in institutionalised care and what dignity might mean in relation to older people.

The training package is designed to be a flexible resource that can be adapted to the needs of the home and those of particular individuals. The flexibility of the package makes it possible for it to be delivered in a formal classroom based training session, or alternatively, be used as a small group or individual based approach to encourage reflective practice. Although currently text based, the vignettes can be read out by a facilitator or acted out in role play so can be helpful for staff whose first language is not English. The aim of the resource is to assist in the development of appropriate attitudes, values, problem solving skills and to promote team work and best practice. The vignettes/scenarios are designed to explore a number of issues that staff encounter in their daily working lives, such as: respectful communication; understanding and managing behaviours; team working; safe-guarding and end of life issues.

The package has been formulated with direct reference to and to support the new CQC Essential Standards criteria and the Skills for Care Common Induction Standards so that staff can develop skills and understanding in order to provide excellent care. The package has been developed to enable the group or the individual to tease out, explore and discuss the salient issues with regard to a particular topic and to encourage creativity for developing effective and collaborative approaches to care avoiding the tendency to think there is only one correct way to address care issues in all settings.

So that the staff can see the relevance of the training package to their day to day practice the training package is set in a fictitious care home with profiles of both staff and residents based on actual case studies observed during the research.

A number of vignettes are used to explore the concepts of dignity and what dignified care means in practice and to encourage reflection on the individuals in question and context. The training package has been developed to promote reflective practice and as such is based on the principles of adult learning as well as being rooted in practice and the real world of the care home.

Development of the Training Package: Content

The full package is included in this report at Appendix 11, although it should be highlighted that the research team do not see this as the definitive version. The team would wish to discuss further development with policy / accreditation bodies such as Skills for Care and CQC. The basic structure comprises an introduction outlining the overall approach and motivation for its adoption, before an outline of the structure of the package. Guidelines as to how the package might be used and facilitator guidelines are also included. There are then a number of exercises that explore various aspects of old age and dignity before introducing the fictional care home, and the residents and staff highlighted in the case studies/ vignettes.

The initial introductory exercises are aimed at exploring the characteristics of ageing and older people in order to encourage participants to think carefully about and promote understanding of who it is they are caring for and the experiences that they may have had in their lifetimes. The package then encourages an exploration of dignity and what dignified care involves. These first two sections are drawn from the Educating for Dignity Workbook (Tadd, 2005) that was compiled from research conducted in six European countries and which has been successfully used in training care home staff for five years.

The vignettes which follow are set in a fictional care home for which there are profiles of a manager, nurse, four care staff and three residents. The vignettes were drawn from specific incidents or combinations of incidents that had been observed during the study. There are ten vignettes in total that explore a number of key topics:

- Independence & control.
- Physical wellbeing / behaviour.
- Risk and fun.
- Disrespectful practice.
- Impact of staff shortage on fundamental care.
- Dealing with relatives.
- Disrespectful communication and feeding.
- Medication and challenging behaviour.
- Team work.
- End of life care.

At the end of each vignette there is a list of discussion points that the group can be encouraged to explore:

- What are the issues raised by this scenario?
- What actions would you take if you saw this happen where you work?
- How can situations such as this be prevented?
- How would you feel if this was your mother or father?
- What would you do if it was your mother or father?
- What are the issues raised by this scenario?
- Why do you think this has happened?
- How can situations such as this be prevented?
- What impact do such actions have on the person's dignity?
- Could this have been handled differently?

The vignettes are intended to facilitate discussion, directed by a facilitator who will encourage the group to recognise that often there is no single correct answer and often what is more important is that staff reflect on and think about their work and the consequences of their actions and attitudes. Further, the vignettes should help to develop team work and the sharing of ideas to improve practice. Incorporated in the guidance is a consideration of timing of the exercises, discussion of the likely responses of participants to the exercises and advice as to the ways that the vignettes can be used.

Development of the Training Package: Piloting and Evaluation

In order to evaluate and finalise the training package a piloting exercise was conducted which consisted of trialling the package in seven of the homes that had been part of the original study. The piloting was completed over November/December 2010 in eight sessions that ranged in size from three to 30 participants. During this piloting exercise 78 staff participated in half-day sessions of between three and three and a half hours in duration. Ideally one day of training would have allowed the staff more time to explore the material and experience different ways in which the material could be used, however limited resources in most homes meant that half a day was all that could be accommodated. Although it was hoped that these training sessions would cover all grades of staff within the homes, in reality it resulted in only care assistants, nurses and administrators/ managers taking part. One of the biggest barriers to more comprehensive participation in the training sessions was the ability of homes to release other staff in the face of limited resources.

Following delivery of the package staff were asked to complete a written evaluation (Appendix 10). Generally the reception of the training package was very positive with little negative feedback. Included below are examples of the positive comments gathered from the evaluation:

> "It gave us the opportunity to discuss topics together…… The training gave us the chance to understand the matter of dignity and our practice in care."

> "I liked the subjects that were raised in the training, also how we were able to discuss and talk about the issues throughout the training."

> "All realistic. It's all about exploring what, why, would you do in situ but without judging if it is a good or bad answer."

Staff indicated that they particularly liked the practice based exercises and the fact that the sessions provided them with an opportunity to discuss and explore issues as a group.

Most of the negative feedback related to the shortness of the sessions but this was due to the difficulties faced by the homes in releasing staff for longer periods, rather than the research team specifying the length of the training sessions. Indeed many staff wanted the opportunity to discuss other scenarios in the pack or to undertake additional exercises.

> "Not long enough."

> "Insufficient time to peruse all of the material."

> "Would have liked it to be slightly longer as there were good topics of conversation to be discussed."

> "The time given is not enough to discuss other scenarios."

One topic that was raised during the evaluation sessions by workers and managers and by attendees at the stakeholder workshops, was the possibility of having the training accredited to build the skills base and status of workers while providing a goal to work towards. This is something that could be investigated if the package is to be developed further.

Development of the Training Package: Stakeholder workshops

The following points were raised by attendees at the three stakeholder workshops, where the training materials were presented. Further details are provided in Appendix 1.

- The ability of the facilitator to guide discussion and manage the session is pivotal to the package's success
- The package was felt to complement messages of person-centred care
- The suggestion was made that similar material can already be found on the Social Care Institute for Excellence and Dignity in Care websites
- The package was felt to enable different interpretations based on different cultures which was seen as a strength in terms of encouraging discussion and reflective practice
- Without accreditation it was felt there was little to encourage organisations to adopt this training as opposed to those which were accredited – the suggestion was made that this could fit into the Quality Curriculum Framework, potentially in the unit 'Role of the Health and Social Care Worker', as well as within the Continuing Professional Development framework
- It was felt that having prompts and consideration points associated with the vignettes would be helpful, e.g. 'how could this situation be handled differently?'
- The package was seen as a potential discussion tool where staff can freely speak about their experiences in work, something that rarely occurs naturally
- The package was also seen as potential preparatory work with managers before taking control of homes, as well as being mentioned as forming part of an induction pack or as an ongoing supervision exercise
- The suggestion was made that reviewing the discussed points and potentially documenting the outcomes to monitor the agreed, emergent consensus on particular issues would be beneficial
- The dissemination of the package was considered to be important with downloading options being mentioned as a means of ensuring homes have access to it, as well as DVDs being seen as a potential way of delivering the vignettes

- Additional vignettes were suggested around the themes of cultural differences between members of staff, risk-taking, handling com plaints or concerns, interacting with relatives, sexual orientation/ sexuality, class, and a resident being asked to move rooms
- If used as a longitudinal exercise, the package would be a useful tool in monitoring changes in attitudes and practice over a period of time
- A concern was raised as to how to ensure the training reached struggling, smaller homes
- It was suggested that the training should be carried out within the home setting, with mentoring and continued professional development being the key focus
- That the training was potentially going to be made available for free was seen as a major benefit by a number of stakeholders

Discussion

As this chapter has highlighted when it comes to the training needs of care home workers there are a number of factors that impact directly and indirectly on the practicality and effectiveness of any training. It is vitally important that any training can be successfully implemented as part of the day to day routines of the care home setting while at the same time satisfying the training needs of the care home workers so that it can make a useful contribution to improving care.

As outlined in the early part of this chapter, the fact that there is no pre-entry training or no universally common standards of training throughout the industry, results in a situation where even if a care worker is very experienced they may need to go through the same induction procedures as someone who is new to the industry if they start in a new home. Unless the management of a home monitors or provides the training themselves they have no clear indication as to what levels of skill staff who have undertaken such training possess.

Due to the various methods of assessing and delivering training there are no verifiable methods of evaluating the effectiveness of training. Anecdotally we were told of one member of staff telling another member of staff which numbers to tick in an e-learning package delivered through a computer. Therefore, an individual could “successfully” complete a training package with little or no understanding of what it was they were being presented with.

Developing effective strategies for training delivery faces a number of challenges including the low levels of linguistic skills and the diverse nature

of the workforce. For many years the low status that the care of older people engenders is an issue that has been raised by a number of studies (Stone et al., 1987; Yaffe, 2008). As the survey data presented in this report has highlighted staff training can boost a sense of self-efficacy in participants' work, staff confidence and in turn competence. Additionally, providing staff with improved knowledge for understanding the nature of their role, gives staff a greater sense of personal accomplishment (see Chapter 3). Although realistically it cannot be expected that any training package can successfully address the issue of the status of care work in wider society the findings of this research underline the importance of effective training in helping workers to take pride in themselves and their work and therefore help teams develop a culture of providing excellent care.

Some of the owners and managers stated that the NVQ Level 2 did not satisfy their requirements. This is supported by other research (Godfrey 2001, Witton 2005) who found respectively that NVQ programmes had little effect on the experience of care received by residents and that the skills provided did not address the holistic needs of older people because some important aspects of care, for example, enabling clients to eat, drink and use toilet facilities, are not necessarily covered.

An overall theme of this research is that the vast majority of care home workers, managers and owners were trying to provide the best quality care possible in the face of limited resources. From the findings, when care quality is compromised it is normally due to a combination of a lack of resources, knowledge, experience and training. Therefore, any training package needs to equip staff with the knowledge and confidence to provide the best care within the resources available to them.

Within the three themes identified for particular focus i.e. that of dignity, respectful communication and dealing with dementia, all are contextual and should not be dealt with by formulaic responses. It is for this reason that the case study / vignette based approach was adopted so that the knowledge and experience of the group could be released and shared and also different contextual considerations could be explored.

During the research and piloting exercise it became clear that flexibility is an essential ingredient of any training package so that it can be used in different ways depending on the needs and practicalities of the particular setting and the individuals involved. This flexibility needs to address a number of different areas to ensure that the package can be used:

- by individuals or groups.
- for varying periods of time.
- as the basis for discussion.
- or individual exercises.
- as a paper exercise.
- or (with further development) as a digital learning package.

During the half-day piloting sessions it was possible to cover two of the introductory exercises and two vignettes as to cover the whole package would need two full days of training. In practice it would be possible to use elements of the training package such as individual exercises or vignettes so that even in a busy home any spare thirty minutes could be spent exploring one vignette or one exercise. Additionally, the material can be modified and added to, so that it meets the needs of individual organisations. One possible scenario discussed during the piloting exercise was that the vignettes could be constructed around a particular resident so that their care needs could be explored via a hypothetical case study. Thus the package also provides a blueprint for further development of tailored materials. By using this package staff will be encouraged to develop a number of skills including behavioural, psycho-social, attitudinal, problem solving, reflective practice and team working, all of which are essential to promote best practice.

Conclusion

As this chapter has highlighted the training provided for those who work in the care home sector is disparate and lightly regulated. For those who work in such a physically and emotionally demanding occupation, current training does not equip staff to fulfil their full potential for delivering excellent care. There are a number of specific challenges that need to be addressed for developing a pragmatic and effective training strategy for those working in the sector. The development and piloting of the approach adopted by the PEACH training package, as recounted in this chapter, seeks to address these challenges and appears to address the training needs of care home workers as identified within this study.

Although the piloting of the package has been restricted to only 7 care homes to date there appears to be great potential for this approach, as it can address the challenges that care workers face on a day to day basis while also overcoming the barriers posed by low literacy skills which can be a characteristic of the workforce. As the quote from Aristotle at the beginning of this chapter highlights it is through practice that excellence can be achieved.

CHAPTER 8

CONCLUSIONS & RECOMMENDATIONS

"People become really quite remarkable when they start thinking that they can do things. When they believe in themselves they have the first secret of success."

(Norman Vincent Peale)

Limitations

This study has explored the needs, knowledge and practices of the care home workforce and undertaken a preliminary evaluation of an evidence-based training package.

A number of difficulties were encountered in relation to engagement with the sector in terms of the postal surveys of care home owners and managers and care workers and in relation to the focus groups with care home owners and managers in which despite the widespread strategies to promote recruitment described in Chapter 2, participation was disappointing. It was originally planned to hold three rounds of focus groups with 48 care home owners and 12 representatives of the Relatives and Residents Association (RRA). In practice only 29 owners and managers participated in the focus groups. Representatives of the RRA on the other hand were very keen to be involved and 15 participated in these groups.

Most of the care homes approached to participate in the ethnographic phase of the study readily agreed to participate and welcomed the researchers into their facilities. One home that expressed interest failed to respond on follow-up and the final home insisted on additional CRB checks before agreeing to participate. Although initially it was hoped to involve homes with different star ratings this proved to be impossible so that seven homes were rated two star and one home three star. Qualitative studies rarely claim to offer generalizable findings and this study is no different in that respect. However it must be pointed out that findings may have been different in homes, which at the time were rated with one or zero stars. Although only 8 homes were involved in the ethnographic study, findings from interviews and the extensive observations were consistent across the homes and therefore can be said to be logically representative of similar homes.

Initially, the research team had hoped to invite up to 96 staff (12 in each care home) to participate in an in-depth interview and to complete a 'Well-being and job satisfaction' survey comprising six validated questionnaires. In practice great reluctance to be interviewed was encountered in all of the homes. The largest number of staff interviewed in any one home was six and the lowest was one. Reasons for this reluctance included being too busy in the working day, not wishing to be interviewed in their own time and concerns about being recorded. Researchers often felt guilty about making repeated requests to staff to be interviewed as due to

the low staffing levels in the majority of the homes, they were acutely aware that time spent in interviews was time taken from delivering care to residents. Although only 33 staff participated in interviews, seventy-three staff did agree to complete the 'Well-being and job satisfaction' survey, which although limited in terms of size provided interesting data and correlations between various characteristics of the workforce and their performance. It would be worthwhile to further test this collection of standardised questionnaires with a larger sample of care home staff.

Despite the difficulties in access described above there was a great deal of consistency in the data collected as can be seen from the previous chapters. Theoretical saturation was achieved in the qualitative data from the interview and focus group transcripts when analysed across the sources. The lengthy periods of observation proved invaluable in adding to the rigour of the study. Thus, what this study offers is thick description of the observed behaviours and care contexts of eight care homes, all of which were rated as being of at least a 'good' standard. This data was based on almost 500 hours of observation and in-depth interviews with 33 staff members. Rather than generalisability, thick description is a way of achieving transferability, by describing situations or phenomena in sufficient detail so that one can begin to evaluate the extent to which the conclusions drawn are transferable to situations with similar parameters, populations and characteristics.

In future studies of the care sector workforce it will be essential to involve wide ranging representatives from across the sector in planning studies as the research team discovered their initial targets for participation were unrealistic given the constraints under which the care home sector operates. Consideration should also be given to ways to incentivise participation in research by the care home sector.

The following discussion and suggestions for consideration are based on the evidence reported in this study.

The Key Findings

Care Home Sector Training

Existing training, both mandatory and additional appears to be task focused such as manual handling, food hygiene and health and safety with little attention being paid to training that would facilitate dignified, person centred care. Many care home owners, managers and training managers

were unhappy with the current NVQ qualification as rather than developing knowledge and skills, it focuses on experience. Thus if the experience available in a home is less than positive the learning is not effective. Also the effectiveness of NVQ qualifications depends to a great extent on the competence of the assessor and many participants expressed concerns about this aspect. Both the costs and the quality of much of the available training varied widely as did the length of time of various courses, from a few hours to a few days.

Constant change with regard to training requirements was bemoaned by many participants. A recent example being the new requirement to complete the mandatory induction training in 12 weeks rather than the previous six, which means that someone can enter care work without any previous experience or training but be providing care directly to residents for three months. The lack of audit in relation to meeting mandatory training requirements means that in some homes 'tick box' approaches such as e-learning and L-boxes are used without any check on the acquired learning or understanding. Thus a great deal of inconsistency exists in the area of training. The lack of any required qualification for entry into social care is a source of concern for many providers and there is considerable confusion about funding for training. The switch to the Qualifications and Credit Framework (QCF) which is currently taking place adds to the general confusion. Within this framework there will be new Health and Social Care level 2 and 3 diplomas to replace the Health and Social Care (HSC) NVQs level 2 and 3. The diplomas are made up of nine mandatory units and a range of optional units. The mandatory units are targeted to meet the Common Induction Standards (CIS) and are common to everyone regardless of the specific sector in which they are working. Many providers want to see better standardisation of training within the sector.

Training Needs of the Care Sector Workforce

Although the majority of the staff who completed **th**e 'Well-being and job satisfaction' survey reported positive attitudes towards ageing and dementia care, high levels of personal accomplishment, low levels of emotional exhaustion and depersonalisation, and a strong sense of mastery there were some important variations that should be noted especially in relating to training provision. Nearly a third (29 per cent) had a moderate to high degree of burnout, in terms of reporting feelings of emotional exhaustion, 21 per cent in terms of feelings of depersonalisation and 43 per cent in terms of reduced personal accomplishment. The correlations identified that negative attitudes to ageing were associated with lower

levels of personal accomplishment and higher levels of depersonalisation. A noteworthy minority of the respondents had high scores on depersonalisation, personal accomplishment and high levels of emotional exhaustion. Clearly a number of the respondents were experiencing some level of burnout, which in turn could negatively influence the level of care provided. It appears that a lack of personal accomplishment is most prevalent and an aim of staff training should be to try to boost a sense of self-efficacy in participants' work. The significance of these findings suggest that better preparation is implicated in positive approaches to care, mastery and personal accomplishment and therefore quality of care provision.

In relation to approaches to training the majority of staff interviewed disliked e-learning or being sat in front of a computer ticking boxes. Many found that existing training, even mandatory skills such as lifting and handling did not really prepare them for using equipment and such like in practice where they had to work with very frail, physically impaired or uncooperative residents. Added to this, the low level of language and literacy skills of many staff meant that approaches which only relied on text based approaches were less effective. Instead staff wanted the opportunity to discuss the practical issues and concerns they faced in their day to day experience with colleagues and experienced and knowledgeable personnel.

In terms of content, the majority of care workers, both surveyed and interviewed wanted further dementia training including communicating with people with dementia, managing aggression and challenging behaviour, providing activities and end of life care. Other requests included practical skills such as catheterisation, infection control, nail care, wound care, venepuncture and nutrition, as well as other aspects such as providing dignified care, safeguarding, dealing with staff bullying and understanding 'how old people in a home must feel.'

Observation of care practices confirmed the lack of knowledge and skills in relation to many of these topics. For instance, many staff struggled to deal with both aggression and challenging behaviour; examples of undignified care were often the result of naive understandings of what dignity entails, rather than uncaring or callous actions. Similarly, examples of poor communication practices such as elderspeak were common and in some homes inappropriate activities such as making 'mother's day' cards were engaged in. Further, some staff displayed attitudes which portrayed little understanding of ageing and/or older people or that the care home was actually the residents' home. Some practices, such as the restriction of people's movements especially the freedom to go outside or 'barricading' residents at risk of falling, and removing residents' property such as

cigarettes, resulting in people having to ask for their own property, demonstrates a poor understanding of both human rights and dignity or indeed policies which require that older people are entitled to take reasonable risks.

The Care Home Sector

As well as training, the care sector overall is faced with constant change and inconsistency. These are experienced in many aspects of care home provision including the way in which people are assessed for care, the way services are inspected and regulated and in the way in which Local Authorities determine the fees payable so that something of a postcode lottery exists. Added to this the dependence of residents is continually increasing; and inspection policies and processes are changing. These changes and inconsistencies are well documented in the Wanless review of social care (King's Fund, 2006) which suggests that the constant change and fragmentation is challenging for providers, making it difficult for them to keep up to date, meet changing responsibilities and plan for the future. This state of affairs also impacts on relatives who are also confused about many aspects of provision, what to expect from various providers and how the various charging policies are determined. The low levels of fees paid by some Local Authorities result in a number of injustices in the system as many self-funding residents are subsidising staff training and activities for Local Authority funded residents.

Life and Work in the Care home: Being a Home

Despite the challenges described above, the care home sector must continue to provide a 'home' and meet the needs of the older people that it serves. Because many older people spend the majority of their time within the confines of the home, the physical characteristics of the home have a significant impact on residents with physical and/or cognitive impairment and on the quality of care delivered by staff. The physical differences between the homes made an immediate impression on each of the researchers. Most homes were designed to maximise the experience of choice and control for residents, their privacy, and sense of community. In particular choice about using outside space was most obviously restricted in some homes, even when gardens were safely enclosed and where only one lounge was available there was limited choice for residents to exercise in relation to association. In one home, privacy for the most basic functions was restricted by removing locks from toilet doors and residents' sense of self was impaired by removing personal toiletries for no obvious reason.

Life and Work in the Care Home: Work

Work organisation and workload are important factors in relation to the quality of care delivery to residents. It is also important in relation to staff stress and burnout. Findings showed that for many care workers, especially those from a multi-cultural background, the experience of racism added to staff stress and impacted not only on the quality of care, but also on retention.

In two homes where teamwork was well developed, staff were empowered and better prepared to make work-related decisions and work more flexibly, rather than adhering to strict routine. Essential for effective team-working is a supportive management culture where staff have positive role models, are mentored and supervised. In 50 per cent of the homes, it was rare to observe managers 'out on the floor', and these were the homes where there was evidence of a number of tensions and conflicts amongst the staff which did not appear to be well managed. This impacted on the quality of care delivered to residents, which while far from abusive, did not measure up to excellence.

Most of the homes were hierarchical in their organisation, with little team working between senior staff, including nurses, and care workers. Instructions in relation to work tended to be passed down to care assistants who were not involved in care planning. In all homes care was task focused, concentrating on getting the jobs done rather than on meeting residents' individual needs and staff talked about their work mainly in terms of a series of tasks to be carried out. Care was of a higher standard where staffing levels were high (Home 2) and often this was related to the fact that staff had more time available to spend in direct contact with residents, talking to them and coming to know them as individuals. In most homes, staff complained of having little time available to spend with residents. There was little evidence of quality improvement initiatives being adopted in the care homes.

The care home workforce in this study appeared to be at risk of significant stress and burnout, due to workload and tensions and conflicts, which did not appear to be well managed. In relation to staff, there was a recognition that 'not everyone is cut out for caring' and in general, they saw their job as difficult, but with some rewarding aspects. Staff attitudes were influenced by organisational factors such as: pressure from management to get the tasks and 'measurable' aspects of work completed; lack of communication and information; staff tensions and conflicts; lack of time and low levels of staffing; poor working conditions and unmet training needs especially in

relation to dementia care and challenging behaviour. Pressures such as staff shortages resulted in care workers: feeling rushed, feeling 'torn'; cutting corners to get the job done by for example speed feeding; juggling the needs of different residents; and reducing independence as it was quicker to do 'to' someone than do 'with' someone. Staff identified such pressures as being one reason for abuse or neglect happening.

Resident Behaviour

Another aspect of care work that significantly impacted on both the work of staff and the stress that they experienced was resident behaviour. Positive impacts were found when residents expressed their appreciation for staff and satisfaction with care home life, however the daily occurrences of difficult or aggressive episodes were particularly challenging, whether these were directed towards the staff or other residents, especially when most staff lacked the skills to deal with this aspect of care.

In particular, resident-to-resident aggression was a prevalent and problematic phenomenon often occurring in communal areas such as the dining or lounge areas or due to one resident taking someone else's property such as Zimmer frames which in some homes were in short supply as was adaptive cutlery and other equipment which could promote residents' independence.

Staff Behaviour

Overall the care home workforce within the eight participating care homes were hard working and committed to providing the best care possible within the situation in which the individuals worked. Where care practices that left something to be desired existed, these were largely due to a lack of training or policies within the home, rather than outright uncaring or callous attitudes.

There were many examples of 'responsiveness to individuals' and of staff being polite and pleasant, with caring and empathic responses also observed frequently. However, patronising and condescending behaviour was also observed including the frequent use of elderspeak; talking about residents not to them; not allowing decision making or risk taking; and disregarding residents' opinions.

Many examples of staff empowering residents were observed throughout the study. The most common examples involved eating and drinking when residents were given a choice of what to eat; the opportunity to feed oneself; appropriate assistance or utensils to promote self-care, such as plate guards or modified cutlery; providing alcohol if desired; giving a choice about wearing protective clothing and having food and drinks available on a self-service basis.

Other ways in which staff tried to empower people included explaining things and offering information and choices, promoting independence, promoting confidence, asking the person for their opinion, accepting refusals and offering choice in what to wear, when to get up and go to bed and in what they would like to do.

However, practices that disempower residents were also evident in each of the care homes including: contradicting what residents were saying; patronising them in a number of ways; and not listening to them or their wishes. Lack of staff resources led to a lack of time, which in turn led to resident disempowerment as staff felt it was quicker to do things for residents rather than promote independence. Other ways in which staff disempowered residents was in the use of elderspeak or disrespectful communication by using patronising language such as pet names, scolding, outpacing, speaking to residents as though they were children, making jokes at the residents' expense, talking about people as if they weren't there and asking questions about them rather than to them. Sometimes staff failed to ascertain what residents were trying to do, and instead made assumptions without checking these with residents. One of the most disempowering actions observed was when residents were made to soil themselves rather than being taken to the toilet, or when privacy was denied by the removal of locks on toilet doors.. This is clearly an abuse of an individual's human rights and their most fundamental dignity and should not be tolerated under any circumstances. Encouraging soiling of incontinence pads occurred on night duty and appeared to be seen as easier than helping someone to use the toilet. Staff need to understand the impact of such practices on an older person and therefore mandatory training should include specific themes beyond those that are task focused, and which promote a more holistic approach to understanding residents' needs.

There were also examples of staff being disempowered by management including: public dressing downs; not being listened to; and feeling that they had no voice.

Despite these difficulties faced by staff, many care workers displayed great empathy in the way in which they treated residents: by noticing distress; recognising the person in simple ways such as saying 'hello' in corridors and explaining situations to residents, even when cognitive impairment made it difficult for them to understand.

The role and contribution that the majority of relatives made to the continued care of the older person was also significant including their role as arbiter of standards, helpful informant about the life of residents, standing in for staff in observing residents. However staff need to remain alert to the actions of a minority of relatives in relation to abuse or disempowerment of residents.

Development of the Training Package

Taking into account the fact that often care workers' first language is not English, or literacy levels may be below average, training that can be modified to minimise reliance on text based approaches will be most efficacious.

Discussions with staff, together with the observations undertaken in the eight care homes, indicated that the factors that impacted most on providing quality care were the lack of resources, knowledge, experience and training. The areas where excellent care could be compromised particularly occurred in the fields of:

- Respectful communication.
- Limited understanding of what constitutes dignified care.
- A tendency of homes to encourage task based approaches to care delivery.
- Dealing with challenging behaviour and dementia.
- The impact that risk management has on resident choice and experience.

Staff stated that their experience of training had not been particularly positive. A number of themes emerged most notably that training content and delivery methods did not address daily practice and experience, i.e. the actual challenges that staff face on a daily basis. Often staff stated that they were expected to undergo training by sitting in front of a computer following an e-learning package. The prevalent view was that this was done to save the home money, while at the same time being able to claim that staff had undergone training. Although staff felt that e-learning probably

did have a place particularly in refresher training and for self-study, generally there was a negative attitude towards it. Instead, staff expressed the wish for more face to face and group based training activity that would provide the opportunity to discuss the situations that they face in practice. Staff in general indicated that the most useful and enjoyable training, with which they connected most, was that based on the reality of day to day practice. Delivery method was also an important consideration. Feedback from focus group participants highlighted the importance of training that enabled staff to comprehensively examine issues rather than being provided with pat answers.

Therefore, any package would need to:

- Contribute to excellent care.
- Be capable of being used flexibly.
- Be effective for people whose first language is not English or those with low literacy skills.
- Promote reflective practice.
- Be low cost.
- Capable of being delivered “in house”.
- Possibly be delivered “in peer groups”.
- Build group dynamics and develop team working.
- Reflect care workers’ day to day realities.
- Equip staff with the knowledge to provide best care within the resources available to them.
- Promote confidence and a sense of achievement.
- Comply and promote the new CQC Essential Standards and Skills for Care Common Induction Standards.

In relation to flexibility any training package needs to address a number of different areas to ensure that the package can be used:

- by individuals or groups.
- for varying periods of time.
- as the basis for discussion.
- or individual exercises.
- as a paper exercise.
- or (with further development) as a digital learning package.

Issues for consideration

From the evidence in this study we recommend the following issues for consideration:

1 Given the general high turnover of staff in the care home sector and the varying costs associated with training provision, we would advocate that mandatory training should include specific themes beyond those that are task focused and which promote a more holistic approach to understanding residents' needs. In particular the following aspects should be included: Respectful communication; dignity and dignified care; dealing with challenging behaviour; understanding risk management.

2 All care workers working with older people should be trained in caring for people with dementia. This is supported by the findings from a survey of what is important for the quality of life for people with dementia (Alzheimer's Society, 2010). This training should include an understanding of the significance of the Mental Capacity Act for day-to-day care practice.

3 Ideally care workers should complete a recognised pre-entry training before entering the workforce, however the researchers recognise that this would involve a considerable cost. Consideration should therefore be given to ensuring that care workers complete the induction training before working with residents.

4 Valuing staff, building their sense of self-efficacy, self-worth and personal accomplishment would have potentially a great impact on quality of life for residents. Staff often do good work, but this is less likely to be acknowledged than the lapses in care. Consideration should be given to developing a recognised career structure and pay structure for care workers which would help to promote a sense of accomplishment and increased self esteem and ultimately reduce burnout.

5 Measures to increase standardisation in terms of required staffing levels, fee structures and training, would make a positive impact on providers, service users and their families, as well contributing to improved quality of care.

6 Training to enable managers to support workers, promote team working, promote quality outcomes together with an environment that enables residents to feel at home should be considered. Leadership and modelling of appropriate attitudes and behaviour are key to improving care quality.

7 Greater attention should be given to developing positive relationships between relatives and care homes, so that residents may benefit from the involvement of their relative(s). This might take the form of a structured programme as well as more informal contacts and communication.

8 The PEACH training materials could be further developed, with consideration given to issues of accreditation, attitudes, skills and training needed by group facilitators, and reducing the reliance on text in delivery. This would benefit from a thorough evaluation of effectiveness. In addition, exploring how PEACH could link in with My Home Life would be extremely beneficial and avoid any unnecessary duplication of efforts.

9 Greater emphasis in training for care staff needs to be placed on non-managerial supervision and reflective practice, rather than 'tick box' approaches to the acquisition of skills and knowledge. There are aspects of the work that are difficult, and may have an emotional cost, especially when it seems that nobody - residents, relatives, colleagues or the wider community - appears to value the work undertaken. Staff should have the opportunity to reflect on, and discuss with colleagues, the impact on them of their work.

10 Attention needs to be given to ensuring that a broad perspective on dignity is brought to the fore in the care home sector. This needs to go beyond important issues of privacy and dignity during personal care, to consider also the maintenance of personal identity and preferences and the avoidance of 'elderspeak'. Further research on the impact of 'elderspeak' in the UK context would be helpful.

Dissemination

The project's plans for dissemination are detailed in Appendix 12. These include:

1 Stakeholder workshops held in Bimingham, Bristol and London. A full report of these workshops is given in Appendix 1. However, it is important to note that these workshops were extremely valuable in allowing us to validate and hone our findings and discuss and refine our conclusions.

2 Once approved, the study report will be available on the website of the PANICOA programme, as well as Cardiff and Bangor University websites. The study report will be printed and circulated to those participants who have requested copies.

3 Developing publication of the training package piloted during the latter phase of the research and presented at the workshops (see Appendix 1). Many participants reacted positively to the package but discussed the possibility of accreditation. It is hoped that this possibility can be explored within the PANICOA initiative as a practical, evidence-based output to promote excellence in the care home sector.

4 Research briefs will be prepared for voluntary organisations, care home staff, the public and older people.

5 Final Project Conference – A final project conference is planned. Invitations will be sent to all care home sector organisations, local authorities and other interested parties.

6 The project findings will be available on the websites of Cardiff and Bangor Universities.

7 Academics and care home providers in Falun and Stockholm Sweden have visited and expressed considerable interest in collaborative working to develop a European model of excellence in care home training and practice, and discussions are ongoing.

8 Presentations and Publications: The research team have developed a comprehensive publication plan to ensure maximum coverage. Abstracts will be submitted to appropriate conferences, especially those aimed at the care home sector and organisations representing them. A number of peer reviewed and professional journals have been identified as potential targets and decisions will be made as to those representing the most appropriate choices.

9 A number of peer reviewed and professional journals have been identified as potential targets and decisions will be made as to those representing the most appropriate choices.

Conclusion

The major strength of the PEACH project is that it is based on extensive and in-depth observations of daily life in eight care homes across England. This provided clear evidence of the challenges experienced by staff working in this context, and demonstrated the range of influences on staff behaviour. There were many examples observed of care delivered in a respectful, person-centred manner, but also a significant number of examples of interactions and practices that diminished dignity. These findings informed the initial development stages of a training package that encourages reflection and consideration of the resident's perspective, and which has been field-tested and subject to scrutiny and feedback from a wide range of stakeholders, whose involvement has added greatly to the relevance and applicability of the work undertaken. There is a plethora of training materials available for care home staff. PEACH is distinctive in that it is drawn from detailed observations of daily life in care homes, focuses on enhancing dignity in day-to-day interactions and forms a basis for reflective discussion and peer supervision – an important area for enhancing good practice in care homes.

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List of Abbreviations

ADQ	Approaches to Dementia Questionnaire
CHAI	Commission for Healthcare Audit and Inspection
CIS	Common Induction Standards
COSHH	Control of Substances Hazardous to Health
CQC	Care Quality Commission
CSCI	Commission for Social Care Inspection
DCM	Dementia Care Mapping
DH	Department of Health
DOE	Dignity and Older Europeans
DOLS	Deprivation of Liberty Safeguards
DWP	Department for Work and Pensions
EEA	European Economic Area
ECCA	English Community Care Association
EMI	Elderly Mentally Infirm
FA	Framework Analysis
HSC	Health and Social Care
GHQ	General Health Questionnaire
GSCC	General Social Care Council
HCHC	House of Commons Health Committee
LA	Local Authority
LFS	Labour Force Survey
MCA	Mental Capacity Act
MHC	Mental Health Commission
MHL	My Home Life
NCA	National Care Association
NCF	National Care Forum
NMC	Nursing and Midwifery Council
NMDS-SC	National Minimum Data Set for Social Care
NVQ	National Vocational Qualifications
OFT	Office of Fair Trading
ONS	Office for National Statistics
OPDM	Office of the Deputy Prime Minister
OPSI	Office of Public Sector Information
PANICOA	Prevention of Abuse and Neglect in the Institutional Care of Older Adults
PEACH	Promoting Excellence in all Care Homes
POVA	Protection of Vulnerable Adults
QCF	Qualifications and Credit Framework
R&RA	Resident and Relatives Association
RNHA	Registered Nursing Home Association

SCIE	Social Care Institute for Excellence
SfC	Skills for Care's
SOVA	Safeguarding of Vulnerable Adults
SSI	Social Services Inspectorate
UK	United Kingdom